The Sister Study
Health, Medical History and Lifestyle
Version DFU6

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

Version 2

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

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

What is 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?

____

We are excited to add a new option for keeping you, our valued participants, updated about the Sister Study! For your convenience, we plan to take advantage of text messaging services to keep those who are interested well-informed about the study. The Sister Study may text you about study news or upcoming study activities, send you links to study newsletters or press releases, or share study findings made possible by your participation over the course of the study. Please note that your cell phone service provider may charge for text messages as part of your individual service plan. View our terms and privacy policy on our website: sisterstudy.niehs.nih.gov/English/index1.htm

If you prefer not to receive text messages from the Sister Study, we will continue to use e-mail, U.S mail, or telephone to communicate with you just as we have in the past.

Please indicate below if you would like to receive text messages on your mobile phone from the Sister Study.

- ○ **I AGREE** to receive text messages from the Sister Study. I understand that my service provider may charge for text messages as part of my individual service plan.

  Please provide the telephone number (cell phone) where you would like to receive text messages:

  (☐☐☐) ☐☐☐ - ☐☐☐☐

- ○ **I DO NOT** wish to receive periodic text messages from the Sister Study.

GENERAL HEALTH

1. In the **past 24 months**, would you say your health has generally been…

   - ○ excellent,
   - ○ very good,
   - ○ good,
   - ○ fair, or
   - ○ poor?

2. In the **past 24 months**, have you...

	NO	YES
a. had a routine physical exam?	○	○
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)?	○	○
e. had a flu vaccine?	○	○
f. had a routine dental exam or dental cleaning?	○	○

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

☐☐☐ POUNDS

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

☐ FEET ☐☐ INCHES

FAMILY MEDICAL HISTORY

5. Since January 1, 2020, were **any** of your sisters diagnosed with breast cancer **for the first time**?

○ No → **GO TO QUESTION 7 ON PAGE 5**

○ Yes

6. Please record breast cancer diagnosis date for each sister diagnosed **for the first time** since January 1, 2020. *Use additional paper if more than two sisters were diagnosed with breast cancer for the first time since January 1, 2020.*

	a. Month and year of breast cancer diagnosis?	b. Sister's age at diagnosis?
1) Sister	☐☐ / 2 0 ☐☐ (MONTH / YEAR)	☐☐ AGE
2) Sister	☐☐ / 2 0 ☐☐ (MONTH / YEAR)	☐☐ AGE

7. In all, how many of your full or half-sisters, living or deceased, have **ever** been diagnosed with breast cancer?

FULL SISTERS ONLY	HALF-SISTERS ONLY
○ None	○ None
○ 1	○ 1
○ 2	○ 2
○ 3	○ 3
○ 4	○ 4
○ 5 or more	○ 5 or more

8. Since January 1, 2020, have any **other** close blood relatives of yours been diagnosed with breast cancer **for the first time**?

○ No → **GO TO QUESTION 10**

○ Yes

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

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

10. Since January 1, 2020, have **any** close blood relatives of yours been diagnosed with ovarian cancer **for the first time**?

○ No → **GO TO QUESTION 12 ON NEXT PAGE**

○ Yes

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

- ○ Sister
- ○ Mother
- ○ Daughter
- ○ Other relative related to you by blood

PERSONAL MEDICAL HISTORY

We are interested in changes to your health in the past few years. Please think about your medical history **since January 1, 2020.**

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
12. breast cancer? *Do not include in situ cancer.*	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
13. ductal (breast) carcinoma in situ (DCIS)?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
14. lobular (breast) carcinoma in situ (LCIS)?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

IF NEVER DIAGNOSED WITH BREAST CANCER, DCIS, OR LCIS
→ GO TO QUESTION 18 ON PAGE 9

15. Since the time of your initial breast cancer diagnosis and treatment were you diagnosed with any of the following?

○ A new primary breast cancer → **GO TO QUESTION 16 ON NEXT PAGE**

○ A breast cancer recurrence
(Note: breast cancer can recur after a period of being apparently breast cancer free and can show up close to the initial cancer or in another part of the body)

○ Breast cancer again, but I'm not sure if it is a new primary cancer or a recurrence

→ **GO TO QUESTION 17 ON PAGE 8**

○ None of these → **GO TO QUESTION 18 ON PAGE 9**

16. If you were diagnosed with a **new primary breast cancer**:

16a. What was the date of the new breast cancer diagnosis?

[ ][ ] / 2 0 [ ][ ]
MONTH YEAR

16b. Was this tumor in the same breast, the other breast or both breasts?

- ○ Same breast
- ○ Other breast
- ○ Both breasts

16c. What was the type of the second breast cancer?

- ○ Invasive breast cancer
- ○ DCIS
- ○ LCIS
- ○ Other

Please specify:

16d. What treatments have you had for this breast cancer? *(Please mark all that apply.)*

- ○ No treatments
- ○ Lumpectomy
- ○ Mastectomy
- ○ Hormone therapy
- ○ Radiation
- ○ Chemotherapy
- ○ Biologic targeted therapy/immunotherapy
- ○ Other

Please specify:

17. If you have had a **breast cancer recurrence** (or you don't know if it was a new primary breast cancer or a recurrence):

17a. What was the date a breast cancer recurrence was first detected?

		/	2	0		
MONTH			YEAR			

17b. Was this recurrence local (that is, did it return to the same area (or close to) where it first appeared) or was it metastatic breast cancer (that is, did it show up in another part of your body)?

- ○ Local → **GO TO QUESTION 17d**
- ○ Metastatic
- ○ Both

17c. If the recurrence was not in your breast, where was the breast cancer tissue found? *(Please mark all that apply.)*

- ○ Lymph nodes
- ○ Bones
- ○ Liver
- ○ Lungs
- ○ Brain
- ○ Other

Please specify:

17d. What treatments have you had for your breast cancer recurrence? *(Please mark all that apply.)*

- ○ No treatments
- ○ Lumpectomy
- ○ Mastectomy
- ○ Hormone therapy
- ○ Radiation
- ○ Chemotherapy
- ○ Biologic targeted therapy/immunotherapy
- ○ Other

Please specify:

