



# The Sister Study Quality of Life and Special Topics Version 4

### 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: ⊗ ✓

If you must change an answer, please mark a single horizontal line through the incorrect answer and bubble in the correct answer completely.

Like this: ● ~~YES~~                      Not like this: ~~●~~ YES

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

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

1	2	3	4	5	6	7	8	9	0
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When writing dates, please follow this example.

EXAMPLE: June 7, 2012 = 

0	6
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 / 

0	7
---	---

 / 

2	0	1	2
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(month)                      (day)                      (year)

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

Version 4



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.

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.

Today's Date:   /   /

MONTH                      DAY                      YEAR

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

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. In general, would you say your quality of life is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. In general, how would you rate your physical health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. In general, how would you rate your mental health, including your mood and your ability to think?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In general, how would you rate your satisfaction with your social activities and relationships?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. 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



8. 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

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

- None
- Mild
- Moderate
- Severe
- Extremely severe

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

No pain										Worst imaginable pain
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10

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

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



12. For each statement below, choose the answer that best indicates how often the statement is true for you.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. I can count on someone to provide me with emotional support (someone to confide in about myself or a problem or who will listen to me when I need to talk).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I can count on someone if I need help (for example, to take me to the doctor or help with daily chores if I am sick).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. There is someone in my immediate family who believes in me and wants me to succeed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. There is someone in my immediate family who makes me feel important or special.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. In general, how many relatives or friends do you feel close to (people you feel at ease with, can talk to about private matters, or call on for help)?

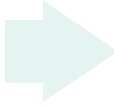
- None
- 1-2
- 3-5
- 6-9
- 10 or more



14. During the **past 12 months**, about how many hours **per week** on average did you provide care for children or grandchildren?

None → **GO TO QUESTION 15**

- 1-8 hours
- 9-20 hours
- 21-40 hours
- 41 or more hours



14a. How stressful would you say it is to provide care for these children or grandchildren?

- Not at all
- A little
- A moderate amount
- A lot

14b. During the **past 12 months**, for whom did you provide such care? *(Please mark all that apply.)*

- My children
- My grandchildren
- Other children

15. During the **past 12 months**, about how many hours **per week** on average did you provide care for an ill or disabled person? This might be a parent, child, sibling, spouse, partner, other relative, or personal friend.

None → **GO TO THE NEXT PAGE, QUESTION 16**

- 1-8 hours
- 9-20 hours
- 21-40 hours
- 41 or more hours



15a. How stressful would you say it is to provide care for these disabled or ill individuals?

- Not at all
- A little
- A moderate amount
- A lot

15b. During the **past 12 months**, for whom did you provide such care? *(Please mark all that apply.)*

- Parent
- Child
- Sibling
- Spouse
- Partner
- Other relative
- Friend

Please use a ballpoint pen for this form



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

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



Since <b>January 1, 2009</b> , have you experienced the death of...	NO	YES	a. Regardless of when this happened, how much distress or anxiety has this caused you in the <b>past 4 weeks</b> ?
17. your spouse or partner?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
18. your sister with breast cancer?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
19. another sibling?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
20. a child?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
21. a parent?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
22. a close personal friend?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot

Please use a ballpoint pen for this form



Since <b>January 1, 2009</b> , have you experienced...	NO	YES	a. Regardless of when this happened, how much distress or anxiety has this caused you in the <b>past 4 weeks</b> ?
23. a major illness that was life threatening or severely disabling to you?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
24. the recurrence or worsening of your sister's breast cancer?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
25. any other close relative's diagnosis of breast cancer?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
26. a major change in, or serious difficulty with a personal relationship (such as a divorce, or child custody issues)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot
27. serious financial or legal troubles such as arrest or bankruptcy (either you or another family member whose troubles would directly affect you)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> None <input type="radio"/> A little <input type="radio"/> A moderate amount <input type="radio"/> A lot





28. In the **past 12 months**, have you had to quit, reduce your hours, or change your job because of your health or to meet the needs of your family?

- No
- Not applicable

Yes



28a. Why did you have to do this? *(Please mark all that apply.)*

- Because of my health
- To meet the needs of my family

29. In the **past 12 months**, have you been forced to leave your job, reduce your hours, or change your job for other reasons such as the economy?

- No
- Not applicable
- Yes

30a. Are you currently unemployed and looking for work?

