



The Sister Study

Health, Medical History and Lifestyle

Version DFU5 - ABBREVIATED

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 1

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



Today's Date:

		/			/	2	0		
MONTH			DAY			YEAR			

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 the relationship to the participant of the person helping with the questionnaire or completing the questionnaire on behalf of the participant?

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

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

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1. 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. had a bone density scan or osteoporosis screening?	<input type="radio"/>	<input type="radio"/>
c. had a screening colonoscopy or sigmoidoscopy exam?	<input type="radio"/>	<input type="radio"/>
d. had a vaccination for shingles (herpes zoster)?	<input type="radio"/>	<input type="radio"/>

3. What is your current weight (in pounds)?

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POUNDS



We are interested in changes to your health in the past few years. Please think about your medical history since January 1, 2017.

Has a doctor or other health professional ever told you that you had...	NEVER DIAGNOSED	DIAGNOSED BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
4. breast cancer? <i>Do not include in situ cancer.</i>	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
5. ductal (breast) carcinoma in situ (DCIS)?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
6. lobular (breast) carcinoma in situ (LCIS)?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
7. lung cancer?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
8. ovarian cancer?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
9. cancer of the uterus or endometrium? <i>Do not include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.</i>	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
10. cancer of the colon or rectum?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
11. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
12. non-Hodgkin's lymphoma?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
13. leukemia?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR
14. thyroid cancer?	<input type="radio"/> Never	<input type="radio"/> <u>Before</u> January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH YEAR



Has a doctor or other health professional ever told you that you had...	NEVER DIAGNOSED	DIAGNOSED BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
15. melanoma? <i>Do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.</i>	<input type="radio"/> Never	<input type="radio"/> Before January 1, 2017	<input type="radio"/> January 1, 2017 or later	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR </div>
16. skin cancer (not melanoma)?	<input type="radio"/> Never	<input type="radio"/> Before January 1, 2017 If diagnosed before January 1, 2017, was it... (Please mark all that apply.) <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?	<input type="radio"/> January 1, 2017 or later Was it... (Please mark all that apply.) <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR </div>
17. any other type of cancer not already listed?	<input type="radio"/> Never	<input type="radio"/> Before January 1, 2017 If diagnosed before January 1, 2017, please specify what type(s) of cancer: 1) <input type="text"/> 2) <input type="text"/>	<input type="radio"/> January 1, 2017 or later If you were diagnosed with any other type(s) of cancer January 1, 2017 or later, please specify what type(s) of cancer: 1) <input type="text"/> 2) <input type="text"/>	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR </div> <div style="text-align: center;"> <input type="text"/> / <input type="text"/> MONTH </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR </div>