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
18. lung cancer?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
19. ovarian cancer?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
20. cancer of the uterus or endometrium? *Please **DO NOT** include:* • *Adenomyosis* • *Endometrial hyperplasia* • *Endometriosis* • *Pelvic inflammatory disease* • *Pre-cancerous cells* • *Uterine fibroids* • *Uterine polyps* • *Uterine prolapse* • *Uterine tuberculosis*	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
21. cancer of the colon or rectum?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
22. Hodgkin's disease or Hodgkin's lymphoma?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
23. non-Hodgkin's lymphoma?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
24. leukemia?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
25. thyroid cancer?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
26. melanoma? *Do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.*	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	☐☐ / MONTH 2 0 ☐☐ YEAR
27. skin cancer (**not** melanoma)?	○ Never	○ Before January 1, 2020 If diagnosed before January 1, 2020, was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?	○ January 1, 2020 or later Was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?	☐☐ / MONTH 2 0 ☐☐ YEAR
28. any other type of cancer not already listed?	○ Never	○ Before January 1, 2020 If diagnosed before January 1, 2020, please specify what type(s) of cancer: 1) ☐ 2) ☐	○ January 1, 2020 or later If you were diagnosed with any other type(s) of cancer January 1, 2020 or later, please specify what type(s) of cancer: 1) ☐ 2) ☐	☐☐ / MONTH 2 0 ☐☐ YEAR ☐☐ / MONTH 2 0 ☐☐ YEAR

Since January 1, 2020, have you received any of the following treatments for breast cancer, another cancer, or any other reason?	**NO**	**YES** *(Please mark all that apply.)*	**TREATED BEFORE 1/1/2020**	**TREATED AFTER 1/1/2020** What month and year were you treated? Or what age?
29. **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	○ No ○ Yes	MONTH / 2 0 YEAR **OR** AGE
30. **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	○ No ○ Yes	MONTH / 2 0 YEAR **OR** AGE
31. **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	○ No ○ Yes	MONTH / 2 0 YEAR **OR** AGE
32. **bone marrow or stem cell transplant**	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	○ No ○ Yes	MONTH / 2 0 YEAR **OR** AGE

Has a doctor or other health professional **ever** told you that you had...	**NO**	**YES**	b. Are you currently taking prescription medications for this condition?
33. high cholesterol (not borderline)?	○ No	○ Yes, first diagnosed before January 1, 2020 ○ Yes, first diagnosed January 1, 2020 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes
34. congestive heart failure?	○ No	○ Yes, first diagnosed before January 1, 2020 ○ Yes, first diagnosed January 1, 2020 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes
35. hypertension or high blood pressure?	○ No	○ Yes, first diagnosed before January 1, 2020 ○ Yes, first diagnosed January 1, 2020 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes

Since January 1, 2020, have you taken any of the following medications, either for high blood pressure or for another reason?	NO	YES	a. Are you **currently** taking this?	b. For what reason(s) are you **currently** taking this? *(Please mark all that apply.)*
36. ACE-inhibitors *These usually end in "-pril", such as lisinopril, benazepril, enalapril, captopril, ramipril, etc.*	○ No	○ Yes	○ No ○ Yes	○ High blood pressure ○ Reason other than high blood pressure
37. Thiazide diuretics *Examples include: hydrochlorothiazide (Microzide, etc.), chlorothiazide (Diuril), chlorthalidone (Hygroton)*	○ No	○ Yes	○ No ○ Yes	○ High blood pressure ○ Reason other than high blood pressure
38. Non-thiazide diuretics *Examples include: triamterene (Dyrenium), furosemide (Lasix), spironolactone (Aldactone), eplerenone (Inspra)*	○ No	○ Yes	○ No ○ Yes	○ High blood pressure ○ Reason other than high blood pressure
39. Angiotensin receptor blockers *These usually end in "-sartan", such as losartan, irbesartan, olmesartan, valsartan, telmisartan, etc.*	○ No	○ Yes	○ No ○ Yes	○ High blood pressure ○ Reason other than high blood pressure
40. Calcium channel blockers *Examples include: diltiazem (Cardizem, etc.), amlodipine (Norvasc, Lotrel), verapamil (Calan, Isoptin, etc.), nifedipine (Adalat, Procardia, etc.)*	○ No	○ Yes	○ No ○ Yes	○ High blood pressure ○ Reason other than high blood pressure
41. Beta-blockers *These usually end in "-olol", such as metoprolol, carvedilol, atenolol, propranolol, nebivolol, etc.*	○ No	○ Yes	○ No ○ Yes	○ High blood pressure ○ Reason other than high blood pressure
42. Other types of medications that lower blood pressure *Examples include: clonidine (Catapres), hydralazine (Apresoline), doxazosin (Cardura), methyldopa (Aldomet), minoxidil (Loniten)* Please specify other medications:	○ No	○ Yes	○ No ○ Yes	○ High blood pressure ○ Reason other than high blood pressure

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
43. cardiac arrhythmia (irregular heartbeat)?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
44. angina?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
45. a heart attack or myocardial infarction?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
46. a stroke (this does not include TIA or "mini-stroke")?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
47. a mini-stroke or TIA (transient ischemic attack)?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

Have you **ever** had...	**NEVER OR BEFORE 1/1/2020**	**HAD PROCEDURE 1/1/2020 OR LATER**	a. If you had this procedure January 1, 2020 or later, what was the month and year?
48. 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, 2020	○ Had procedure January 1, 2020 or later	MONTH / 2 0 YEAR
49. a coronary artery bypass graft surgery?	○ Never had procedure ○ Had procedure before January 1, 2020	○ Had procedure January 1, 2020 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
50. pre-diabetes, borderline diabetes, or an elevated A1C test **without diabetes**?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
51. diabetes? *Do NOT include pre-diabetes or borderline diabetes.*	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	☐☐ / 2 0 ☐☐ MONTH YEAR

52. Have you used insulin for diabetes since January 1, 2020?

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

○ Yes

52a. Do you **currently** take insulin?

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

Please specify:

53. Have you used any other prescription medications, **not including insulin**, for diabetes (not prediabetes) **since January 1, 2020**?

○ No → **GO TO QUESTION 54 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. **GLP-1 and dual GLP-1/GIP receptor agonists** *Examples include Dulaglutide (**Trulicity**), Exenatide (**Byetta**), Exenatide extended-release (**Bydureon**), Liraglutide (**Victoza**), Lixisenatide (**Adlyxin**), Injectable semaglutide (**Ozempic**)*	○ No	○ Yes	○ No ○ Yes
e. **Any other, please specify:** _____	○ No	○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**
54. Parkinson's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2020	○ Diagnosed January 1, 2020 or later ↓ a. What month and year were you diagnosed? ☐☐ / ☐☐☐☐ MONTH YEAR

↓ **IF DIAGNOSED with Parkinson's disease** ↓

54b. Do you still have the diagnosis of Parkinson's disease? ○ No ○ Yes

55. Have you **ever** used any prescription medications for Parkinson's disease? Examples include Levodopa, Sinemet, Stalevo, Parcopa, Rytary, Duodopa, Bendopa, Larodopa, Mirapex, Requip, Neupro patch, Apokyn, Permax, Parlodel, Eldepryl or Zelapar, Azilect, and Nourianz.

