



The Sister Study

Health, Medical History and Lifestyle

A-Version 2

Instructions:

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

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

Like this: ●

Not like this: ⊗ ✓

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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Version 2A

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

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, BELOW**

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?

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 bone density scan or osteoporosis screening?	<input type="radio"/>	<input type="radio"/>
d. had a screening colonoscopy or sigmoidoscopy exam?	<input type="radio"/>	<input type="radio"/>
e. had a flu vaccination (either a flu shot or nasal spray)?	<input type="radio"/>	<input type="radio"/>
f. 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, Medicaid or Affordable Care Act (ACA)?

- 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, 2014, 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)?

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POUNDS

7. What is your current height? Please round to the nearest inch.

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FEET INCHES



FAMILY MEDICAL HISTORY

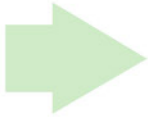
8. Since January 1, 2014, were **any** of your sisters diagnosed with breast cancer **for the first time**?
- No
 - Yes

9. In all, how many of your full or half sisters, living or deceased, have ever been diagnosed with breast cancer?
- None
 - 1
 - 2
 - 3
 - 4
 - 5 or more

10. Since January 1, 2014, have any **other** close blood relatives of yours been diagnosed with breast cancer **for the first time**?

No → **GO TO QUESTION 11**

Yes



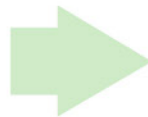
10a. What is/are the relative(s)' relationship to you?
(Please mark all that apply.)

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

11. Since January 1, 2014, 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



12. Have **any** of the following blood relatives: specifically your mother, father, sister, brother, daughter, or son **ever been diagnosed with...**

(Please mark a response for each item below.)

	NO	YES
a. Parkinson's disease?	<input type="radio"/>	<input type="radio"/>
b. Alzheimer's disease?	<input type="radio"/>	<input type="radio"/>
c. diabetes?	<input type="radio"/>	<input type="radio"/>
d. heart disease?	<input type="radio"/>	<input type="radio"/>
e. a stroke?	<input type="radio"/>	<input type="radio"/>
f. ovarian, fallopian tube, or primary peritoneal cancer?	<input type="radio"/>	<input type="radio"/>
g. cervix or cervical cancer?	<input type="radio"/>	<input type="radio"/>
h. uterus or endometrial cancer?	<input type="radio"/>	<input type="radio"/>
i. prostate cancer?	<input type="radio"/>	<input type="radio"/>
j. testicle or testicular cancer?	<input type="radio"/>	<input type="radio"/>
k. colon, bowel, or rectal cancer?	<input type="radio"/>	<input type="radio"/>
l. lung cancer?	<input type="radio"/>	<input type="radio"/>
m. leukemia or blood cancer?	<input type="radio"/>	<input type="radio"/>
n. non-Hodgkin's lymphoma?	<input type="radio"/>	<input type="radio"/>
o. Hodgkin's disease?	<input type="radio"/>	<input type="radio"/>
p. melanoma?	<input type="radio"/>	<input type="radio"/>
q. bladder cancer?	<input type="radio"/>	<input type="radio"/>
r. another cancer? Do not include non-melanoma skin cancer (basal or squamous cell carcinoma).	<input type="radio"/>	<input type="radio"/>

Please specify what type(s) of other cancer:

1).

2).

3).



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, 2014**.

Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
13. breast cancer? Please do not include in situ cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
14. ductal (breast) carcinoma in situ (DCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
15. lobular (breast) carcinoma in situ (LCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
16. lung cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
17. ovarian cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
18. cancer of the uterus or endometrium? Please do not 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, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
19. cancer of the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
20. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
21. non-Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
22. leukemia?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
23. thyroid cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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; 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="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 style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div>
24. melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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; 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="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 style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div>
25. skin cancer (not melanoma)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014 If diagnosed before January 1, 2014, was it... (Please mark all that apply.) <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?	<input type="radio"/> Diagnosed January 1, 2014 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; 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="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 style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div> <p style="margin-top: 10px;">Was it... (Please mark all that apply.)</p> <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?
26. any other type of cancer not already listed?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014 If diagnosed before January 1, 2014, please specify what type(s) of cancer: 1). <input style="width: 150px; height: 20px;" type="text"/> 2). <input style="width: 150px; height: 20px;" type="text"/>	<input type="radio"/> Diagnosed January 1, 2014 or later If you were diagnosed with any other type(s) of cancer January 1, 2014 or later, please specify what type(s) of cancer: 1). <input style="width: 150px; height: 20px;" type="text"/> 2). <input style="width: 150px; height: 20px;" type="text"/>	<div style="display: flex; align-items: center; margin-bottom: 20px;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; 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="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 style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div> <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; 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="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 style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div>



27. Has a doctor or other health professional ever told you that you had high cholesterol or borderline high cholesterol?

No → GO TO QUESTION 29

Yes



Has a doctor or other health professional ever told you that you had...	NO	YES	a. What month and year were you diagnosed?	b. Have you ever used any prescription medications for this condition?	c. <i>If yes</i> , are you currently taking prescription medications?
28. high cholesterol (not borderline)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> / <input type="text"/> MONTH YEAR	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

Has a doctor or other health professional ever told you that you had...	NO	YES	b. Have you ever used any prescription medications for this condition?	c. <i>If yes</i> , are you currently taking prescription medications?
29. hypertension or high blood pressure?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed before January 1, 2014 <input type="radio"/> Yes, first diagnosed January 1, 2014 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> a. What month and year were you diagnosed? <input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
30. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed before January 1, 2014 <input type="radio"/> Yes, first diagnosed January 1, 2014 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> a. What month and year were you diagnosed? <input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



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?	c. Have you ever used any prescription medications for this condition?	d. <i>If yes</i> , are you currently taking prescription medications?
31. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2014 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2014 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> a. What month and year were you diagnosed? <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; 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="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> MONTH YEAR </div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
32. angina?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2014 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2014 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> a. What month and year were you diagnosed? <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; 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="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> MONTH YEAR </div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional ever told you that you had...	NO	YES	a. If you had this January 1, 2014 or later, what was the month and year?
33. 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, 2014 <input type="radio"/> Yes, my <u>first</u> heart attack was January 1, 2014 or later →	<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="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="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; width: 100%; margin-top: 5px;"> MONTH YEAR </div>
34. 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, 2014 <input type="radio"/> Yes, my <u>first</u> stroke was January 1, 2014 or later →	<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="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="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; width: 100%; margin-top: 5px;"> MONTH YEAR </div>
35. 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, 2014 <input type="radio"/> Yes, my <u>first</u> mini-stroke was January 1, 2014 or later →	<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="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="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; width: 100%; margin-top: 5px;"> MONTH YEAR </div>