<p>The Sister Study enrollment started in 2003 and ended in 2009. <u>Since your enrollment in the Sister Study</u>, have you received any of the following treatments for breast cancer, another cancer, or any other reason?</p>	<p>NO</p>	<p>YES (Please mark all that apply.)</p>	<p>a. When was the first treatment?</p>	<p>b. When was the most recent treatment?</p>
<p>18. chemotherapy <i>By chemotherapy we mean drugs used to kill cancer cells. Examples of chemotherapy include: Adriamycin, Taxol, and Carboplatin. There are many other chemotherapy drugs.</i></p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes, for breast cancer <input type="radio"/> Yes, for a cancer other than breast cancer <input type="radio"/> Yes, for another reason</p>	<p><input type="text"/> / <input type="text"/> MONTH 2 0 <input type="text"/> <input type="text"/> YEAR OR <input type="text"/> <input type="text"/> AGE</p>	<p><input type="text"/> / <input type="text"/> MONTH 2 0 <input type="text"/> <input type="text"/> YEAR OR <input type="text"/> <input type="text"/> AGE</p>
<p>19. radiation treatments <i>This may involve treatment with high dose x-rays, radioactive implants or seeds, or other ways of delivering radiation to a cancer and nearby tissues.</i></p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes, for breast cancer <input type="radio"/> Yes, for a cancer other than breast cancer <input type="radio"/> Yes, for another reason</p>	<p><input type="text"/> / <input type="text"/> MONTH 2 0 <input type="text"/> <input type="text"/> YEAR OR <input type="text"/> <input type="text"/> AGE</p>	<p><input type="text"/> / <input type="text"/> MONTH 2 0 <input type="text"/> <input type="text"/> YEAR OR <input type="text"/> <input type="text"/> AGE</p>
<p>20. immunotherapy treatments <i>By immunotherapy, we mean treatments that use your body's immune system to better find and destroy cancer cells. Examples of immunotherapy include: Herceptin, nivolumab (Opdivo), atezolizumab (Tecentriq), Keytruda, monoclonal antibodies, immune checkpoint inhibitors, cytokines, cancer vaccines, and adoptive cell transfer.</i></p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes, for breast cancer <input type="radio"/> Yes, for a cancer other than breast cancer <input type="radio"/> Yes, for another reason</p>	<p><input type="text"/> / <input type="text"/> MONTH 2 0 <input type="text"/> <input type="text"/> YEAR OR <input type="text"/> <input type="text"/> AGE</p>	<p><input type="text"/> / <input type="text"/> MONTH 2 0 <input type="text"/> <input type="text"/> YEAR OR <input type="text"/> <input type="text"/> AGE</p>
<p>21. bone marrow or stem cell transplant</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes, for breast cancer <input type="radio"/> Yes, for a cancer other than breast cancer <input type="radio"/> Yes, for another reason</p>	<p>a. What month and year did you have this treatment? <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR OR <input type="text"/> <input type="text"/> AGE</p>	



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. If yes, are you currently taking prescription medications?
22. high cholesterol (not borderline)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2017 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2017 or later ↓ <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 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; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 2px;"> MONTH YEAR </div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
23. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2017 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2017 or later ↓ <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 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; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 2px;"> MONTH YEAR </div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
24. hypertension or high blood pressure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2017 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2017 or later ↓ <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> 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; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 2px;"> MONTH YEAR </div> </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. If yes, are you currently taking prescription medications?														
25. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2017 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2017 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; 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	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
		/	2	0															
MONTH			YEAR																
26. angina?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2017 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2017 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; 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	<input type="radio"/> No <input type="radio"/> Yes	<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...	NO	YES	a. If you had this January 1, 2017 or later, what was the month and year?														
27. 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, 2017 <input type="radio"/> Yes, my <u>first</u> heart attack was January 1, 2017 or later →	<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; 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			
		/	2	0													
MONTH			YEAR														
28. 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, 2017 <input type="radio"/> Yes, my <u>first</u> stroke was January 1, 2017 or later →	<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; 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			
		/	2	0													
MONTH			YEAR														
29. 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, 2017 <input type="radio"/> Yes, my <u>first</u> mini-stroke was January 1, 2017 or later →	<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; 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			
		/	2	0													
MONTH			YEAR														



Have you ever had...	NEVER OR BEFORE 1/1/2017	HAD PROCEDURE 1/1/2017 OR LATER	a. If you had this procedure January 1, 2017 or later, what was the month and year?
30. a balloon angioplasty, stent placement, or other procedure to open or widen a heart artery? <i>These procedures are different from the test used to diagnose a blockage.</i>	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2017	<input type="radio"/> Had procedure January 1, 2017 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="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 style="margin-left: 5px;">YEAR</div> </div>
31. a coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2017	<input type="radio"/> Had procedure January 1, 2017 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="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 style="margin-left: 5px;">YEAR</div> </div>

