



# The Sister Study Health and Medical History ABBREVIATED



### Instructions:

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

Like this: ●

Not like this: ⊗ ⊙

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			

Version 1

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



## PERSONAL MEDICAL HISTORY

We are interested in changes to your health in the past few years. Please think about your medical history since **January 1, 2012**.

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
1. breast cancer? Please do <b>not</b> include in situ cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
2. ductal breast carcinoma in situ or DCIS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
3. lobular breast carcinoma in situ or LCIS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
4. lung cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
5. ovarian cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
6. cancer of the uterus or endometrium? Please do <b>not</b> include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
7. cancer of the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
8. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
9. non-Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>
10. leukemia?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">             MONTH           </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;">             YEAR           </div> </div> </div>



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
11. melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="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-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
12. skin cancer that was <b>not</b> melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012  If diagnosed before January 1, 2012, was it... <i>(Please mark all that apply.)</i>  <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?	<input type="radio"/> Diagnosed January 1, 2012 or later	a. MONTH/YEAR DIAGNOSED <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-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> b. Was it... <i>(Please mark all that apply.)</i> <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?
13. any other type of cancer not already listed?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012  If diagnosed before January 1, 2012, please specify what type(s) of cancer: <div style="border: 1px solid black; width: 180px; height: 25px; margin-bottom: 10px;"></div> <div style="border: 1px solid black; width: 180px; height: 25px;"></div>	<input type="radio"/> Diagnosed January 1, 2012 or later	a. MONTH/YEAR DIAGNOSED <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-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> b. Please specify what type of cancer: <div style="border: 1px solid black; width: 200px; height: 25px; margin-bottom: 10px;"></div> c. If you were diagnosed with a second <b>other</b> type of cancer January 1, 2012 or later, what month and year were you diagnosed? <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-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> d. Please specify what type of cancer: <div style="border: 1px solid black; width: 200px; height: 25px;"></div>

Please use a ballpoint pen for this form



Has a doctor or other health professional ever told you that you had...	NO	YES	b. Have you had this condition in the past 12 months?
14. hypertension or high blood pressure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
15. angina?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
16. cardiac arrhythmia or irregular heartbeat?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
17. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 8px; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional told you that you had...	NO	YES	b. Have you had another incident since then?
18. a heart attack or myocardial infarction?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> heart attack was <u>before</u> January 1, 2012  <input type="radio"/> Yes, my <u>first</u> heart attack was January 1, 2012 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           a. What month and year was your first heart attack?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; 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%; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           c. What month and year was your most recent heart attack?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>
19. a stroke this does not include TIA or "mini-stroke"?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> stroke was <u>before</u> January 1, 2012  <input type="radio"/> Yes, my <u>first</u> stroke was January 1, 2012 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           a. What month and year was your first stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; 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%; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           c. What month and year was your most recent stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>
20. a mini-stroke or TIA or transient ischemic attack?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> mini-stroke was <u>before</u> January 1, 2012  <input type="radio"/> Yes, my <u>first</u> mini-stroke was January 1, 2012 or later ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           a. What month and year was your first mini-stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; 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%; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           c. What month and year was your most recent mini-stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>

Please use a ballpoint pen for this form



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



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

NO

YES

25. diabetes?

No

Yes, first diagnosed before January 1, 2012

Yes, first diagnosed January 1, 2012 or later →

a. What month and year were you diagnosed?

		/	2	0		
MONTH			YEAR			

b. Do you still have this condition?

No

Yes

c. Do you currently take insulin for diabetes?

No → GO TO 25e

Yes →

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

		/				
MONTH			YEAR			

e. Do you currently take other medications for diabetes?

No

Yes

Please use a ballpoint pen for this form



Since January 1, 2012, has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
26. Graves' disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
27. other hyperthyroidism or overactive thyroid?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
28. Hashimoto's thyroiditis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
29. other hypothyroidism or underactive thyroid?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
30. an enlarged thyroid or goiter?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
31. thyroid nodules?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
32. another thyroid problem? Please do <b>not</b> include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	a. MONTH/YEAR DIAGNOSED <input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR  b. Please specify the problem: <input type="text"/>
33. rheumatoid arthritis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR





Since January 1, 2012, has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>DIAGNOSED 1/1/2012 OR LATER</b>	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
34. multiple sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
35. scleroderma or systemic sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
36. systemic lupus erythematosus or SLE?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
37. discoid lupus?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
38. Parkinson's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>



39. 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 42.