Have you ever had...	NEVER OR BEFORE 1/1/2014	HAD PROCEDURE 1/1/2014 OR LATER	a. If you had this procedure January 1, 2014 or later, what was the month and year?
36. a 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, 2014	<input type="radio"/> Had procedure January 1, 2014 or later	<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="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="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; width: 100%; margin-top: 5px;"> MONTH YEAR </div>
37. a coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2014	<input type="radio"/> Had procedure January 1, 2014 or later	<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="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="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; width: 100%; margin-top: 5px;"> MONTH YEAR </div>

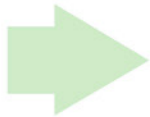


Has a doctor or other health professional ever told you that you had...	NO	YES	b. Do you still have this condition?														
38. diabetes? <i>If no, were you ever told that you had pre-diabetes, borderline diabetes, or an elevated A1C test?</i> <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2014 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2014 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="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;">MONTH</td> <td></td> <td colspan="4" style="text-align: center;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														

39. Did you **ever** take insulin for diabetes? Only answer this question if you have ever been diagnosed with diabetes.

No → **GO TO QUESTION 40 ON NEXT PAGE**

Yes



39a. When did you first use insulin?
 /
 MONTH YEAR

39b. Do you **currently** take insulin?
 No
 Yes



40. Have you **ever** used any other prescription medications for diabetes? Only answer this question if you have ever been diagnosed with diabetes.

No → **GO TO QUESTION 41 ON NEXT PAGE**

Yes



Have you ever taken the following prescription medications for diabetes?	NO	YES	a. If yes, are you currently taking this medication?
a. Metformin monotherapy: Metformin (Glucophage), Metformin liquid (Riomet), or Metformin extended release (Glucophage XR, Fortamet, Glumetza)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
b. Metformin combination therapy: Pioglitazone & metformin (Actoplus Met), Glyburide & metformin (Glucovance), Glipizide & metformin (Metaglip), Sitagliptin & metformin (Janumet), Saxagliptin & metformin (Kombiglyze), or Repaglinide & metformin (Prandimet)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
c. Sulfonylureas: Glimepiride (Amaryl), Glyburide (Micronase, DiaBeta), Glipizide (Glucotrol), or Micronized glyburide (Glynase)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
d. DPP-4 inhibitors: Sitagliptin (Januvia), Saxagliptin (Onglyza), or Linagliptin (Tradjenta)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
e. Thiazolidinediones: Pioglitazone (Actos)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
f. GLP-1 analogs: Exenatide (Byetta, Bydureon), Liraglutide (Victoza, Saxenda)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
g. Other, please specify: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER								
41. Parkinson's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later ↓ a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed? <div style="text-align: center;"> <table border="1" style="display: inline-table; margin-right: 10px;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center;">MONTH</td></tr> </table> / <table border="1" style="display: inline-table; margin-left: 10px;"> <tr><td style="width: 20px; height: 20px; text-align: center;">2</td><td style="width: 20px; height: 20px; text-align: center;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center;">YEAR</td></tr> </table> </div>			MONTH	2	0			YEAR
MONTH										
2	0									
YEAR										

42. Have you ever used any prescription medications for Parkinson's disease? Only answer this question if you have ever been diagnosed with Parkinson's disease.

No → GO TO QUESTION 43 ON NEXT PAGE

Yes



Have you ever taken the following prescription medications for Parkinson's disease? <i>Please only report medication as YES if taken for Parkinson's disease.</i>	NO	YES	a. If yes, are you currently taking this medication?
a. Carbidopa or levodopa such as Sinemet, Stalevo, or Parcopa	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
b. Pramipexole or Mirapex	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
c. Ropinirole or Requip	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
d. Pergolide or Permax	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
e. Selegiline such as Eldepryl or Zelapar	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
f. Rasagiline or Azilect	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
g. Trihexyphenidyl such as Artane, Amantadine, or Symmetrel	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



Have you ever had...	NEVER OR BEFORE 1/1/2014	1/1/2014 OR LATER	a. What was the month and year that this first happened since January 1, 2014?	b. How many times has this happened since January 1, 2014?
43. a hip fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2014	<input type="radio"/> January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES
44. a wrist fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2014	<input type="radio"/> January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES
45. a spine (vertebral) fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2014	<input type="radio"/> January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES
46. a rib fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2014	<input type="radio"/> January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES

	NO	YES	a. If yes, how many times?	b. Age at first injury?	c. Age at most recent injury?
47. Have you ever had a serious head injury that resulted in unconsciousness, coma, or hospitalization?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="text"/> <input type="text"/> AGE	<input type="text"/> <input type="text"/> AGE

48. How many times have you fallen in the past 12 months?

None → GO TO QUESTION 49 ON NEXT PAGE

Once

Twice

Three or more



48a. Did you seek medical care as a result of any of your falls?

No
 Yes



Have you ever...	NO	YES	b. Have you lost any adult teeth in the past 12 months?
49. 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, <u>first</u> lost any adult teeth <u>before</u> January 1, 2014 <input type="radio"/> Yes, <u>first</u> lost any adult teeth January 1, 2014 or later ↓ a. What month and year did you first lose any adult teeth? <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; 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="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 style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes

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?
50. periodontal (gum) disease?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2014 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; 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="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 style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes

	NO	YES	b. Have you had this condition in the past 12 months?
51. depression?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2014 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; 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="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 style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes c. Have you taken medication for depression in the past 12 months? <input type="radio"/> No <input type="radio"/> Yes



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?														
52. asthma?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> January 1, 2014 <input type="radio"/> Yes, first diagnosed January 1, 2014 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 c. Have you taken medication for asthma in the past 12 months? <input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														

Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 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, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<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>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
54. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<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>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
55. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<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>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														



56. Have you **ever** been diagnosed with a thyroid condition, such as Graves' disease, Hashimoto's thyroiditis, thyroid nodules, or another thyroid problem? Do not include thyroid cancer.

No → **GO TO QUESTION 60 ON PAGE B-12**

Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
a. Graves' disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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; font-size: small;"> MONTH YEAR </div>
b. other hyperthyroidism (overactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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; font-size: small;"> MONTH YEAR </div>
c. Hashimoto's thyroiditis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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; font-size: small;"> MONTH YEAR </div>
d. other hypothyroidism (underactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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; font-size: small;"> MONTH YEAR </div>
e. an enlarged thyroid or goiter?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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; font-size: small;"> MONTH YEAR </div>
f. thyroid nodules? <i>If diagnosed, was it called "toxic"?</i> <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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; font-size: small;"> MONTH YEAR </div>
g. another thyroid problem? Please do not include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<p>a. MONTH/YEAR DIAGNOSED</p> <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; font-size: small;"> MONTH YEAR </div> <p>b. Please specify the problem:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>



57. Have you **ever** used any prescription medications to treat a thyroid condition? Only answer this question if you have ever been diagnosed with a thyroid condition.