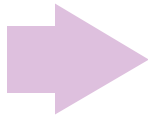
Has a doctor or other health professional ever told you that you had...	NO	YES	b. Do you still have this condition?
32. pre-diabetes, borderline diabetes, or an elevated A1C test without diabetes?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2017 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2017 or later <div style="text-align: center;">↓</div> <div style="border: 1px solid black; padding: 5px;"> a. If first diagnosed 1/1/2017 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: 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="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 style="margin-left: 5px;">YEAR</div> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
33. diabetes? <i>Do NOT include pre-diabetes or borderline diabetes.</i>	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2017 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2017 or later <div style="text-align: center;">↓</div> <div style="border: 1px solid black; padding: 5px;"> a. If first diagnosed 1/1/2017 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: 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="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 style="margin-left: 5px;">YEAR</div> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes



34. Did you **ever** take insulin for diabetes?

No → GO TO QUESTION 35

Yes



34a. When did you first use insulin?

/
 MONTH YEAR

34b. Do you **currently** take insulin?

- No
- Yes, by injection
- Yes, by indwelling pump
- Yes, by other method

Please specify:

35. Have you **ever** used any other prescription medications, **not including insulin**, for diabetes?

No → GO TO QUESTION 36 ON NEXT PAGE

Yes



Have you ever used the following prescription medications for diabetes?	NO	YES	a. If yes, are you currently taking this medication?
a. Metformin alone (not in combination with other medications) <i>Examples include Metformin (Glucophage), Metformin liquid (Riomet), or Metformin extended release (Glucophage XR, Fortamet, Glumetza)</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
b. Metformin in combination with other medications <i>Examples include Pioglitazone & metformin (Actoplus Met), Glyburide & metformin (Glucovance), Glipizide & metformin (Metaglip), Sitagliptin & metformin (Janumet), Saxagliptin & metformin (Kombiglyze), Repaglinide & metformin (Prandimet), Linagliptin and metformin (Jentadueto), Empagliflozin and metformin (Synjardy), Dapagliflozin and metformin (Xigduo XR)</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
c. Sulfonylureas <i>Examples include Glimepiride (Amaryl), Glyburide (Micronase, DiaBeta), Glipizide (Glucotrol), or Micronized glyburide (Glynase)</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
d. Any other, please specify: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

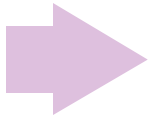


Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER											
36. Parkinson's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 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;"> <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 colspan="4" style="text-align: center;">YEAR</td></tr> </table> </div>			MONTH	2	0			YEAR			
MONTH													
2	0												
YEAR													

37. Have you **ever** used any prescription medications for Parkinson's disease? Examples include Levodopa, Sinemet, Parcopa, Stalevo, Mirapex, Requip, Neupro patch, or Azilect.

No → **GO TO QUESTION 38**

Yes



37a. Did your symptoms ever improve after taking any of these medications?	<input type="radio"/> No <input type="radio"/> Yes
37b. Are you currently taking any of these medications?	<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?											
38. depression?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2017 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2017 or later ↓ a. 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;"> <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 colspan="4" style="text-align: center;">YEAR</td></tr> </table> </div>			MONTH	2	0			YEAR				<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
MONTH														
2	0													
YEAR														



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
39. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 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="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; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> MONTH YEAR </div>
40. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 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="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; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> MONTH YEAR </div>

Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
41. Graves' disease, or hyperthyroidism, or overactive thyroid?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> 1/1/2017	<input type="radio"/> Diagnosed 1/1/2017 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="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; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> MONTH YEAR </div>

IF DIAGNOSED ↓

b. Were you treated with radioactive iodine?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> 1/1/2017 <input type="radio"/> Yes, 1/1/2017 or later
c. Did you have surgery to remove your thyroid?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> 1/1/2017 <input type="radio"/> Yes, 1/1/2017 or later



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
42. Hashimoto's thyroiditis, or hypothyroidism, or underactive thyroid?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> 1/1/2017	<input type="radio"/> Diagnosed 1/1/2017 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;"> MONTHYEAR </div>
43. any other type of thyroid disease or thyroid condition? Do NOT include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> 1/1/2017 If diagnosed before January 1, 2017, please specify the condition: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="radio"/> Diagnosed 1/1/2017 or later If you were diagnosed January 1, 2017 or later, please specify the condition: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<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;"> MONTHYEAR </div>

44. Are you **currently** taking propylthiouracil/PTU (Propylcil) or Methimazole/MMI (Tapazole) for thyroid disease or a thyroid condition?

