The Sister Study
Health, Medical History and Lifestyle
Version DFU5 - ABBREVIATED

Version 2

Instructions:

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

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

Like this: ● Not like this: ⊘ ✓

Please write responses in all capital letters and numbers without touching the sides of the boxes.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z

1	2	3	4	5	6	7	8	9	0

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: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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?

☐

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?	○	○
b. had a bone density scan or osteoporosis screening?	○	○
c. had a screening colonoscopy or sigmoidoscopy exam?	○	○
d. had a vaccination for shingles (herpes zoster)?	○	○

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

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? *Do not include in situ cancer.*	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
5. ductal (breast) carcinoma in situ (DCIS)?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
6. lobular (breast) carcinoma in situ (LCIS)?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
7. lung cancer?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
8. ovarian cancer?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
9. cancer of the uterus or endometrium? *Do not include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.*	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
10. cancer of the colon or rectum?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
11. Hodgkin's disease or Hodgkin's lymphoma?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
12. non-Hodgkin's lymphoma?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
13. leukemia?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
14. thyroid cancer?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 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? *Do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.*	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	☐☐ / MONTH 2 0 ☐☐ YEAR
16. skin cancer (**not** melanoma)?	○ Never	○ Before January 1, 2017 If diagnosed before January 1, 2017, was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?	○ January 1, 2017 or later Was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?	☐☐ / MONTH 2 0 ☐☐ YEAR
17. any other type of cancer not already listed?	○ Never	○ Before January 1, 2017 If diagnosed before January 1, 2017, please specify what type(s) of cancer: 1) ☐ 2) ☐	○ 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) ☐ 2) ☐	☐☐ / MONTH 2 0 ☐☐ YEAR ☐☐ / MONTH 2 0 ☐☐ YEAR

The Sister Study enrollment started in 2003 and ended in 2009. ***Since your enrollment in the Sister Study***, have you received any of the following treatments for breast cancer, another cancer, or any other reason?	**NO**	**YES** *(Please mark all that apply.)*	a. When was the **first** treatment?	b. When was the **most recent** treatment?
18. **chemotherapy** *By chemotherapy we mean drugs used to kill cancer cells.* *Examples of chemotherapy include: Adriamycin, Taxol, and Carboplatin. There are many other chemotherapy drugs.*	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	MONTH / 2 0 YEAR OR AGE	MONTH / 2 0 YEAR OR AGE
19. **radiation treatments** *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.*	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	MONTH / 2 0 YEAR OR AGE	MONTH / 2 0 YEAR OR AGE
20. **immunotherapy treatments** *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.*	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	MONTH / 2 0 YEAR OR AGE	MONTH / 2 0 YEAR OR AGE
21. **bone marrow or stem cell transplant**	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	a. What month and year did you have this treatment? MONTH / 2 0 YEAR OR AGE	

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)?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 20 YEAR	○ No ○ Yes	○ No ○ Yes
23. congestive heart failure?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 20 YEAR	○ No ○ Yes	○ No ○ Yes
24. hypertension or high blood pressure?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 20 YEAR	○ No ○ Yes	○ No ○ 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)?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
26. angina?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes

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?	○ No	○ Yes, my first heart attack was before January 1, 2017 ○ Yes, my first heart attack was January 1, 2017 or later →	MONTH / 2 0 YEAR
28. a stroke (this does not include TIA or "mini-stroke")?	○ No	○ Yes, my first stroke was before January 1, 2017 ○ Yes, my first stroke was January 1, 2017 or later →	MONTH / 2 0 YEAR
29. a mini-stroke or TIA (transient ischemic attack)?	○ No	○ Yes, my first mini-stroke was before January 1, 2017 ○ Yes, my first mini-stroke was January 1, 2017 or later →	MONTH / 2 0 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? *These procedures are different from the test used to diagnose a blockage.*	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	MONTH / 2 0 YEAR
31. a coronary artery bypass graft surgery?	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	MONTH / 2 0 YEAR