No → **GO TO QUESTION 58**

Yes



Have you ever taken the following prescription medications for a thyroid condition?	NO	YES	a. If yes, are you currently taking this medication?
a. Levothyroxine, such as Levothroid, Levo-T, Levoxyl, Synthroid, Tirosint, or Unithroid	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
b. Propylthiouracil/PTU such as Propycil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
c. Methimazole/MMI such as Tapazole	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
d. Other, please specify: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

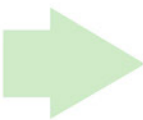
58. Only answer this question if you have ever been diagnosed with a thyroid condition. Have you **ever** received...

	NO	YES	If yes, what year?
a. radioactive iodine (I131) therapy for a thyroid condition?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> YEAR
b. thyroid surgery (partial or resection) for a thyroid condition?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> YEAR

59. Have you **ever** taken medication(s) that caused your thyroid problems such as Lithium/Lithobid, or Amiodarone/Cordarone? Only answer this question if you have ever been diagnosed with a thyroid condition.

No → **GO TO QUESTION 60 ON NEXT PAGE**

Yes



59a. Did your thyroid problem go away after stopping medications such as Lithium/Lithobid, or Amiodarone/Cordarone?

No
 Yes
 Have not stopped medication



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER
60. rheumatoid arthritis? Do not include osteoarthritis.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later ↓ a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed? <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; 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="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 style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> MONTH YEAR </div>

61. Have you **ever** used any prescription medications to treat rheumatoid arthritis? Only answer this question if you have ever been diagnosed with rheumatoid arthritis.

No → **GO TO QUESTION 62 ON NEXT PAGE**

Yes



Have you ever taken the following prescription medications for rheumatoid arthritis? <i>Please only report medications as YES if taken for rheumatoid arthritis.</i>	NO	YES	a. If yes, are you currently taking this medication?
a. Hydroxychloroquine or chloroquine, also called Plaquenil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
b. Methotrexate, also called Rheumatrex or Trexall	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
c. Biologics, given by infusion or injection, such as Remicade, Humira, Enbrel, or other If other, please specify: <input style="width: 200px; height: 20px;" type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
d. Corticosteroids, such as prednisone or solumedrol, either oral or intravenous (but not by injection, for example in a joint)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?	b. Have you ever used any prescription medications to treat this condition?	c. <i>If yes</i> , are you currently taking this?
62. osteoarthritis (age-related arthritis)? Do not include rheumatoid arthritis.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
63. osteoporosis (bone loss, or bone thinning)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes	Do not count calcium or Vitamin D. <input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
64. osteopenia, or low bone density?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes	Do not count calcium or Vitamin D. <input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
65. multiple sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
66. scleroderma or systemic sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER								
67. systemic lupus erythematosus (SLE)? Do not include discoid lupus.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later ↓ a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed? <div style="text-align: center;"> <table border="1" style="display: inline-table; margin-right: 10px;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center;">MONTH</td></tr> </table> / <table border="1" style="display: inline-table; margin-left: 10px;"> <tr><td style="width: 20px; height: 20px; text-align: center;">2</td><td style="width: 20px; height: 20px; text-align: center;">0</td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="text-align: center;">YEAR</td></tr> </table> </div>			MONTH	2	0			YEAR
MONTH										
2	0									
YEAR										

68. Have you ever used any prescription medications to treat systemic lupus erythematosus (SLE)? Only answer this question if you have ever been diagnosed with systemic lupus erythematosus (SLE).

No → **GO TO QUESTION 69 ON NEXT PAGE**

Yes



Have you ever taken the following prescription medications for systemic lupus erythematosus (SLE)? <i>Please only report medications as YES if taken for systemic lupus erythematosus (SLE).</i>	NO	YES	a. If yes, are you currently taking this medication?
a. Hydroxychloroquine or chloroquine, also called Plaquenil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
b. Methotrexate, also called Rheumatrex or Trexall	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
c. Biologics, given by infusion or injection, such as Benlysta or other If other, please specify: <input style="width: 200px; height: 20px;" type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
d. Azathioprine, also called Imuran, Cellcept, Cytoxan, or Cyclosporine	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
e. Corticosteroids, such as prednisone or solumedrol, either oral or intravenous (but not by injection, for example in a joint)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER														
69. Sjögren's syndrome?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later ↓ a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed? <div style="text-align: center;"> <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; text-align: center;">/</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">MONTH</td> <td></td> <td colspan="2" style="text-align: center;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0												
MONTH			YEAR													

70. Have you **ever** used any prescription medications to treat Sjögren's syndrome? Only answer this question if you have ever been diagnosed with Sjögren's syndrome.

No → **GO TO QUESTION 71 ON NEXT PAGE**

Yes



Have you ever taken the following prescription medications for Sjögren's syndrome? <i>Please only report medications as YES if taken for Sjögren's syndrome.</i>	NO	YES	a. If yes, are you currently taking this medication?
a. Hydroxychloroquine or chloroquine, also called Plaquenil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
b. Methotrexate, also called Rheumatrex or Trexall	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
c. Biologics, given by infusion or injection, such as Rituximab, also called Rituxan, or other If other, please specify: <input style="width: 200px; height: 20px;" type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
d. Pilocarpine, also called Salagen; or Cevimeline, also called Evoxac; or Cyclosporine Ophthalmic, also called Restasis	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
e. Corticosteroids, such as prednisone or solumedrol, either oral or intravenous (but not by injection, for example in a joint)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
71. Crohn's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR </div>
72. ulcerative colitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR </div>
73. shingles?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR </div>
74. polyps in the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR </div>
75. polycystic ovarian syndrome or PCOS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR </div>
76. one or more ovarian cysts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR </div>
77. uterine fibroids or fibroid tumors?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR </div>
78. endometriosis? <i>If diagnosed, was your endometriosis confirmed by laparoscopy (insertion of a thin, lighted tube through a small incision in the abdomen to examine organs)?</i> <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR </div>



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
79. Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
80. dementia excluding Alzheimer's disease? Please specify type: <input type="text"/>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
81. cognitive impairment?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
82. kidney failure requiring dialysis or transplant?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
83. kidney stones?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
84. gallstones or gallbladder disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
85. gout?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
86. cataracts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
87. glaucoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
88. macular degeneration?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014	<input type="radio"/> Diagnosed January 1, 2014 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, 2014	<input type="radio"/> Diagnosed January 1, 2014 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, 2014	<input type="radio"/> Diagnosed January 1, 2014 or later	<input type="text"/> / <input type="text"/> MONTH YEAR

Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
91. any other major health condition? Please do not report any cancer or health condition you already reported in this questionnaire.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2014 If diagnosed before January 1, 2014, please specify what type of major health condition(s): 1). <input type="text"/> 2). <input type="text"/>	<input type="radio"/> Diagnosed January 1, 2014 or later If you were diagnosed with any other major health condition(s) January 1, 2014 or later, please specify what type of major health condition(s): 1). <input type="text"/> 2). <input type="text"/>	<input type="text"/> / <input type="text"/> MONTH YEAR <input type="text"/> / <input type="text"/> MONTH YEAR



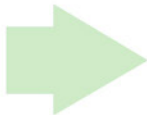
Have you ever had...	NEVER OR BEFORE 1/1/2014	HAD PROCEDURE 1/1/2014 OR LATER	a. If you had this procedure January 1, 2014 or later, what was the month and year?
92. gallbladder surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2014	<input type="radio"/> Had procedure January 1, 2014 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="display: flex; align-items: center;"> <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> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> MONTH YEAR </div>

Have you ever had any of the following weight loss procedures...	NEVER OR BEFORE 1/1/2014	HAD PROCEDURE 1/1/2014 OR LATER	a. If you had this procedure January 1, 2014 or later, what was the month and year?
93. lap band?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2014	<input type="radio"/> Had procedure January 1, 2014 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="display: flex; align-items: center;"> <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> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> MONTH YEAR </div>
94. bariatric surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2014	<input type="radio"/> Had procedure January 1, 2014 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="display: flex; align-items: center;"> <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> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> MONTH YEAR </div>

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

No → **GO TO QUESTION 96 ON NEXT PAGE**

Yes



95a. How old were you the first time you noticed this problem?
AGE

95b. Are there any reasons (such as head injury) that explain the decrease in your sense of smell?

No

Yes, specify:



96. Since January 1, 2014, have you experienced any of the following medical symptoms...
(Please mark a response for each item below.)

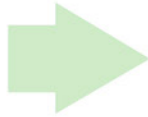
	NO	YES
a. swelling in your wrist, finger, elbow, or knee joints lasting six or more weeks?	<input type="radio"/>	<input type="radio"/>
b. joint stiffness in the mornings, lasting at least one hour, and for more than six weeks (do not include stiffness related or due to an injury or surgery)?	<input type="radio"/>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



97. Since January 1, 2014, have you had a mammogram, breast ultrasound, or breast MRI?

No → GO TO QUESTION 98 ON NEXT PAGE

Yes



97a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2014?

--	--

TIMES

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

		/	2	0		
MONTH			YEAR			

97c. Since January 1, 2014, have you been told you had abnormal findings on a mammogram, breast ultrasound, or breast MRI?

No → GO TO QUESTION 98 ON NEXT PAGE

Yes



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

		/	2	0		
MONTH			YEAR			

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

- Left breast
- Right breast
- Both breasts

97f. 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
- Potentially malignant tumor
- Other
- Don't know



98. Since January 1, 2014, have you had a breast cyst or cysts drained (aspirated) or removed?

- No
- Yes

99. Since January 1, 2014, have you had a surgical, needle, or other biopsy to diagnose or rule out a breast condition?

No → **GO TO QUESTION 100**

Yes →

99a. On how many occasions have you had this since January 1, 2014?	<input type="text"/> <input type="text"/> # OCCASIONS
99b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
99c. On which breast was the most recent biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts

100. Since January 1, 2014, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

No → **GO TO QUESTION 101 ON NEXT PAGE**

Yes →

100a. On how many occasions have you had this since January 1, 2014?	<input type="text"/> <input type="text"/> # OCCASIONS
100b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
100c. On which breast was the most recent lumpectomy or excisional biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts



Have you ever had...	NEVER OR BEFORE 1/1/2014	1/1/2014 OR LATER	a. If you had this procedure January 1, 2014 or later, what was the month and year?	b. Why was this done?
101. a mastectomy of your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both
102. a mastectomy of your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both

Have you ever had...	NEVER OR BEFORE 1/1/2014	1/1/2014 OR LATER	a. If you had this procedure January 1, 2014 or later, what was the month and year of the most recent surgery?	b. Did you have a silicone gel implant?
103. breast reconstruction surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR	<input type="radio"/> No <input type="radio"/> Yes
104. breast reconstruction surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR	<input type="radio"/> No <input type="radio"/> Yes



Since January 1, 2014, were you told you had any of the following benign breast conditions after a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy?

Have you ever had...	NEVER OR BEFORE 1/1/2014	1/1/2014 OR LATER	a. If you had this January 1, 2014 or later, what was the month and year?
105. fibrocystic or benign nonproliferative changes within normal range? For example, cysts, mild hyperplasia, benign calcifications, fibrosis, etc.	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
106. fibroadenoma?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014 b. What type? <input type="radio"/> Simple fibroadenoma <input type="radio"/> Complex fibroadenoma <input type="radio"/> Both <input type="radio"/> Don't know	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR b. What type? <input type="radio"/> Simple fibroadenoma <input type="radio"/> Complex fibroadenoma <input type="radio"/> Both <input type="radio"/> Don't know
107. benign breast disease?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
108. proliferation without atypia ? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
109. atypical hyperplasia?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014 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	<input type="radio"/> Yes, January 1, 2014 or later	<input type="text"/> / <input type="text"/> 2 0 <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



110. 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

Have you ever had...	NEVER OR BEFORE 1/1/2014	1/1/2014 OR LATER	a. If you had this procedure January 1, 2014 or later, what was the month and year?	b. Did you have a silicone gel implant?
111. breast enlargement surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 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; font-size: small;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes
112. breast enlargement surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 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; font-size: small;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes
113. a breast implant surgically removed from your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 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; font-size: small;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes
114. a breast implant surgically removed from your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2014	<input type="radio"/> Yes, January 1, 2014 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; font-size: small;"> MONTH YEAR </div>	<input type="radio"/> No <input type="radio"/> Yes

MENSTRUAL HISTORY

115a. Have you had a menstrual period or pregnancy in the past 10 years?

- No → **GO TO QUESTION 116 ON PAGE C-7**
- Yes → **GO TO QUESTION 115b1 ON NEXT PAGE**



115b1. Are you currently pregnant or breastfeeding?

- No → GO TO QUESTION 115b2, BELOW
- Yes → GO TO QUESTION 115h ON PAGE C-3

115b2. 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 115e.