○ No → **GO TO QUESTION 56 ON NEXT PAGE**

○ Yes

55a. Did your symptoms ever improve after taking any of these medications? ○ No ○ Yes

55b. Are you currently taking any of these medications? ○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
56. osteoarthritis (age-related arthritis)? **Do not include rheumatoid arthritis or psoriatic arthritis.**	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
57. osteoporosis (bone loss, or bone thinning)?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
58. osteopenia, or low bone density?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

59. Since January 1, 2020, have you used any prescription medications to treat or prevent osteoporosis or osteopenia?

Do not count calcium or Vitamin D.

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

○ Yes

Have you **ever** taken the following prescription medications to treat or prevent osteoporosis or osteopenia?	**NO**	**YES**	a. If yes, are you **currently** taking this type of medication?
a. **Bisphosphonates** *Examples include **Fosamax**, **Actonel**, **Boniva**, or **Reclast***	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
b. **Other bone-altering prescription medications (not bisphosphonates)** *Examples include **Prolia** (denosumab), **Forteo**, or **Tymlos***	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
c. **Other type of prescription medication, not including bisphosphonates or other bone-altering medications** Please **specify** medication or type of medication: 1)	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
2)	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed

Have you **ever** had...	**NEVER**	**BEFORE 1/1/2020**	**1/1/2020 OR LATER**	a. What was the month and year that this **first** happened since January 1, 2020?
60. a hip fracture?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
61. a wrist fracture?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
62. a spine (vertebral) fracture?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
63. a rib fracture?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
64. any other fracture?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

Please specify type of other fracture before January 1, 2020:

Please specify type of other fracture you had since January 1, 2020:

65. How many bone fractures total have you had? Please enter "0" if none.

OF FRACTURES

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

○ None → **GO TO QUESTION 67**

○ Once
○ Twice
○ Three or more

66a. Did you seek medical care as a result of any of your falls? ○ 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?**
67. depression?	○ No	○ Yes, first diagnosed before January 1, 2020 ○ Yes, first diagnosed January 1, 2020 or later ↓ a. What month and year were you diagnosed? MONTH / 20 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 DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
68. emphysema?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 20 YEAR
69. chronic obstructive pulmonary disease (COPD)?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 20 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
70. Graves' disease?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
71. other hyperthyroidism (overactive thyroid)?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

IF DIAGNOSED with Graves' disease OR other hyperthyroidism (overactive thyroid)

71b. Were you treated with radioactive iodine?
- ○ Never
- ○ Yes, before 1/1/2020
- ○ Yes, 1/1/2020 or later

71c. Did you have surgery to remove your thyroid?
- ○ Never
- ○ Yes, before 1/1/2020
- ○ Yes, 1/1/2020 or later

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2020**	**1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
72. Hashimoto's thyroiditis?	○ Never diagnosed ○ Diagnosed before 1/1/2020	○ Diagnosed 1/1/2020 or later	MONTH / 2 0 YEAR
73. other hypothyroidism (underactive thyroid)?	○ Never diagnosed ○ Diagnosed before 1/1/2020	○ Diagnosed 1/1/2020 or later	MONTH / 2 0 YEAR
74. any other type of thyroid disease or thyroid condition? Do NOT include thyroid cancer.	○ Never diagnosed ○ Diagnosed before 1/1/2020 If diagnosed before January 1, 2020, please specify the condition:	○ Diagnosed 1/1/2020 or later If you were diagnosed January 1, 2020 or later, please specify the condition:	MONTH / 2 0 YEAR

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

○ No
○ Yes

76. 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 DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
77. rheumatoid arthritis? ***Do not include osteoarthritis or psoriatic arthritis.***	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
78. psoriatic arthritis? ***Do not include osteoarthritis or rheumatoid arthritis.***	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
79. scleroderma or systemic sclerosis?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
80. systemic lupus erythematosus (SLE)? ***Do not include discoid lupus.***	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
81. Sjögren's syndrome?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
82. Crohn's disease?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
83. ulcerative colitis?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
84. multiple sclerosis?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

85. 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), Sjögren's syndrome, Crohn's disease, or ulcerative colitis?

○ No → **GO TO QUESTION 87 ON PAGE 26**

○ 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**), **Cyclosporine**, Mercaptopurine or 6-MP (**Purinethol**), Sulfasalazine (**Azulfidine**), Leflunomide (**Arava**)*	○ 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

86. Have you **ever** used any of the following types of medications for multiple sclerosis?	**NO**	**YES**	a. If yes, are you **currently** taking this type of medication?
a. **Immune-modifying prescription medications** *Examples: Corticosteroids (e.g., prednisone, intravenous methylprednisolone) or plasmapheresis to treat MS attacks*	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
b. **Injectable treatments** *to modify progression such as Interferon beta medications, glatiramer acetate (**Copaxone**, **Glatopa**), monoclonal antibodies*	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
c. **Oral disease modifying treatments** *Examples: Teriflunomide (**Aubagio**), Dimethyl fumarate (**Tecfidera**), Diroximel fumarate (**Vumerity**), Monomethyl fumarate (**Bafiertam**), Fingolimod (**Gilenya**), Siponimod (**Mayzent**), Ozanimod (**Zeposia**), Ponesimod (**Ponvory**), Cladribine (**Mavenclad**)*	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
d. **Infusion treatments** *Examples: Natalizumab (**Tysabri**), Ocrelizumab (**Ocrevus**), Alemtuzumab (**Campath**, **Lemtrada**)*	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed

Diverticulosis is a condition where pouches or pockets called diverticula form in the wall of the colon. These pouches can become inflamed or infected. When these pouches (diverticula) are inflamed or infected, the condition is then called ***diverticulitis*** (not diverticulosis).

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
87. diverticul**osis** (intestinal pouches or pockets called diverticula)?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
88. diverticul**itis** (inflamed or infected intestinal pouches or pockets (i.e. inflamed or infected diverticula))?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
89. polyps in the colon or rectum?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
90. Alzheimer's disease?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
91. Vascular dementia?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
91a. Other dementia?	○ Never	○ Before January 1, 2020 Please specify:	○ January 1, 2020 or later Please specify:	MONTH / 2 0 YEAR
92. cognitive impairment?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
93. shingles?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2020**	**DIAGNOSED 1/1/2020 OR LATER**	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
94. cataracts?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
95. glaucoma?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
96. macular degeneration?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
97. pulmonary embolism?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
98. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
99. kidney failure requiring dialysis or transplant?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
100. kidney stones?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / YEAR
101. gout?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR
102. gallstones or gallbladder disease?	○ Never	○ Before January 1, 2020	○ January 1, 2020 or later	MONTH / 2 0 YEAR