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**?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. If first diagnosed 1/1/2017 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes
33. diabetes? *Do NOT include pre-diabetes or borderline diabetes.*	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. If first diagnosed 1/1/2017 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ 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) *Examples include Metformin (**Glucophage**), Metformin liquid (**Riomet**), or Metformin extended release (**Glucophage XR**, **Fortamet**, **Glumetza**)*	○ No	○ Yes	○ No ○ Yes
b. **Metformin in combination with other medications** *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**)*	○ No	○ Yes	○ No ○ Yes
c. **Sulfonylureas** *Examples include Glimepiride (**Amaryl**), Glyburide (**Micronase**, **DiaBeta**), Glipizide (**Glucotrol**), or Micronized glyburide (**Glynase**)*	○ No	○ Yes	○ No ○ Yes
d. **Any other, please specify:** ☐	○ No	○ Yes	○ 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**
36. Parkinson's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed? 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?	○ No ○ Yes
37b. Are you currently taking any of these medications?	○ No ○ 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?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes c. Have you taken medication for depression in the **past 12 months?** ○ 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?
39. emphysema?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
40. chronic obstructive pulmonary disease (COPD)?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR

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?	○ Never diagnosed ○ Diagnosed before 1/1/2017	○ Diagnosed 1/1/2017 or later	MONTH / 2 0 YEAR

IF DIAGNOSED ↓

b. Were you treated with radioactive iodine?	○ Never ○ Yes, before 1/1/2017 ○ Yes, 1/1/2017 or later
c. Did you have surgery to remove your thyroid?	○ Never ○ Yes, before 1/1/2017 ○ 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?	○ Never diagnosed ○ Diagnosed before 1/1/2017	○ Diagnosed 1/1/2017 or later	MONTH / 2 0 YEAR
43. any other type of thyroid disease or thyroid condition? Do NOT include thyroid cancer.	○ Never diagnosed ○ Diagnosed before 1/1/2017 If diagnosed before January 1, 2017, please specify the condition:	○ Diagnosed 1/1/2017 or later If you were diagnosed January 1, 2017 or later, please specify the condition:	MONTH / 2 0 YEAR

44. Are you **currently** taking propylthiouracil/PTU (Propycil) 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? ***Do not include osteoarthritis or psoriatic arthritis.***	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
47. psoriatic arthritis? ***Do not include osteoarthritis or rheumatoid arthritis.***	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
48. multiple sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
49. scleroderma or systemic sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
50. systemic lupus erythematosus (SLE)? ***Do not include discoid lupus.***	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
51. Sjögren's syndrome?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR

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?
a. **Immune-modifying prescription medications** *Examples: Hydroxychloroquine or chloroquine (**Plaquenil**); Methotrexate (**Rheumatrex or Trexall**); Azathioprine (**Imuran**), Mycophenolate mofetil (**Cellcept**), Cyclophosphamide (**Cytoxan**), and **Cyclosporine***	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
b. **Biologics** *Examples: **Remicade**, **Humira**, **Enbrel**, **Benlysta**, and rituximab **(Rituxan)***	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
c. **Other types of prescription medications, not including immune-modifying prescription medications or biologics** *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)].* Specify *first/only* **other type of prescription medication:** 1)	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
Specify any *additional* **other type of prescription medication:** 2)	○ No	○ Yes	○ No ○ Yes, regularly ○ 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?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 20 YEAR
54. ulcerative colitis?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 20 YEAR
55. Alzheimer's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 20 YEAR
56. dementia excluding Alzheimer's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2017 **Please specify type of dementia you had before January 1, 2017:**	○ Diagnosed January 1, 2017 or later **Please specify type of dementia you had since January 1, 2017:**	MONTH / 20 YEAR
57. shingles?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 20 YEAR

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? *Do not report any cancer or health condition reported elsewhere in this questionnaire.*	○ Never diagnosed ○ Diagnosed before January 1, 2017 If diagnosed before January 1, 2017, please specify what type of major health condition(s): 1) ☐ 2) ☐	○ 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) ☐ 2) ☐	☐☐ / 2 0 ☐☐ MONTH YEAR ☐☐ / 2 0 ☐☐ MONTH YEAR

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? ☐☐ # TIMES

59b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI? ☐☐ / 2 0 ☐☐ 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.	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR
61. fibroadenoma?	○ Never ○ Yes, before January 1, 2017 b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know
62. benign breast disease?	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR
63. proliferation **without atypia**? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR
64. atypical hyperplasia?	○ Never ○ Yes, before January 1, 2017 b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ 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?

		/					**OR**		
MONTH			YEAR					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?