- No
- Yes

45. Are you **currently** taking levothyroxine (e.g. Levoxyl, Levo-T, Synthroid, Tirosint, Unithroid) for thyroid disease or a thyroid condition?

- No
- Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
46. rheumatoid arthritis? <i>Do not include osteoarthritis or psoriatic arthritis.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 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="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
47. psoriatic arthritis? <i>Do not include osteoarthritis or rheumatoid arthritis.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 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="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
48. multiple sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 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="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
49. scleroderma or systemic sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 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="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
50. systemic lupus erythematosus (SLE)? <i>Do not include discoid lupus.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 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="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
51. Sjögren's syndrome?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 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="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>



52. Have you **ever** used any prescription medications for autoimmune diseases such as rheumatoid arthritis, multiple sclerosis, scleroderma or systemic sclerosis, systemic lupus erythematosus (SLE; do not include discoid lupus), psoriatic arthritis (do not include psoriasis without arthritis), or Sjögren’s syndrome?

No → **GO TO QUESTION 53 ON NEXT PAGE**

Yes



Have you ever used any of the following types of medications for an autoimmune disease?	NO	YES	a. If yes, are you currently taking this type of medication?
<p>a. Immune-modifying prescription medications</p> <p><i>Examples: Hydroxychloroquine or chloroquine (Plaquenil); Methotrexate (Rheumatrex or Trexall); Azathioprine (Imuran), Mycophenolate mofetil (Cellcept), Cyclophosphamide (Cytoxan), and Cyclosporine</i></p>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
<p>b. Biologics</p> <p><i>Examples: Remicade, Humira, Enbrel, Benlysta, and rituximab (Rituxan)</i></p>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
<p>c. Other types of prescription medications, not including immune-modifying prescription medications or biologics</p> <p><i>Do not include corticosteroids/steroids such as prednisone, cortisone or methylprednisolone (Medrol). Also do not include over-the-counter pain relievers such as acetaminophen (Tylenol), aspirin, or non-steroidal anti-inflammatory medications [e.g. ibuprofen (Motrin), naproxen (Naprosyn)].</i></p> <p>Specify <i>first/only</i> other type of prescription medication:</p> <p>1) <input type="text"/></p>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
<p>Specify any <i>additional</i> other type of prescription medication:</p> <p>2) <input type="text"/></p>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
53. Crohn's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div>
54. ulcerative colitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div>
55. Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div>
56. dementia excluding Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017 Please specify type of dementia you had before January 1, 2017: <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<input type="radio"/> Diagnosed January 1, 2017 or later Please specify type of dementia you had since January 1, 2017: <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></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; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div>
57. shingles?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> MONTH YEAR </div>

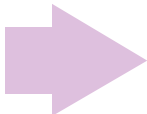


Since January 1, 2017, has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
58. any other major health condition? <i>Do not report any cancer or health condition reported elsewhere in this questionnaire.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017 If diagnosed before January 1, 2017, please specify what type of major health condition(s): 1) <input type="text"/> 2) <input type="text"/>	<input type="radio"/> Diagnosed January 1, 2017 or later If you were diagnosed with any other major health condition(s) January 1, 2017 or later, please specify what type of major health condition(s): 1) <input type="text"/> 2) <input type="text"/>	<div style="text-align: right;"> <input type="text"/><input type="text"/> / <input type="text"/>2<input type="text"/>0<input type="text"/><input type="text"/> MONTH YEAR </div> <div style="text-align: right;"> <input type="text"/><input type="text"/> / <input type="text"/>2<input type="text"/>0<input type="text"/><input type="text"/> MONTH YEAR </div>