115c. 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 135 and 136).
- My periods stopped due to radiation or chemotherapy.
- My periods stopped after having a uterine or endometrial ablation.
- My periods stopped after having a uterine embolization, also known as a uterine artery embolization or uterine fibroid embolization.
- 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:

115d. 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 QUESTION 115h ON PAGE C-3



BOX B

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

115e. 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			

115f. 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 QUESTION 115h
ON NEXT PAGE

OR

- My periods stopped sometime in the last 12 months. → GO TO QUESTION 115g

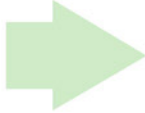
115g. Why did your periods stop? Please choose one response that best describes your situation.

- 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 135 and 136).
- My periods stopped due to radiation or chemotherapy.
- My periods stopped after having a uterine or endometrial ablation.
- My periods stopped after having a uterine embolization, also known as a uterine artery embolization or uterine fibroid embolization.
- 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:

115h. Have you had a pregnancy since January 1, 2014?

No → GO TO QUESTION 115o ON PAGE C-5

Yes



115h1.	Are you currently pregnant?	<input type="radio"/> No <input type="radio"/> Yes
115h2.	How many times have you been pregnant since January 1, 2014 (including your current pregnancy, if you are pregnant now)?	<input type="text"/> # TIMES



**THIS SECTION IS FOR WOMEN WHO HAVE BEEN PREGNANT SINCE JANUARY 1, 2014.
ALL OTHERS GO TO THE NEXT PAGE, QUESTION 115o.**

	FIRST PREGNANCY (since January 1, 2014)	SECOND PREGNANCY (since January 1, 2014)
115i. 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
115j. 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
115k. What month and year did this pregnancy end?	<input type="text"/> / <input type="text"/> MONTH YEAR OR <input type="radio"/> Still pregnant now	<input type="text"/> / <input type="text"/> MONTH YEAR OR <input type="radio"/> Still pregnant now
115l. 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
115m. 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 115n <input type="radio"/> Did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 115o	<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 115n <input type="radio"/> Did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 115o
115n. 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, 2014,
PLEASE ANSWER THE SAME QUESTIONS FOR EACH PREGNANCY AND
RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.**



115o. Since January 1, 2012, have you used any fertility medications?

No → **GO TO QUESTION 115r ON NEXT PAGE**

Yes



Since January 1, 2012, have you taken...	NO	YES	a. <i>If yes</i> , how many months or menstrual cycles in all have you used this since January 1, 2012?	b. Since January 1, 2012, did you become pregnant in a menstrual cycle where you were treated with these fertility medications?	c. Since January 1, 2012, how many times did you get pregnant while using these fertility medications?
115p. Clomiphene, Clomid, or Serophene?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES	<input type="radio"/> No <input type="radio"/> Yes →	<input type="text"/> <input type="text"/> # PREGNANCIES
115q. drugs that contain follicle-stimulating hormones (FSH) – Follistim, Puregon, Gonal-F, Urofollitropin, Metrodin, Fertinex, Bravelle, human menopausal gonadotropin (hMG), menotropin, Pergonal, Humegon, or Repronex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES	<input type="radio"/> No <input type="radio"/> Yes →	<input type="text"/> <input type="text"/> # PREGNANCIES



115r. Since January 1, 2014, have you used any hormonal birth control?

No → **GO TO QUESTION 116 ON NEXT PAGE**

Yes



Since January 1, 2014, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2014?	b. Do you currently use this?
115s. birth control pills?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No → GO TO 115t <input type="radio"/> Yes c. Do you take the type of pills that stop your menstrual periods for several months or longer? <input type="radio"/> No <input type="radio"/> Yes
115t. 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
115u. 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
115v. 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
115w. 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
115x. 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
115y. 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, 2014, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2014?	b. Do you currently use this female hormone product(s)?
116. 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
117. 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
118. an estrogen pill (such as Premarin) and 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
119. 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
120. 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
121. an estrogen-only patch and 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
122. 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



Since January 1, 2014, have you used...	NO	YES	If yes, how many months in all have you used this since January 1, 2014?
<p>123. vaginal estrogen creams, rings, or suppositories?</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p>	<p>a. <input type="text"/> <input type="text"/> # MONTHS</p> <p>b. Do you currently use this female hormone product(s)?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Does this product also contain progesterone?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know</p> <p>d. Did you also take progesterone in another form (e.g., patch, pill) during the time you were using vaginal estrogen creams, rings, or suppositories?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p>
<p>124. any other estrogen products, including "natural" estrogens?</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p>	<p>a. <input type="text"/> <input type="text"/> # MONTHS</p> <p>b. Do you currently use this female hormone product(s)?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Which of the following products have you used since January 1, 2014? (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, 2014, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2014?	b. Do you currently use this?	c. Why did you use this? (Please mark all that apply.)
125. 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
126. ospemifene or Osphena?	<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
127. 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
Aromatase inhibitors:					
128. 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
129. 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	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
130. 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	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
131. 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	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
Please specify: <input type="text"/>					
132. Herceptin?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
133. testosterone?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
134. Estratest?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	



Have you ever had...	NEVER OR BEFORE 1/1/2014	HAD PROCEDURE 1/1/2014 OR LATER	If you had this procedure January 1, 2014 or later, what was the month and year?
<p>135. a hysterectomy (surgical removal of the uterus)?</p>	<p><input type="radio"/> Never had procedure</p> <p><input type="radio"/> Had procedure <u>before</u> January 1, 2014</p>	<p><input type="radio"/> Had procedure January 1, 2014 or later</p>	<p>a. MONTH/YEAR HAD PROCEDURE</p> <p><input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/></p> <p>MONTH YEAR</p> <p>b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy?</p> <p><input type="radio"/> No → GO TO QUESTION 136</p> <p><input type="radio"/> Yes</p> <p>c. Did you have...</p> <p><input type="radio"/> both ovaries completely removed?</p> <p><input type="radio"/> one ovary and part of the other ovary removed?</p> <p><input type="radio"/> one ovary removed?</p> <p><input type="radio"/> part of one or part of both ovaries removed?</p> <p>d. Did you have all or part of either ovary left after this surgery?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p>136. a separate surgery to remove part or all of one or both ovaries (but not your uterus)?</p>	<p><input type="radio"/> Never had procedure</p> <p><input type="radio"/> Had procedure <u>before</u> January 1, 2014</p>	<p><input type="radio"/> Had procedure January 1, 2014 or later</p>	<p>a. MONTH/YEAR HAD PROCEDURE</p> <p><input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/></p> <p>MONTH YEAR</p> <p>b. Did you have...</p> <p><input type="radio"/> both ovaries completely removed?</p> <p><input type="radio"/> one ovary and part of the other ovary removed?</p> <p><input type="radio"/> one ovary removed?</p> <p><input type="radio"/> part of one or part of both ovaries removed?</p> <p>c. Did you have all or part of either ovary left after this surgery?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>



137. Have you ever douched?

No → GO TO QUESTION 138 ON PAGE C-13

Yes



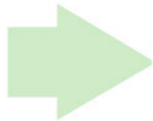
137a. How old were you when you first douched?