- No
- Yes

30b. Are you currently unemployed and **not** looking for work?

- No
- Yes

Please use a ballpoint pen for this form



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
31. have you noticed that your judgment (e.g., ability to make decisions and think clearly) is not as good as it used to be?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. has your interest in hobbies or activities decreased?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. have you noticed that you tend to repeat things over and over (questions, stories, or statements) more often than you used to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. has it become harder to learn how to use a new tool, appliance or gadget (e.g., computer, microwave, remote control)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. have you noticed more problems remembering the month or year?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. have you had more problems handling complicated financial affairs (e.g., balancing checkbook, preparing income taxes, paying bills) than you used to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. has it become more difficult to remember appointments?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. do you notice more daily problems with thinking and/or memory?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please answer the following questions about sleep.

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

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# HOURS

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

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# HOURS



41. In the **past month**, how many hours of sleep per night on average did you typically get?

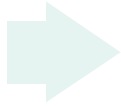
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# HOURS

42. Do you have difficulty falling asleep or staying asleep on a regular basis?

No → GO TO QUESTION 43

Yes



42a. How many nights in a typical month do you have trouble sleeping?

--	--

# NIGHTS

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

No → GO TO QUESTION 44

Yes



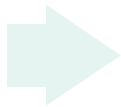
43a. In the **past month**, about how often did you feel excessively sleepy during the day?

- Less than once a week
- 1 - 2 days per week
- 3 - 5 days per week
- 6 days per week or daily

44. Have you **ever** been told, or suspected yourself, that you seem to "act out your dreams" while asleep, for example, punching or flailing arms in the air, making running movements, shouting, or screaming?

No → GO TO NEXT PAGE, QUESTION 45

Yes



44a. How often do you do this?

- Less than 3 times in total
- Less than once a month
- 1 - 3 times a month
- Once a week
- More than once a week

44b. How old were you when you first knew you did this?

--	--

AGE

Please use a ballpoint pen for this form



45. Has a doctor or other health professional **ever** told you that you have restless leg syndrome?

- No
- Yes

	No	Yes
46. Do you have, or have you had, recurrent uncomfortable feelings or sensations in your legs while you are sitting or lying down?	<input type="radio"/>	<input type="radio"/>
47. Do you have, or have you had, a recurrent need or urge to move your legs while you were sitting or lying down?	<input type="radio"/>	<input type="radio"/>



**IF YOU  
ANSWERED NO  
TO BOTH, GO  
TO QUESTION  
58, PAGE 15**



**IF YOU  
ANSWERED YES  
TO EITHER OF  
THE ABOVE,  
GO TO  
QUESTION 48**

If you answered **Yes** to either 46 or 47:

48. Are you more likely to have these feelings when you are resting (either sitting or lying down) or when you are physically active?

- Resting
- Active

49. If you get up or move around when you have these feelings do these feelings get any better while you actually keep moving?

- No
- Yes
- Don't know



50. Which times of day are these feelings in your legs **most** likely to occur?  
(Please mark all that apply.)

- Morning
- Mid-day
- Afternoon
- Evening
- Night
- About equal at all times

51. Will simply changing leg position by itself **once** without continuing to move usually relieve these feelings?

- Usually relieves
- Does not usually relieve
- Don't know

52. Are these feelings **ever** due to muscle cramps?

- No
- Don't know

GO TO QUESTION 53

Yes



52a. Are they **always** due to muscle cramps?

- No
- Yes
- Don't know

53. Do these feelings occur when sitting or when lying down?

- Only when sitting
- Only when lying down
- Both when sitting and when lying down
- Neither



54. When you experience the feelings in your legs, how **distressing** are they?

- Not at all distressing
- A little bit
- Moderately
- Extremely distressing

55. In the **past 12 months**, how often did you experience these feelings in your legs?  
(Please mark the best single answer.)

- 6 times per week or daily
- 4 - 5 days per week
- 2 - 3 days per week
- 1 day per week
- 2 - 3 days per month
- 1 day per month or less
- Never

56. Approximately how old were you when you **first** noticed these feelings in your legs?  
(Please write age.)

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AGE

57. Did you **first** notice these feelings during a pregnancy?

- No
- Never been pregnant

} GO TO NEXT PAGE, QUESTION 58

Yes



57a. Other than pregnancy, about how old were you when you **first** noticed these feelings in your legs?