59. Since January 1, 2017, have you had a mammogram, breast ultrasound, or breast MRI?

No → GO TO QUESTION 60 ON NEXT PAGE

Yes



59a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2017?	<input type="text"/> <input type="text"/> # TIMES
59b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI?	<input type="text"/> <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR



Since January 1, 2017, 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 1/1/2017	1/1/2017 OR LATER	a. If you had this January 1, 2017 or later, what was the month and year?
60. 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, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
61. fibroadenoma?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017 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, 2017 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <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
62. benign breast disease?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
63. 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, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
64. atypical hyperplasia?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017 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, 2017 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR b. What type? <input type="radio"/> Atypical ductal hyperplasia <input type="radio"/> Atypical lobular hyperplasia <input type="radio"/> Both <input type="radio"/> Don't know

65. 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?

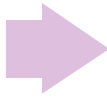
- No
- Yes → **PLEASE INCLUDE A COPY WITH YOUR COMPLETED QUESTIONNAIRE.**
- Not applicable



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

No → GO TO QUESTION 67 ON PAGE 21

Yes



66a. Have you had a menstrual period in the past 12 months?

No → ANSWER BOX A BELOW

Yes → ANSWER BOX B ON PAGE 20

BOX A

THIS BOX IS FOR WOMEN WHO HAVE NOT HAD A MENSTRUAL PERIOD IN THE PAST 12 MONTHS. ALL OTHERS GO TO QUESTION 66d ON NEXT PAGE.

66b. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

--	--

MONTH

/

--	--	--	--

YEAR

OR

--	--

AGE

66c. 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 71 and 72 on page 23).
- 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 in the box below:

--

GO TO QUESTION 66g ON PAGE 21



BOX B

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

66d. 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			

66e. 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 66g
ON NEXT PAGE

OR

- My periods stopped sometime in the last 12 months. → GO TO QUESTION 66f

66f. 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 71 and 72 on page 23).
- 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 in the box below:



66g. Since January 1, 2017, have you used any hormonal birth control?

No → **GO TO QUESTION 67**

Yes

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

Since January 1, 2017, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2017?	b. Do you currently use this female hormone product(s)?
67. estrogen and progesterone at the same time , whether as a combination product (such as Prempro or Combipatch) or as separate medications (for example Premarin plus Provera or a progesterone shot)? <i>Do not include vaginal creams, rings, or suppositories.</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
68. estrogen alone , whether as a pill (such as Premarin), patch, or other form (such as a spray, gel, or implant), with no additional progesterone in any form? <i>Do not include vaginal creams, rings, or suppositories.</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
69. 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, 2017, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2017?
70. vaginal estrogen creams, rings, or suppositories?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto; display: flex; justify-content: space-between;"> </div> <p style="text-align: center;"># 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>



Have you ever had...	NEVER OR BEFORE 1/1/2017	HAD PROCEDURE 1/1/2017 OR LATER	If you had this procedure January 1, 2017 or later, what was the month and year?
<p>71. 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, 2017</p>	<p><input type="radio"/> Had procedure January 1, 2017 or later</p>	<p>a. MONTH/YEAR HAD PROCEDURE</p> <p><input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="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 72</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>72. a separate surgery to remove part or all of one or both ovaries (oophorectomy), but not your uterus?</p>	<p><input type="radio"/> Never had procedure</p> <p><input type="radio"/> Had procedure <u>before</u> January 1, 2017</p>	<p><input type="radio"/> Had procedure January 1, 2017 or later</p>	<p>a. MONTH/YEAR HAD PROCEDURE</p> <p><input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="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>