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AGE

137b. Have you douched in the past 12 months?

No



137c. How old were you when you last douched?

--	--

AGE

Yes

Did you douche...	NO	YES	IF YES, on average, how frequently did you douche?	How did you use it? <i>(Please mark all that apply.)</i>	What solutions did you use most often when you were douching? <i>(Please mark all that apply.)</i>
137d. in your teens?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To treat vaginal symptoms <input type="radio"/> Other	<input type="radio"/> Water <input type="radio"/> Homemade water and vinegar mixture <input type="radio"/> Commercial water and vinegar product <input type="radio"/> Commercial scented product <input type="radio"/> Commercial medicated product such as those containing iodine or betadine <input type="radio"/> Other
137e. in your 20s?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To treat vaginal symptoms <input type="radio"/> Other	<input type="radio"/> Water <input type="radio"/> Homemade water and vinegar mixture <input type="radio"/> Commercial water and vinegar product <input type="radio"/> Commercial scented product <input type="radio"/> Commercial medicated product such as those containing iodine or betadine <input type="radio"/> Other



Did you douche...	NO	YES	IF YES, on average, how frequently did you douche?	How did you use it? <i>(Please mark all that apply.)</i>	What solutions did you use most often when you were douching? <i>(Please mark all that apply.)</i>
137f. in your 30s?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To treat vaginal symptoms <input type="radio"/> Other	<input type="radio"/> Water <input type="radio"/> Homemade water and vinegar mixture <input type="radio"/> Commercial water and vinegar product <input type="radio"/> Commercial scented product <input type="radio"/> Commercial medicated product such as those containing iodine or betadine <input type="radio"/> Other
137g. in your 40s?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To treat vaginal symptoms <input type="radio"/> Other	<input type="radio"/> Water <input type="radio"/> Homemade water and vinegar mixture <input type="radio"/> Commercial water and vinegar product <input type="radio"/> Commercial scented product <input type="radio"/> Commercial medicated product such as those containing iodine or betadine <input type="radio"/> Other
137h. in your 50s? ↓ IF YOU HAVE NOT REACHED THIS AGE, GO TO THE NEXT PAGE	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To treat vaginal symptoms <input type="radio"/> Other	<input type="radio"/> Water <input type="radio"/> Homemade water and vinegar mixture <input type="radio"/> Commercial water and vinegar product <input type="radio"/> Commercial scented product <input type="radio"/> Commercial medicated product such as those containing iodine or betadine <input type="radio"/> Other



138. Have you **ever** applied talcum powder to a sanitary napkin, tampon, underwear, diaphragm, cervical cap, or directly to your vaginal area?

No → **GO TO QUESTION 139 ON PAGE C-15**

Yes



138a. How old were you when you first used talcum powder on or near your vaginal area?

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AGE

138b. Have you used talcum powder on or near your vaginal area in the **past 12 months**?

No



138c. How old were you when you last used talcum powder on or near your vaginal area?

--	--

AGE

Yes

Did you use talcum powder on or near your vaginal area...	NO	YES	IF YES, on average, how frequently did you use talcum powder on or near your vaginal area?	How did you use it? <i>(Please mark all that apply.)</i>
138d. in your teens?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To prevent dampness and chafing <input type="radio"/> Other
138e. in your 20s?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To prevent dampness and chafing <input type="radio"/> Other



Did you use talcum powder on or near your vaginal area...	NO	YES	IF YES, on average, how frequently did you use talcum powder on or near your vaginal area?	How did you use it? <i>(Please mark all that apply.)</i>
138f. in your 30s?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To prevent dampness and chafing <input type="radio"/> Other
138g. in your 40s?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To prevent dampness and chafing <input type="radio"/> Other
138h. in your 50s? ↓ IF YOU HAVE NOT REACHED THIS AGE, GO TO THE NEXT PAGE	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> 2-11 times per year <input type="radio"/> 1-3 times per month <input type="radio"/> Once a week or more	<input type="radio"/> After your menstrual period <input type="radio"/> To feel clean <input type="radio"/> To reduce vaginal odor <input type="radio"/> Before sex <input type="radio"/> After sex <input type="radio"/> To prevent dampness and chafing <input type="radio"/> Other



MEDICATIONS

Since January 1, 2014, 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, 2014?	
139. 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
140. "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
141. 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
142. 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
143. 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
144. Aleve or Naprosyn?	<input type="radio"/> No	<input type="radio"/> Yes 48	<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
145. 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
146. 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



b. On average, how many days per week have you taken this?	c. On days when you take it, how many times do you take it?	d. Are you currently taking this?
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
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<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
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<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
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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
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<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other

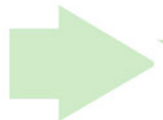


c. How often do you take it?	d. On days when you take it, how many times do you take it?	e. In what form did you take this? <i>(Please mark all that apply.)</i>	
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/>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



148. 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 149

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



148a. How many years have you been married or living as though married with this spouse/partner?

YEARS

OR Less than 1 year

148b. Is your spouse/partner a man or a woman?

Man

Woman

149. 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

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

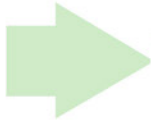
- 1
- 2
- 3-4
- 5-6
- 7-8
- More than 8



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

No → GO TO QUESTION 152

Yes



151a. What is your current smoking status?

- Former smoker
- Current smoker

151b. When did you first start smoking?

- Before 2014
- 2014
- 2015
- 2016
- 2017
- 2018
- 2019

151c. Did you smoke at least 10 cigarettes since January 1, 2014?

- No
- Yes

151d. When did you last smoke?

- I am a current smoker
- I last smoked in 2019
- I last smoked in 2018
- I last smoked in 2017
- I last smoked in 2016
- I last smoked in 2015
- I last smoked in 2014
- I last smoked before 2014

151e. During the years you smoked, how many days per week do/did you smoke?

- Less than one day per week
- 1-3 days per week
- 4-6 days per week
- Every day

151f. During the years you smoked, how many cigarettes do/did you usually smoke per day on the days you smoked?

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CIGARETTES

152. Since January 1, 2014, how many regular smokers have you lived with (not counting yourself, if you smoke)?

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



153. About how many minutes or hours 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

154. 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 155 ON NEXT PAGE**

Yes



154a. Do you now use e-cigarettes...

- Every day
- Some days
- Not at all

154b. What brand of e-cigarette do/did you use?

BRAND

154c. About how many disposable e-cigarettes or e-cigarette cartridges have you used in the past year?

- None
- 1 or more puffs but never a whole one
- 1-10
- 11-20
- 21-50
- 51-99
- 100 or more



155. Have you **ever** used marijuana, even once? Please include smoking or ingesting marijuana, using cannabis oil, etc.