Have you **ever** had...	**NEVER OR BEFORE 1/1/2020**	**HAD PROCEDURE 1/1/2020 OR LATER**	a. If you had this procedure January 1, 2020 or later, what was the month and year?
103. gallbladder surgery?	○ Never had procedure ○ Had procedure before January 1, 2020	○ Had procedure January 1, 2020 or later	MONTH / 2 0 YEAR

Since January 1, 2020, has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2020	DIAGNOSED 1/1/2020 OR LATER	a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed?
104. any other major health condition? *Do not report any cancer or health condition reported elsewhere in this questionnaire.*	○ Never diagnosed ○ Diagnosed before January 1, 2020 If diagnosed before January 1, 2020, please specify what type of major health condition(s): 1) ☐☐☐☐☐☐☐☐☐☐ 2) ☐☐☐☐☐☐☐☐☐☐	○ Diagnosed January 1, 2020 or later If you were diagnosed with any other major health condition(s) January 1, 2020 or later, please specify what type of major health condition(s): 1) ☐☐☐☐☐☐☐☐☐☐ 2) ☐☐☐☐☐☐☐☐☐☐	☐☐ / 2 0 ☐☐ MONTH YEAR ☐☐ / 2 0 ☐☐ MONTH YEAR

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

○ No → **GO TO QUESTION 106 ON NEXT PAGE**

○ Yes

105a. How old were you the **first** time you noticed this problem? ☐☐ AGE

105b. Do any of the following reasons explain your decrease in or loss of sense of smell? *(Please mark all that apply.)*

○ COVID-19
○ Head injury
○ Other

Please specify: ☐☐☐☐☐☐☐☐☐☐

105c. Is your loss of smell total?

○ No
○ Yes

106. Since January 1, 2020, have you experienced any of the following **medical symptoms**...
(Please mark a response for each item below.)

	NO	YES
a. swelling in your wrist, finger, elbow, or knee joints lasting six or more weeks?	○	○
b. joint stiffness in the mornings, lasting at least one hour, and for more than six weeks (do not include stiffness related or due to an injury or surgery)?	○	○
c. a tremor or trembling in either of your hands?	○	○
d. walking or other movements getting noticeably slower?	○	○
e. handwriting getting noticeably smaller?	○	○
f. difficulty getting started when walking or making other movements?	○	○
g. wheezing or whistling in your chest?	○	○
h. shortness of breath when hurrying on level ground, or when walking up a slight hill, or when climbing a flight of stairs at your usual pace?	○	○
i. shortness of breath when at rest?	○	○
j. shortness of breath when lying down?	○	○
k. shortness of breath when walking?	○	○
l. swelling (or edema) in your legs?	○	○

107. Since January 1, 2020, have you had a mammogram, breast ultrasound, or breast MRI?

○ No → **GO TO QUESTION 108 ON NEXT PAGE**

○ Yes

107a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2020? ☐☐ # TIMES

107b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI? ☐☐ / 2 0 ☐☐
MONTH YEAR

108. Since January 1, 2020, have you had a breast cyst or cysts drained (aspirated) or removed?

○ No
○ Yes

109. Since January 1, 2020, have you had a surgical, needle, or other biopsy to diagnose or rule out a breast condition?

○ No → **GO TO QUESTION 110**

○ Yes

109a. On how many occasions have you had this since January 1, 2020?
OCCASIONS

109b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

109c. On which breast was the most recent biopsy performed?
○ Left breast
○ Right breast
○ Both breasts

110. Since January 1, 2020, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

○ No → **GO TO QUESTION 111 ON NEXT PAGE**

○ Yes

110a. On how many occasions have you had this since January 1, 2020?
OCCASIONS

110b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

110c. On which breast was the most recent lumpectomy or excisional biopsy performed?
○ Left breast
○ Right breast
○ Both breasts

Since January 1, 2020, 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 1/1/2020**	**1/1/2020 OR LATER**	a. If you had this January 1, 2020 or later, what was the month and year?
111. fibrocystic or **benign nonproliferative** changes within normal range? For example, cysts, mild hyperplasia, benign calcifications, fibrosis, etc.	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
112. fibroadenoma?	○ Never ○ Yes, before January 1, 2020 b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know	○ Yes, January 1, 2020 or later	☐☐ / 2 0 ☐☐ MONTH YEAR b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know
113. benign breast disease?	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
114. proliferation **without atypia**? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
115. atypical hyperplasia?	○ Never ○ Yes, before January 1, 2020 b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know	○ Yes, January 1, 2020 or later	☐☐ / 2 0 ☐☐ MONTH YEAR b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know

116. Regardless of the findings, did you keep a copy of the pathology report(s) from the cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy that you are willing to share with us?

○ No

○ Yes → **PLEASE INCLUDE A COPY WITH YOUR COMPLETED QUESTIONNAIRE.**

○ Not applicable

Have you **ever** had...	**NEVER OR BEFORE 1/1/2020**	**1/1/2020 OR LATER**	a. If you had this procedure January 1, 2020 or later, what was the month and year?	b. Why was this done?
117. a mastectomy of your **left** breast?	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	MONTH / 2 0 YEAR	○ To treat breast cancer ○ To prevent breast cancer ○ Both
118. a mastectomy of your **right** breast?	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	MONTH / 2 0 YEAR	○ To treat breast cancer ○ To prevent breast cancer ○ Both

Have you **ever** had...	**NEVER OR BEFORE 1/1/2020**	**1/1/2020 OR LATER**	a. If you had this procedure January 1, 2020 or later, what was the month and year?	b. Did you have a silicone gel implant?
119. breast reconstruction or enlargement surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	MONTH / 2 0 YEAR	○ No ○ Yes
120. breast reconstruction or enlargement surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	MONTH / 2 0 YEAR	○ No ○ Yes
121. a breast implant surgically removed from your **left** breast?	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	MONTH / 2 0 YEAR	○ No ○ Yes
122. a breast implant surgically removed from your **right** breast?	○ Never ○ Yes, before January 1, 2020	○ Yes, January 1, 2020 or later	MONTH / 2 0 YEAR	○ No ○ Yes

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

○ No → **GO TO QUESTION 125 ON PAGE 35**

○ Yes

124. Have you had a menstrual period in the last 12 months?

○ No

124a. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

		/	2	0			OR		
MONTH			YEAR					AGE	

124b. 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 133 and 134 on page 37).**
- ○ 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:

○ Yes → **GO TO QUESTION 124c ON NEXT PAGE**

124c. Since January 1, 2020, have you used any **hormonal birth control**?