		/	2	0		
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)? *Do not include vaginal creams, rings, or suppositories.*	○ No	○ Yes	☐☐ # MONTHS	○ No ○ 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? *Do not include vaginal creams, rings, or suppositories.*	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes
69. **progesterone alone** (not for birth control)?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ 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?	○ No	○ Yes	☐☐ # MONTHS b. Do you currently use this female hormone product(s)? ○ No ○ Yes c. Does this product also contain progesterone? ○ No ○ Yes ○ Don't know 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? ○ No ○ Yes

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?
71. a hysterectomy (surgical removal of the uterus)?	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	a. MONTH/YEAR HAD PROCEDURE [ ][ ] / 2 0 [ ][ ] MONTH YEAR b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy? ○ No → **GO TO QUESTION 72** ○ Yes c. Did you have... ○ both ovaries completely removed? ○ one ovary and part of the other ovary removed? ○ one ovary removed? ○ part of one or part of both ovaries removed? d. Did you have all or part of either ovary left after this surgery? ○ No ○ Yes
72. a separate surgery to remove part or all of one or both ovaries (oophorectomy), but not your uterus?	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	a. MONTH/YEAR HAD PROCEDURE [ ][ ] / 2 0 [ ][ ] MONTH YEAR b. Did you have... ○ both ovaries completely removed? ○ one ovary and part of the other ovary removed? ○ one ovary removed? ○ part of one or part of both ovaries removed? c. Did you have all or part of either ovary left after this surgery? ○ No ○ Yes

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 *without vitamin D*?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	Calcium: ○ Less than 600 mg ○ 600 mg ○ More than 600 mg
75.	Calcium *plus vitamin D*?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	Calcium: ○ Less than 600 mg ○ 600 mg ○ More than 600 mg Vitamin D: ○ Less than 2000 IU ○ 2000 IU ○ More than 2000 IU
76.	Vitamin D alone?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	Vitamin D: ○ Less than 2000 IU ○ 2000 IU ○ 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...	NO	YES	a. IF YES, in which years did you smoke? *(Please mark all that apply.)*	*During the years you smoked,* 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?	○ No	○ Yes	○ 2017 ○ 2018 ○ 2019 ○ 2020 ○ 2021 ○ 2022	○ Less than one day per week ○ 1-3 days per week ○ 4-6 days per week ○ Every day	☐☐☐ # CIGARETTES

Since January 1, 2017...	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?**	○ No	○ Yes	○ 2017 ○ 2018 ○ 2019 ○ 2020 ○ 2021 ○ 2022	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 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?

MONTH / 2 0 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 received a COVID-19 vaccine?

○ No → **GO TO QUESTION 85 ON NEXT PAGE**

○ Yes

↓

84a. Which of the following applies? I have received...

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

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

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

84a1. Have you received a booster vaccine shot?

○ No → **GO TO QUESTION 85 ON NEXT PAGE**

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

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

85. 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 86 ON PAGE 31

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

↓

85a. What was the approximate date you started feeling sick? *If you had this more than once, report for the time <u>when you were the most sick</u>.*

MONTH / 2 0 YEAR

85a1. When you were sick with COVID-19 or symptoms similar to COVID-19, which of the following symptoms did you experience? (*If you were sick **with COVID-19 symptoms** more than once, please report for the <u>time you were the most sick</u>.) Please mark all that apply.*

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

  [ ]
- ○ I did not have any symptoms → **GO TO Q86, Pg31**

85b. How many days until you recovered? That is, how many days until you felt well enough to resume your normal activities?

[ ][ ][ ] # DAYS **OR** ○ Not yet recovered →

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

85c. Were you admitted to the hospital? *Do NOT include visit(s) to the Emergency Department only.*

○ No

○ Yes →

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

DAYS

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

○ No
○ Yes

85d. Are you still experiencing symptoms due to COVID-19?

○ No → **GO TO QUESTION 86 ON NEXT PAGE**

○ Yes

↓

85d1. Which symptoms have you continued to experience? *(Please mark all that apply.)*

HEAD/SENSORY

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

PAIN

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

OTHERS

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

Please specify other symptoms:

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

○ No → **GO TO QUESTION 87**

○ Yes

86a. What was the sample collection date of the first positive test?

		/	2	0		
MONTH			YEAR			

86b. Was it confirmed with a second test?

○ No

○ Yes

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

○ No

○ Yes

↓

Please specify:

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!

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.

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