No → GO TO QUESTION 156 ON NEXT PAGE

Yes



155a. How old were you the **first** or **only** time you used marijuana?

--	--

AGE

155b. Have you ever used marijuana **regularly**, over a period of months or years? Please include smoking or ingesting marijuana, using cannabis oil, etc.

No → GO TO QUESTION 156
 Yes

155c. At what ages did you use marijuana regularly?
(Please mark all that apply.)

Teens 50s
 20s 60s
 30s 70s
 40s 80s

155d. Did you use marijuana for...
(Please mark all that apply.)

Medical purposes
 Recreation

155e. Have you used marijuana regularly in the **past 12 months**?

No
 Yes

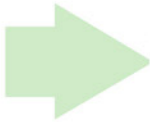


Since January 1, 2014...	NO	YES	a. IF YES, in which years since January 1, 2014 did you drink alcohol? (Please mark all that apply.)	b. About how often did you drink alcohol?	c. On average, how many drinks did you have on the days that you drank alcohol?
156. have you drunk alcoholic beverages?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2014 <input type="radio"/> 2015 <input type="radio"/> 2016 <input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019	<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

157. Since January 1, 2014, did you ever drink four or more alcoholic beverages in a row, in one sitting?

No → GO TO QUESTION 158

Yes



157a. How often has this happened since January 1, 2014?

- 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

158. Since January 1, 2014, has a doctor or other health professional told you that your drinking was hurting your health?

No

Yes



In the past year...	NO	YES	a. About how often did you drink this?	b. On average, how many drinks did you have on the days that you drank this?
159. have you drunk regular coffee ?	<input type="radio"/> No	<input type="radio"/> Yes	<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
160. have you drunk decaffeinated coffee ?	<input type="radio"/> No	<input type="radio"/> Yes	<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
161. have you drunk tea or iced tea (not herbal teas) ?	<input type="radio"/> No	<input type="radio"/> Yes	<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
162. have you drunk decaffeinated tea or decaffeinated iced tea ?	<input type="radio"/> No	<input type="radio"/> Yes	<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 the past year...	NO	YES	a. About how often did you drink this?	b. On average, how many drinks did you have on the days that you drank this?
163. have you drunk regular or decaffeinated green tea?	<input type="radio"/> No	<input type="radio"/> Yes	<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
164. have you drunk regular, non-diet soft drinks?	<input type="radio"/> No	<input type="radio"/> Yes	<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
165. have you drunk artificially sweetened soft drinks?	<input type="radio"/> No	<input type="radio"/> Yes	<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

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

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

During the past 7 days , how much time did you...	
169. usually spend sitting on a weekday ? This includes sitting while at work, at home, while doing course work, and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure
170. usually spend standing on a weekday ? This includes standing while at work, at home, and during leisure time.	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure

171. 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



172. Since January 1, 2014, have you used hair dye to color your hair?

No → GO TO QUESTION 173 ON NEXT PAGE

Yes



172a. In what years did you do this? *(Please mark all that apply.)*

- 2014
- 2015
- 2016
- 2017
- 2018
- 2019

172b. What color did you usually use?

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

172c. 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)

175. Since January 1, 2014, 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 QUESTION 176**

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



175a. 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

175b. When pest control chemicals were applied since January 1, 2014, 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

176. Since January 1, 2014, 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 177 ON NEXT PAGE

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



176a. When weed killers or insecticides were used in the garden or yard since January 1, 2014, 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



177. Since January 1, 2014 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



177a. Which of the following **best** describes your current situation?

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

GO TO QUESTION 188 ON PAGE E-1

Yes → **GO TO QUESTION 177b ON NEXT PAGE**



IF YOU DID NOT HAVE A JOB SINCE JANUARY 1, 2014, GO TO QUESTION 188 ON PAGE E-1

177b. How many different jobs have you had since January 1, 2014?

--	--

OF JOBS

Please tell us about the jobs you have had since January 1, 2014, starting with the most recent and working backwards. **PLEASE DO NOT REPORT JOBS YOU STOPPED WORKING BEFORE 2014.**

	JOB 1	JOB 2														
178. When did you first start this job?	<input type="radio"/> Before 2014 <input type="radio"/> 2014 <input type="radio"/> 2015 <input type="radio"/> 2016 <input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019	<input type="radio"/> Before 2014 <input type="radio"/> 2014 <input type="radio"/> 2015 <input type="radio"/> 2016 <input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019														
179. When did you last have this job?	<input type="radio"/> 2014 <input type="radio"/> 2015 <input type="radio"/> 2016 <input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> I still work there	<input type="radio"/> 2014 <input type="radio"/> 2015 <input type="radio"/> 2016 <input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> I still work there														
180. Where did/do you work? Please write down the name of the company you worked for and the full street address of this workplace.	<input type="text"/> NAME OF COMPANY/PLACE OF WORK <input type="text"/> STREET # <input type="text"/> STREET NAME <input type="text"/> SUITE # <input type="text"/> CITY OR TOWN <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> STATE <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> ZIP CODE								<input type="text"/> NAME OF COMPANY/PLACE OF WORK <input type="text"/> STREET # <input type="text"/> STREET NAME <input type="text"/> SUITE # <input type="text"/> CITY OR TOWN <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> STATE <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> ZIP CODE							
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.	<input type="text"/> COUNTY	<input type="text"/> COUNTY														



	JOB 1	JOB 2
181. What was/is your job title?	<input type="text"/> JOB TITLE	<input type="text"/> JOB TITLE
182. What type of company or organization did/do you work for? (What do they make or what services do they provide?)	<input type="text"/> INDUSTRY	<input type="text"/> INDUSTRY
183. What are the specific tasks that you usually did/do in your job?	<input type="text"/> JOB DUTIES	<input type="text"/> JOB DUTIES
184. How many hours per week did/do you usually work at this job?	<input type="radio"/> Less than 10 <input type="radio"/> 11-20 <input type="radio"/> 21-30 <input type="radio"/> 31-40 <input type="radio"/> More than 40	<input type="radio"/> Less than 10 <input type="radio"/> 11-20 <input type="radio"/> 21-30 <input type="radio"/> 31-40 <input type="radio"/> More than 40
185. What hours of the day did/do you usually work at this job?	<p>START TIME: <i>(mark one)</i></p> <input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM <i>(hr) (min)</i>	<p>START TIME: <i>(mark one)</i></p> <input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM <i>(hr) (min)</i>
	<p>STOP TIME: <i>(mark one)</i></p> <input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM <i>(hr) (min)</i>	<p>STOP TIME: <i>(mark one)</i></p> <input type="text"/> : <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM <i>(hr) (min)</i>
	<p>OR</p> <input type="radio"/> I work(ed) irregular hours <input type="radio"/> I work(ed) rotating shifts	<p>OR</p> <input type="radio"/> I work(ed) irregular hours <input type="radio"/> I work(ed) rotating shifts