○ No → **GO TO QUESTION 125 ON NEXT PAGE**

○ Yes

Since January 1, 2020, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2020?	b. Do you currently use this?
124d. birth control pills?	○ No	○ Yes	☐☐ # MONTHS	○ No → **GO TO 124e** ○ Yes c. Do you currently take the type of pills that stop your menstrual periods for several months or longer? ○ No ○ Yes
124e. a hormonal IUD (intrauterine device)?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes
124f. any other hormonal birth control? Specify: ☐	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes

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

Since January 1, 2020, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2020?	b. Do you **currently** use this female hormone product(s)?
125. **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
126. **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
127. **progesterone alone** (not for birth control)?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes

Since January 1, 2020, have you used...	NO	YES	a. Do you currently use this female hormone product(s)?
128. vaginal estrogen creams, rings, or suppositories?	○ No	○ Yes	○ No ○ Yes

Since January 1, 2020, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2020?	b. Do you **currently** use this?	c. Why did you use this? *(Please mark all that apply.)*
129. tamoxifen or Nolvadex?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
130. raloxifene or Evista?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
131. any aromatase inhibitors? *Examples include: anastrozole (**Arimidex**), exemestane (**Aromasin**), and letrozole (**Femara**)*	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
132. testosterone?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	

Have you **ever** had...		**NEVER OR BEFORE 1/1/2020**	**HAD PROCEDURE 1/1/2020 OR LATER**	If you had this procedure January 1, 2020 or later, what was the month and year?
133.	a hysterectomy (surgical removal of the uterus)?	○ Never had procedure ○ Had procedure before January 1, 2020	○ Had procedure January 1, 2020 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 134** ○ 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
134.	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, 2020	○ Had procedure January 1, 2020 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

135. Have you **ever** had both of your fallopian tubes removed (bilateral salpingectomy)?

○ No → **GO TO QUESTION 136**

○ Yes

135a. What month and year did you have this procedure or how old were you when you had this procedure?

☐☐ / ☐☐☐☐ MONTH YEAR **OR** ☐☐ AGE

VITAMINS, SUPPLEMENTS, AND MEDICATIONS

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

○ No, not regularly → **GO TO QUESTION 141 ON PAGE 40**

○ 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. Did you usually take types that...
137. Multivitamin containing vitamin D (e.g., One A Day)?	○ 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	○ contain minerals, iron, zinc, etc.? ○ do not contain minerals? ○ Don't know

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?
138.	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
139.	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
140.	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

141. Since January 1, 2020, have you followed an intermittent fasting diet for longer than a month?

○ No → **GO TO QUESTION 142**

○ Yes

141a. How long did you follow this diet?

○ Less than 8 weeks
○ 8 weeks – 1 year
○ More than 1 year

142. Have you **ever** had a lap band procedure or bariatric surgery for weight management?

○ No → **GO TO QUESTION 143 ON NEXT PAGE**

○ Yes

142a. What was the date of your first surgery for weight management?

MONTH / YEAR

142b. What type(s) of surgery have you had?

(Please mark all that apply.)

○ Gastric Sleeve (sleeve gastrectomy)
○ Gastric bypass (Roux-en-Y gastric bypass)
○ Gastric reduction duodenal switch (BPD-DS)
○ Stomach intestinal pyloris sparing surgery (SIPS) or Loop duodenal switch (SADI-S)
○ Gastric band surgery (LAP-Band)
○ I use a different term:
○ Prefer not to answer

143. Have you used the following medications for weight loss since January 1, 2020?

○ No → **GO TO QUESTION 144**

○ Yes

143a. Please mark medications you are currently using:

- ○ Naltrexone/bupropion **(Contrave)**
- ○ Semaglutide **(Wegovy)**
- ○ Liraglutide **(Saxenda)**
- ○ Phentermine/topiramate **(Qsymia)**
- ○ Orlistat **(Alli, Xenical)**
- ○ Phentermine **(Adipex-P, Lomaira)**
- ○ Diethylpropion
- ○ Phendimetrazine
- ○ Benzphetamine
- ○ Setmelanotide **(Imcivree)**

144. Have you used the following medications (sometimes used for other conditions) specifically for weight loss since January 1, 2020?

○ No → **GO TO QUESTION 145 ON NEXT PAGE**

○ Yes

144a. Please mark medications you are currently using:

- ○ Metformin
- ○ Tirzepatide **(Mounjaro)**
- ○ Semaglutide **(Ozempic** or **Rybelsus)**
- ○ Dulaglutide **(Trulicity)**
- ○ Pramlintide **(Symlin)**
- ○ Topiramate **(Topamax)**
- ○ Bupropion **(Wellbutrin SR, Wellbutrin XL)**
- ○ Zonisamide **(Zonegran)**

Since January 1, 2020, have you regularly (at least once a week for at least three months in a row) taken...		NO	YES	a. If yes, for about how long have you taken this regularly (at least once a week for at least three months in a row) since January 1, 2020?
145.	antibiotics?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
146.	acetaminophen (Tylenol)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
147.	"baby aspirin" or low-dose aspirin (100 mg/tablet or less)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
148.	aspirin or other aspirin containing products (325 mg/tablet or more)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
149.	ibuprofen (such as Advil, Motrin, Nuprin, etc.)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
150.	Celebrex or other COX-2 inhibitors?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
151.	Aleve or Naprosyn (naproxen)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
152.	Relafen, Ketoprofen, Anaprox, or other non-steroidal anti-inflammatories?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years

b. On average, how many days per week have you taken this?	c. On days when you take it, how many times do you take it?	d. Are you currently taking this?
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes
○ 1 day per week ○ 2-3 days per week ○ 4-5 days per week ○ 6-7 days per week	○ 1 time per day ○ 2 times per day ○ 3 times per day ○ 4 times per day ○ 5 or more times per day	○ No ○ Yes

153. Are you taking any prescription or other medications (including vitamins and supplements) **regularly, seasonally, or as needed?**

Please include all medications, including inhalers, nasal sprays, infusions, shots, patches, and other medications, even if you use them only as needed, for example to treat asthma symptoms or migraines. Also include any medications prescribed in once a month or once a year doses, such as some medications for osteoporosis or other conditions.

○ No → **GO TO QUESTION 154 ON PAGE 48**

○ Yes

TOTAL #

a. What is/are the name(s) of the prescription or non-prescription medication(s) that you **currently take regularly, seasonally, or as needed?**	b. For how long have you used this regularly, seasonally, or as needed?
1.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
2.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
3.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
4.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
5.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years

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

a. What is/are the name(s) of the prescription or non-prescription medication(s) that you **currently take regularly, seasonally, or as needed?** (If you need more space, answer the same questions for each medication and record it on a separate sheet.)	b. For how long have you used this regularly, seasonally, or as needed?
6.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
7.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
8.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
9.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
10.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
11.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
12.	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years

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

154. 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 155**

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

→ 154a. How many years have you been married or living as though married with this spouse/partner?