40. 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 45 and 46).
- My periods stopped due to radiation or chemotherapy.
- My periods stopped due to medicine that causes the ovaries to make less hormones or medicine that has this as a side effect.
- My periods stopped because I am taking the kind of birth control pills that make me not have periods.
- My periods stopped for some other reason, please describe:

41. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

		/						OR		
MONTH			YEAR						AGE	

GO TO PAGE 12, QUESTION 45



## BOX B

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

42. 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			

43. What statement best describes you?

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

GO TO PAGE 12,  
QUESTION 45

OR

- My periods stopped sometime in the last 12 months. → GO TO QUESTION 44

44. 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 45 and 46).
- My periods stopped due to radiation or chemotherapy.
- My periods stopped due to medicine that causes the ovaries to make less hormones or medicine that has this as a side effect.
- My periods stopped because I am taking the kind of birth control pills that make me not have periods.
- My periods stopped for some other reason, please describe:

Please use a ballpoint pen for this form



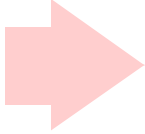
Since January 1, 2012, have you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>HAD PROCEDURE 1/1/2012 OR LATER</b>	If you had this procedure January 1, 2012 or later, what was the month and year?														
45. a hysterectomy or surgical removal of the uterus?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 or later	<p>a. MONTH/YEAR HAD PROCEDURE</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; 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="3" style="text-align: center;">MONTH</td> <td colspan="4" style="text-align: center;">YEAR</td> </tr> </table> <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 → <b>GO TO QUESTION 46</b>  <input type="radio"/> Yes</p> <p>c. Did you have...</p> <p><input type="radio"/> both ovaries completely removed?  <input type="radio"/> one ovary and part of the other ovary removed?  <input type="radio"/> one ovary removed?  <input type="radio"/> part of one or part of both ovaries removed?</p> <p>d. Did you have all or part of either ovary left after this surgery?</p> <p><input type="radio"/> No  <input type="radio"/> Yes</p>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
46. a separate surgery to remove part or all of one or both ovaries but not your uterus?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 or later	<p>a. MONTH/YEAR HAD PROCEDURE</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; 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="3" style="text-align: center;">MONTH</td> <td colspan="4" style="text-align: center;">YEAR</td> </tr> </table> <p>b. Did you have...</p> <p><input type="radio"/> both ovaries completely removed?  <input type="radio"/> one ovary and part of the other ovary removed?  <input type="radio"/> one ovary removed?  <input type="radio"/> part of one or part of both ovaries removed?</p> <p>c. Did you have all or part of either ovary left after this surgery?</p> <p><input type="radio"/> No  <input type="radio"/> Yes</p>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														



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

No → GO TO QUESTION 48

Yes



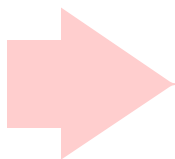
47a. What is your current smoking status?	<input type="radio"/> Former smoker <input type="radio"/> Current smoker			
47b. When did you first start smoking?	<input type="radio"/> Before 2012 <input type="radio"/> 2012 <input type="radio"/> 2013 <input type="radio"/> 2014 <input type="radio"/> 2015			
47c. Did you smoke at least 10 cigarettes since January 1, 2012?	<input type="radio"/> No <input type="radio"/> Yes			
47d. When did you last smoke?	<input type="radio"/> I am a current smoker <input type="radio"/> I last smoked in 2015 <input type="radio"/> I last smoked in 2014 <input type="radio"/> I last smoked in 2013 <input type="radio"/> I last smoked in 2012 <input type="radio"/> I last smoked before 2012			
47e. During the years you smoked, how many days per week do/did you smoke?	<input type="radio"/> Less than one day per week <input type="radio"/> 1-3 days per week <input type="radio"/> 4-6 days per week <input type="radio"/> Every day			
47f. During the years you smoked, how many cigarettes do/did you usually smoke per day on the days you smoked?	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table> # CIGARETTES			

Please use a ballpoint pen for this form



48. Since January 1, 2012 have you had a full-time or part-time job other than homemaking that you held for at least 12 months or if it was a teaching job, for at least 9 months?

No



Yes

48a. Which of the following **best** describes your current situation?

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

---

Please check to see that all questions are answered.

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

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

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

---