73. During the **past 12 months**, have you taken any vitamins or minerals regularly?

No, not regularly → **GO TO QUESTION 77 ON NEXT PAGE**

Yes, fairly regularly

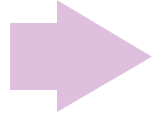


During the past 12 months , have you taken...		NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
74.	Calcium <i>without</i> vitamin D?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	Calcium: <input type="radio"/> Less than 600 mg <input type="radio"/> 600 mg <input type="radio"/> More than 600 mg
75.	Calcium <i>plus</i> vitamin D?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	Calcium: <input type="radio"/> Less than 600 mg <input type="radio"/> 600 mg <input type="radio"/> More than 600 mg Vitamin D: <input type="radio"/> Less than 2000 IU <input type="radio"/> 2000 IU <input type="radio"/> More than 2000 IU
76.	Vitamin D alone?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	Vitamin D: <input type="radio"/> Less than 2000 IU <input type="radio"/> 2000 IU <input type="radio"/> More than 2000 IU



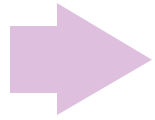
77. Which of the following best describes your **current** marital status? Please choose the **one** response that best describes your current situation.

- Never married
- Widowed
- Divorced
- Separated



GO TO QUESTION 78

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



77a. How many years have you been married or living as though married with this spouse/partner?

YEARS

OR Less than 1 year

77b. Is your spouse/partner a man or a woman?

Man

Woman

78. 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

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

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

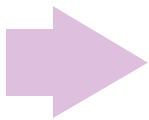


Since January 1, 2017...		During the years you smoked,				
NO		YES	a. IF YES, in which years did you smoke? (Please mark all that apply.)	b. How many days per week do/did you smoke?	c. How many cigarettes do/did you usually smoke per day on the days you smoked?	
80.	did you smoke 10 cigarettes or more?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> 2020 <input type="radio"/> 2021	<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	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> # CIGARETTES

Since January 1, 2017...		During the years you smoked,				
NO		YES	a. If yes, in which years since January 1, 2017 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?	
81.	have you drunk alcoholic beverages?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> 2020 <input type="radio"/> 2021	<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

82. Since January 1, 2017, 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



82a. Which of the following **best** describes your current situation?

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

GO TO QUESTION 83 ON NEXT PAGE

Yes → **GO TO QUESTION 83 ON NEXT PAGE**



83. Have you moved since January 1, 2017?

No → GO TO QUESTION 84 ON NEXT PAGE

Yes →

83a. What month and year did you move into your current residence?

		/	2	0		
MONTH			YEAR			

83b. Please write down your current address.

--	--	--	--	--	--	--	--	--	--

STREET #

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

STREET NAME

--	--	--	--	--	--	--	--

APT #

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CITY OR TOWN

--	--

STATE

--	--	--	--	--	--	--	--	--	--

ZIP CODE

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

COUNTY

83c. Please write down the name of the nearest cross street (the street that intersects with the street where you live):

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NAME OF NEAREST CROSS STREET



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

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

GO TO QUESTION 85 ON NEXT PAGE

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



84a. What was the approximate date you started feeling sick? *If you had this more than once, report for the time when you were the most sick.*

		/	2	0		
MONTH			YEAR			

84b. How many days until you recovered? That is, how many days until you felt well enough to resume your normal activities?

# DAYS	

Not yet recovered →

b1. Approximately how many days have you been sick so far?

# DAYS	

84c. Were you admitted to the hospital? *Do NOT include visit(s) to the Emergency Department only.*

No → GO TO QUESTION 85 ON NEXT PAGE

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

# DAYS	

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

- No
- Yes



85. Have you ever been tested for an ACTIVE COVID-19 infection? This tests for virus causing infection at that time. (Do NOT include antibody tests, blood tests used to measure past infection with COVID-19.)

No → GO TO QUESTION 86

Yes (nasal or throat swab, or saliva sample)



85a. Have you ever had a positive test result for COVID-19 infection?

- No
- Still waiting for results

} GO TO QUESTION 86

Yes → b. What was the sample collection date of the first positive test?

		/	2	0		
MONTH			YEAR			

c. Was it confirmed with a second test?

- No
- Yes



86. Are there any other health or life events you wish we had asked about?

No

Yes



Please specify:

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!