[ ][ ] # YEARS OR ○ Less than 1 year

Research shows that individuals have unique health needs based on their sexual orientation. We are asking the following questions to better understand those health experiences. If you would prefer not to answer these questions, please mark "Prefer not to answer."

155. Which of the following best represents how you think of yourself? *(Please select one.)*

- ○ Lesbian or gay
- ○ Straight, that is not lesbian or gay
- ○ Bisexual
- ○ I use a different term: [ ]
- ○ I don't know
- ○ Prefer not to answer

Questions 156 and 157 are not available for use at this time.

158. 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

159. 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, 2020...	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?
160. did you smoke 10 cigarettes or more?	○ No	○ Yes	○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025	○ Less than one day per week ○ 1-3 days per week ○ 4-6 days per week ○ Every day	☐☐☐ # CIGARETTES

161. Since January 1, 2020, have you used an electronic cigarette or e-cigarette, such as Juul, NJOY, Blu, or Smoking Everywhere, even one or two times?

○ No → **GO TO QUESTION 162 ON NEXT PAGE**

○ Yes

161a. Do you now use e-cigarettes…
- ○ Every day
- ○ Some days
- ○ Not at all

Since January 1, 2020...	NO	YES	a. IF YES, in which years since January 1, 2020 have you **smoked/ vaped** marijuana (not CBD)? *(Please mark all that apply.)*	b. About how often did you **smoke/vape** marijuana (not CBD)?
162. have you **smoked/vaped** marijuana (not CBD)?	○ No	○ Yes	○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025	○ 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

Since January 1, 2020...	NO	YES	a. IF YES, in which years since January 1, 2020 have you **ingested** marijuana? *(Please mark all that apply.)*	b. About how often did you **ingest** marijuana (e.g., edibles)?
163. have you **ingested** marijuana (e.g., edibles) (not CBD)?	○ No	○ Yes	○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025	○ 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

Since January 1, 2020...	NO	YES	a. IF YES, in which years since January 1, 2020 have you used **cannabidiol, also called CBD**? *(Please mark all that apply.)*	b. About how often did you use **cannabidiol, also called CBD**?
164. have you used **cannabidiol, also called CBD**?	○ No	○ Yes	○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025	○ 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

Since January 1, 2020...	NO	YES	a. IF YES, in which years since January 1, 2020 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?
165. have you drunk **alcoholic beverages**?	○ No	○ Yes	○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025	○ 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

166. Since January 1, 2020, did you **ever** drink four or more alcoholic beverages in a row, in one sitting?

○ No → **GO TO QUESTION 167**

○ Yes

166a. How often has this happened since January 1, 2020?

○ More than once a week
○ Once a week
○ More than once a month but less than once a week
○ Once a month
○ 7-11 times a year
○ 4-6 times a year
○ 2-3 times a year
○ Once a year
○ Once or twice

167. Since January 1, 2020, has a doctor or other health professional told you that your drinking was hurting your health?

○ No
○ Yes

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

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

During the **past 7 days**, how much time did you...	
171. usually spend **sitting** on a **weekday**? This includes sitting while at work, at home, while doing course work, and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.	☐☐ HOURS PER DAY **AND** ☐☐ MINUTES PER DAY ○ Not sure
172. usually spend **standing** on a **weekday**? This includes standing while at work, at home, and during leisure time.	☐☐ HOURS PER DAY **AND** ☐☐ MINUTES PER DAY ○ Not sure

173. How similar was your level of activity this past week to your usual level of activity?

- ○ Less than usual
- ○ About the same
- ○ More than usual

174. During the **past year**, on average, how much time per day did you usually spend outdoors in daylight?

	Not at all	Less than 30 minutes per day	30 minutes or more per day
a. Winter season (Dec, Jan, Feb)	○	○	○
b. Spring season (Mar, Apr, May)	○	○	○
c. Summer season (Jun, Jul, Aug)	○	○	○
d. Fall season (Sep, Oct, Nov)	○	○	○

175. In a typical week, approximately how much time do you usually spend in natural environments including, but not limited to, public parks, gardens, or trails?

☐☐ HOURS **AND** ☐☐ MINUTES PER WEEK

176. Do you use sunscreen?

○ No → **GO TO QUESTION 177 ON NEXT PAGE**

○ Yes

176a. How frequently do you use sunscreens (do not include other products that may include sunscreens) in summer months?	○ Never ○ Occasionally (less than once a month) ○ Sometimes (1-3 times per month) ○ Often (1 or more times a week) ○ Every day
176b. How frequently do you apply sunscreens (do not include other products that may include sunscreens) other months of the year?	○ Never ○ Occasionally (less than once a month) ○ Sometimes (1-3 times per month) ○ Often (1 or more times a week) ○ Every day
176c. When you use sunscreen, what SPF do you typically use?	○ 15 or less ○ 30 ○ 50 ○ Higher than 50
176d. How frequently do you apply products including SPF other than sunscreen (such as make-up, lotions, or creams)?	○ Never ○ Occasionally (less than once a month) ○ Sometimes (1-3 times per month) ○ Often (1 or more times a week) ○ Every day

177. Have you **ever** gotten a tattoo (do not count tattoos received for radiation therapy)?

○ No → **GO TO QUESTION 178 ON NEXT PAGE**

○ Yes

Please tell us about your experience with tattooing. Please include every tattoo you have ever gotten using a tattoo machine even if it is faded, covered up, or has been removed.

177a. What is the total number of tattooing sessions you have had? ☐☐☐ # SESSIONS

177b. How many of your tattoos were bigger than your palm? ☐☐☐ # TATTOOS

177c. How many of your tattoos cover more than half the surface area of one or more limbs (e.g., a “half sleeve" or "full sleeve”)? ☐☐☐ # TATTOOS

177d. How old were you when you got your <u>first</u> tattoo? ☐☐ AGE

177e. How old were you when you got your <u>last</u> tattoo? ☐☐ AGE

177f. What colors are in your tattoos?