	JOB 1	JOB 2																																																						
186. 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.	<input type="radio"/> Never <input type="radio"/> 1-2 times/month <input type="radio"/> 3-5 times/month <input type="radio"/> 6-10 times/month <input type="radio"/> 11-15 times/month <input type="radio"/> More than 15 times per month	<input type="radio"/> Never <input type="radio"/> 1-2 times/month <input type="radio"/> 3-5 times/month <input type="radio"/> 6-10 times/month <input type="radio"/> 11-15 times/month <input type="radio"/> More than 15 times per month																																																						
187. While working at this job did/do you regularly...	<table> <thead> <tr> <th></th> <th>NO</th> <th>YES</th> </tr> </thead> <tbody> <tr> <td>a. work in dusty conditions?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>b. breathe in chemical vapors or fumes?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>c. get chemicals or oils on your skin or clothing?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>d. come in contact with solvents or degreasers?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>e. come in contact with metal chips, dust, or fumes?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>f. come in contact with pesticides?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>g. use cleaning solutions (not counting dish or laundry detergents)?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>h. travel in a vehicle?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </table>		NO	YES	a. work in dusty conditions?	<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"/>	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"/>	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"/>	h. travel in a vehicle?	<input type="radio"/>	<input type="radio"/>	<table> <thead> <tr> <th></th> <th>NO</th> <th>YES</th> </tr> </thead> <tbody> <tr> <td>a. work in dusty conditions?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>b. breathe in chemical vapors or fumes?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>c. get chemicals or oils on your skin or clothing?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>d. come in contact with solvents or degreasers?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>e. come in contact with metal chips, dust, or fumes?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>f. come in contact with pesticides?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>g. use cleaning solutions (not counting dish or laundry detergents)?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> <tr> <td>h. travel in a vehicle?</td> <td><input type="radio"/></td> <td><input type="radio"/></td> </tr> </tbody> </table>		NO	YES	a. work in dusty conditions?	<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"/>	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"/>	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"/>	h. travel in a vehicle?	<input type="radio"/>	<input type="radio"/>
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SPACE IS PROVIDED FOR TWO JOBS. IF YOU HAVE HAD MORE THAN TWO JOBS LASTING 12 MONTHS OR MORE SINCE JANUARY 1, 2014, PLEASE ANSWER THE SAME QUESTIONS FOR EACH JOB AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.



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.

188. 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"/>

189. 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



190. 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

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

- None
- Mild
- Moderate
- Severe
- Extremely severe

192. 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"/>
0	1	2	3	4	5	6	7	8	9	10

193. 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"/>



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

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

195. Since **January 1, 2014**, have you experienced...

	NO	YES
a. the death of your spouse or partner?	<input type="radio"/>	<input type="radio"/>
b. the death of a sibling?	<input type="radio"/>	<input type="radio"/>
c. the death of a child?	<input type="radio"/>	<input type="radio"/>
d. the death of a parent?	<input type="radio"/>	<input type="radio"/>
e. the death of a close personal friend?	<input type="radio"/>	<input type="radio"/>
f. a major illness that was life threatening or severely disabling to you?	<input type="radio"/>	<input type="radio"/>
g. the recurrence or worsening of a sister's breast cancer?	<input type="radio"/>	<input type="radio"/>
h. a major change in or serious difficulty with a personal relationship?	<input type="radio"/>	<input type="radio"/>
i. serious financial or legal troubles that directly affect you?	<input type="radio"/>	<input type="radio"/>



196. As people age, some begin to worry about their ability to think clearly, make decisions and remember things. In the last several years...

	No	Yes	Don't Know	Not applicable
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"/>
i. have family or friends told you that you have trouble thinking clearly, making decisions, or remembering things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions about sleep. We are interested in what time you go to bed and when you wake up. Please consider a typical 24 hour period which may include sleeping during the day if you are working at night. Questions ask about your usual bedtimes and waking times when you are working (work days) or on non-work days. If you are not working, think about your usual patterns on weekdays versus weekends.

197. What time do you usually go to bed on weekdays or workdays?

(mark one)

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

AM
 PM

198. What time do you usually wake up on weekdays or workdays?

(mark one)

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

AM
 PM



199. What time do you usually go to bed on weekends or non-workdays?

(mark one)

		:			<input type="radio"/> AM <input type="radio"/> PM
(hr)			(min)		

200. What time do you usually wake up on weekends or non-workdays?

(mark one)

		:			<input type="radio"/> AM <input type="radio"/> PM
(hr)			(min)		

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

# HOURS	

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

# HOURS	

203. In the **past 7 days**...

	Not At All	A Little Bit	Some-what	Quite A Bit	Very Much
a. my sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I was satisfied with my sleep.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. my sleep was refreshing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I had difficulty falling asleep.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



204. In the **past 7 days**...

	Never	Rarely	Some- times	Often	Always
a. I had trouble staying asleep.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I had trouble sleeping.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I got enough sleep.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

205. In the **past 7 days** my sleep quality was...

- Very poor
- Poor
- Fair
- Good
- Very good

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

No → **GO TO QUESTION 207**

Yes



206a. 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

207. During the **past month**, how often have you had trouble sleeping because you...

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. cannot get to sleep within 30 minutes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. wake up in the middle of the night or early morning.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. have to get up to use the bathroom.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. cannot breathe comfortably.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. cough or snore loudly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



208. During the **past month**, how often have you had trouble sleeping because you...

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. feel too cold.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. feel too hot.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. have bad dreams.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. have pain.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. other reason(s), please specify: <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

210. During the **past month**, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

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



211. 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 QUESTION 212**

Yes



211a. Has this happened more than 3 times?

Yes

No

211b. How old were you when you first knew you did this?

--	--

AGE

212. Have you **ever** been told that you sleepwalk?

No

Yes

213. Has a doctor or other health professional **ever** told you that you had sleep apnea?

No → **GO TO QUESTION 214**

Yes



213a. Do you currently have this condition?

No

Yes

213b. Do you use a continuous positive airway pressure (CPAP) machine?

No

Yes

	NO	YES
214a. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	<input type="radio"/>	<input type="radio"/>
214b. Has anyone observed you stop breathing during your sleep?	<input type="radio"/>	<input type="radio"/>
214c. Do you often feel tired or fatigued during daytime?	<input type="radio"/>	<input type="radio"/>



Please check to see that all questions are answered.

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

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

The Sister Study, 4505 Emperor Blvd, Suite 400, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org

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

Thank you!