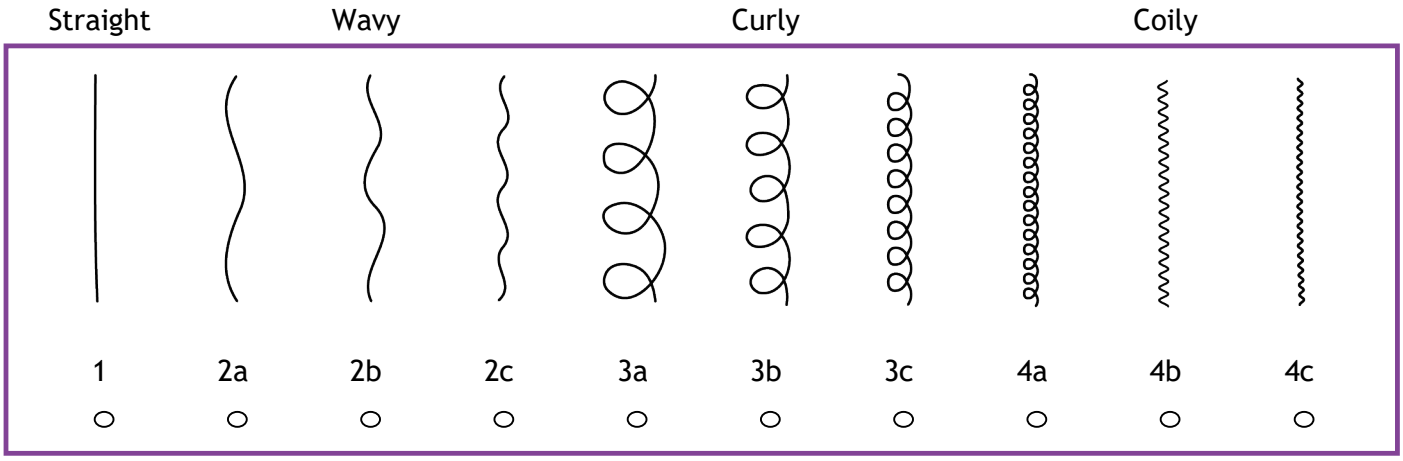
○ Black/grey ink
○ Other colors
○ Both

177g. Besides normal healing and peeling, have you had any allergies, infections, or other skin issues related to any of your tattoos?

○ No
○ Yes

177h. How many sessions of laser removal treatment did you ever have for removing tattoos? Please enter "0" if none. ☐☐☐ # SESSIONS

178. For your natural hair, what type of curl is most dominant? (*Please mark one.*)



179. Have you **ever** received negative comments about or felt discriminated against because of your hair?

○ No → **GO TO QUESTION 180 ON NEXT PAGE**

○ Yes

179a. When has this happened? *(Please mark all that apply.)*
- ○ During childhood/ adolescence (<18 years)
- ○ As an adult

179b. What specific characteristic(s) of your hair were targeted? *(Please mark all that apply.)*
- ○ Hair texture
- ○ Hair style
- ○ Hair color
- ○ Hair length

179c. Who was the source of the negative comments/ discrimination? *(Please mark all that apply.)*
- ○ Family member
- ○ Peers-e.g., friends, classmates, work colleagues
- ○ Supervisor or teacher
- ○ Strangers
- ○ Other

180. Since January 1, 2020, 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

180a. Which of the following **best** describes your current situation?

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

GO TO QUESTION 191 ON PAGE 61

○ Yes

181. How many different jobs have you had since January 1, 2020? ☐☐ # OF JOBS

Please tell us about the jobs you have had since January 1, 2020, starting with the most recent and working backwards. **PLEASE DO NOT REPORT JOBS YOU STOPPED WORKING BEFORE 2020.**

	JOB 1	JOB 2
182. When did you first start this job?	○ Before 2020 ○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025	○ Before 2020 ○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025
183. When did you last have this job?	○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025 ○ I still work there	○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024 ○ 2025 ○ I still work there

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

	JOB 1	JOB 2
189. How many times per month did/do you work at night? "Work at night" means any shift that includes at least one hour between midnight and 2:00 AM.	○ Never ○ 1-2 times/month ○ 3-5 times/month ○ 6-10 times/month ○ 11-15 times/month ○ More than 15 times per month	○ Never ○ 1-2 times/month ○ 3-5 times/month ○ 6-10 times/month ○ 11-15 times/month ○ More than 15 times per month

190. While working at this job did/do you regularly...	JOB 1	NO	YES	JOB 2	NO	YES
	a. work in dusty conditions?	○	○	a. work in dusty conditions?	○	○
	b. breathe in chemical vapors or fumes?	○	○	b. breathe in chemical vapors or fumes?	○	○
	c. get chemicals or oils on your skin or clothing?	○	○	c. get chemicals or oils on your skin or clothing?	○	○
	d. come in contact with solvents or degreasers?	○	○	d. come in contact with solvents or degreasers?	○	○
	e. come in contact with metal chips, dust, or fumes?	○	○	e. come in contact with metal chips, dust, or fumes?	○	○
	f. come in contact with pesticides?	○	○	f. come in contact with pesticides?	○	○
	g. use cleaning solutions (not counting dish or laundry detergents)?	○	○	g. use cleaning solutions (not counting dish or laundry detergents)?	○	○
	h. travel in a vehicle?	○	○	h. travel in a vehicle?	○	○

SPACE IS PROVIDED FOR TWO JOBS. IF YOU HAVE HAD MORE THAN TWO JOBS LASTING 12 MONTHS OR MORE SINCE JANUARY 1, 2020, PLEASE ANSWER THE SAME QUESTIONS FOR EACH JOB AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.

Please mark the category that best describes your response. There are no right or wrong answers. Try not to let your response to one statement influence your responses to other statements. Answer according to your own feelings, rather than how you think "most people" would answer. Don't take too long thinking over your replies; your immediate reaction will probably be more accurate than a long, thought-out response.

191. Please respond to each item by marking one answer per row.

	Excellent	Very good	Good	Fair	Poor
a. In general, would you say your health is...	○	○	○	○	○
b. In general, would you say your quality of life is...	○	○	○	○	○
c. In general, how would you rate your physical health?	○	○	○	○	○
d. In general, how would you rate your mental health, including your mood and your ability to think?	○	○	○	○	○
e. In general, how would you rate your satisfaction with your social activities and relationships?	○	○	○	○	○
f. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	○	○	○	○	○

192. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

○ Completely
○ Mostly
○ Moderately
○ A little
○ Not at all

193. Can you stand up from a chair without using your hands to push off?

○ No
○ Yes

194. In the **past 7 days**, how often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?

- ○ Never
- ○ Rarely
- ○ Sometimes
- ○ Often
- ○ Always

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

- ○ None
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Extremely severe

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

No pain										**Worst imaginable pain**
○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

197. How often during the **past 30 days**, have you...

	Never	Almost never	Some-times	Fairly often	Very often
a. felt that you were unable to control the important things in your life?	○	○	○	○	○
b. felt confident about your ability to handle your personal problems?	○	○	○	○	○
c. felt that things were going your way?	○	○	○	○	○
d. felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

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

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

199. **Over the last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Feeling nervous, anxious or on edge	○	○	○	○
b. Not being able to stop or control worrying	○	○	○	○

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

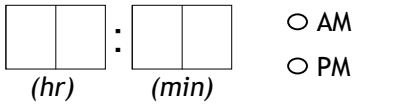
	No	Yes	Don't know	Not applicable
a. have you noticed that your judgment (e.g., ability to make decisions and think clearly) is not as good as it used to be?	○	○	○	○
b. has your interest in hobbies or activities decreased?	○	○	○	○
c. have you noticed that you tend to repeat things over and over (questions, stories, or statements) more often than you used to?	○	○	○	○
d. has it become harder to learn how to use a new tool, appliance or gadget (e.g., computer, microwave, remote control)?	○	○	○	○
e. have you noticed more problems remembering the month or year?	○	○	○	○
f. have you had more problems handling complicated financial affairs (e.g., balancing checkbook, preparing income taxes, paying bills) than you used to?	○	○	○	○
g. has it become more difficult to remember appointments?	○	○	○	○
h. do you notice more daily problems with thinking and/or memory?	○	○	○	○

201. Have family or friends told you that you have trouble thinking clearly, making decisions, or remembering things?

○ No
○ Yes
○ Don't know

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

202. During the **past month**, what time have you usually gone to bed at night?



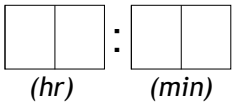
(mark one)
○ AM
○ PM

BEDTIME

203. During the **past month**, how long (in minutes) has it usually taken you to fall asleep each night?

OF MINUTES

204. During the **past month**, what time have you usually gotten up in the morning?



(mark one)
○ AM
○ PM

GETTING UP TIME

205. During the **past month**, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF
SLEEP PER NIGHT

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

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. cannot get to sleep within 30 minutes?	○	○	○	○
b. wake up in the middle of the night or early morning?	○	○	○	○
c. have to get up to use the bathroom?	○	○	○	○
d. cannot breathe comfortably?	○	○	○	○
e. cough or snore loudly?	○	○	○	○
f. feel too cold?	○	○	○	○
g. feel too hot?	○	○	○	○
h. had bad dreams?	○	○	○	○
i. have pain?	○	○	○	○
j. other reason(s), please describe:	○	○	○	○

During the **past month**...	Very good	Fairly good	Fairly bad	Very bad
207. how would you rate your sleep quality overall?	○	○	○	○

During the **past month**...	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
208. how often have you taken medicine to help you sleep (prescribed or "over the counter")?	○	○	○	○
209. how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?	○	○	○	○

During the **past month**...	No problem at all	Only a very slight problem	Somewhat of a problem	A very big problem
210. how much of a problem has it been for you to keep up enough enthusiasm to get things done?	○	○	○	○

In the **past 7 days**...	Very Poor	Poor	Fair	Good	Very Good
211. my sleep quality was...	○	○	○	○	○

212. In the **past 7 days**...

	Not At All	A Little Bit	Some-what	Quite A Bit	Very Much
a. my sleep was refreshing...	○	○	○	○	○
b. I had a problem with my sleep...	○	○	○	○	○
c. I had difficulty falling asleep...	○	○	○	○	○

Have you **ever** been told...	**NEVER OR BEFORE 1/1/2020**	**1/1/2020 OR LATER**	a. Has this happened more than 3 times since 1/1/2020?	b. If you first knew this after 1/1/2020, what was the year, or how old were you?
213. or suspected yourself, that you seem to **"act out your dreams" while asleep**? *For example, punching or flailing arms in the air, making running movements, shouting, or screaming.*	○ Never ○ Yes, first knew this before 1/1/2020	○ Yes, first knew this after 1/1/2020	○ No ○ Yes (more than 3 times)	2 0 ☐ ☐ YEAR **OR** ☐☐ AGE

214. Since January 1, 2020, has a doctor or other health professional told you that you had sleep apnea?

○ No → **GO TO QUESTION 215 ON NEXT PAGE**

○ Yes

214a. If diagnosed January 1, 2020 or later, what month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH / YEAR

214b. Do you **currently** have this condition? ○ No ○ Yes

214c. Do you **currently** use a CPAP machine or other device or implant to treat sleep apnea? *Please include BiPAP (bi-level PAP), VPAP (variable PAP), and APAP (auto-titrating PAP) machines.* ○ No ○ Yes

		NO	YES
215.	Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	○	○
216.	Has anyone observed you stop breathing or choking/gasping during your sleep?	○	○
217.	Do you often feel tired, fatigued, or sleepy during the daytime (such as falling asleep during driving or talking to someone)?	○	○

218. Have you moved since January 1, 2020?

○ No → **GO TO QUESTION 219 ON NEXT PAGE**

○ Yes

218a. What month and year did you move into your current residence? ☐☐ / 2 0 ☐☐
MONTH YEAR

218b. Please write down your current address.

STREET #

STREET NAME

APT #

CITY OR TOWN STATE ZIP CODE

COUNTY

218c. 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

The following questions will help us better understand possible health effects of air temperature and quality.

219. Do you use air conditioning in your residence?

○ No → **GO TO QUESTION 220**

○ Yes

219a. What type of air conditioning does your residence have?
(Please mark all that apply.)

○ Central A/C

○ Window unit(s). How many of them are there? ☐☐

○ Other, please specify:

☐

220. Do you use an air cleaner/filter in your residence (stand-alone or central)?

○ No → **GO TO QUESTION 221 ON NEXT PAGE**

○ Yes

220a. What type of air cleaner/filter is used?
(Please mark all that apply.)

○ HEPA filter

○ Electrostatic precipitator

○ Negative ion generator

○ Ozone generator

○ Regular or fiberglass furnace filter

○ Don't know

○ Other, please specify:

☐

220b. How often is the air cleaner/filter used?

○ Never

○ A few days a month

○ More than half of the days of the month, but less than daily

○ Every day or nearly every day

○ Don't know

221. How many times have you been sick with suspected or confirmed COVID-19, whether or not you were tested for active COVID-19 infection at that time?

☐☐ # OF TIMES → **IF NONE, PLEASE ENTER 0 AND SKIP TO QUESTION 224**

222. When you were most sick with COVID-19, how would you describe your illness?

- ○ No symptoms
- ○ Mild
- ○ Moderate
- ○ Severe

223. Have you ever had or been told you had long-term COVID-19 (often defined as symptoms lasting, arising, or recurring more than 4 weeks after initial infection)?

- ○ No → **GO TO QUESTION 224**
- ○ Yes

223a. How long was your long-term COVID-19?

- ○ 1 month
- ○ 2 to 3 months
- ○ 4 to 6 months
- ○ More than 6 months
- ○ I am still sick →

223b. Approximately how many days have you been sick so far? ☐☐☐ # DAYS

224. Have you had a vaccine for COVID-19 in the past year?

- ○ No
- ○ Yes

225. 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!