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AGE

- Never felt this outside of pregnancy



58. During the **past 12 months**, have you taken any vitamins or minerals regularly, at least once a month?

No, not regularly → **GO TO PAGE 21, QUESTION 79**

Yes, fairly regularly



During the <b>past 12 months</b> , 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...
<b>Multiple Vitamins</b> 59. One A Day, Centrum, or Thera type multiple vitamins?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> contain minerals, iron, zinc, etc.? <input type="radio"/> do not contain minerals? <input type="radio"/> Don't know
60. Stress-tabs or B-Complex type multiple vitamins?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	
61. Antioxidant combination-type multiple vitamins?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	

Please use a ballpoint pen for this form



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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>  62. Vitamin A (not beta-carotene)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 8000 IU <input type="radio"/> 8000 IU <input type="radio"/> More than 8000 IU
63. Beta-carotene?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	
64. Thiamin (B1)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 100 mg <input type="radio"/> 100-250 mg <input type="radio"/> More than 250 mg
65. Niacin (B3)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 500 mg <input type="radio"/> 500 mg <input type="radio"/> More than 500 mg





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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>					
66. Vitamin B6?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 100 mg <input type="radio"/> 100 mg <input type="radio"/> More than 100 mg
67. Vitamin B12?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 500 mcg <input type="radio"/> 500 mcg <input type="radio"/> 1000 mcg <input type="radio"/> 2000 mcg <input type="radio"/> More than 2000 mcg
68. Vitamin C?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 500 mg <input type="radio"/> 500 mg <input type="radio"/> 1000 mg <input type="radio"/> More than 1000 mg
69. Vitamin D alone?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 2000 IU <input type="radio"/> 2000 IU <input type="radio"/> More than 2000 IU



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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>					
70. Vitamin E?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 400 IU <input type="radio"/> 400 IU <input type="radio"/> More than 400 IU
71. Folic acid, folate?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 400 mcg <input type="radio"/> 400 mcg <input type="radio"/> More than 400 mcg
72. Calcium plus vitamin D?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	
73. Calcium without vitamin D?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 600 mg <input type="radio"/> 600 mg <input type="radio"/> More than 600 mg



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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>					
74. Chromium?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 200 mcg <input type="radio"/> 200 - 1000 mcg <input type="radio"/> More than 1000 mcg
75. Iron?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 65 mg <input type="radio"/> 65 mg <input type="radio"/> More than 65 mg
76. Magnesium?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 250 mg <input type="radio"/> 250 mg <input type="radio"/> More than 250 mg
77. Selenium?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 200 mcg <input type="radio"/> 200 mcg <input type="radio"/> More than 200 mcg



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?
<b>Single Vitamins and Minerals (not part of multiple vitamins)</b>  78. Zinc, alone or combined with something else?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> A few days per month <input type="radio"/> 1 - 3 days per week <input type="radio"/> 4 - 6 days per week <input type="radio"/> Every day	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years	<input type="radio"/> Less than 50 mg <input type="radio"/> 50 mg <input type="radio"/> More than 50 mg



In the past 12 months, did you take any of these supplements at least once a month?	NO	YES	a.	b.
			How frequently did you take this?	For how many years in all have you taken this?
79. Black cohosh	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
80. Chamomile	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
81. Co-enzyme Q10 (CoQ10)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
82. Cod liver oil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
83. Cranberry pills	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
84. DHEA	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years



In the past 12 months, did you take any of these supplements at least once a month?	NO	YES	a. How frequently did you take this?	b. For how many years in all have you taken this?
85. Echinacea	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
86. Evening primrose oil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
87. Fiber supplement	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
88. Fish oil (EPA)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
89. Flax seed/flax seed oil	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
90. Garlic pills	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years



In the past 12 months, did you take any of these supplements at least once a month?	NO	YES	a. How frequently did you take this?	b. For how many years in all have you taken this?
91. Ginger	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
92. Ginkgo	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
93. Ginseng	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
94. Glucosamine/Chondroitin	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
95. Kava Kava	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
96. Lecithin	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years



In the past 12 months, did you take any of these supplements at least once a month?		NO	YES	a. How frequently did you take this?	b. For how many years in all have you taken this?
97.	Lutein	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
98.	Melatonin	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
99.	Milk thistle	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
100.	Mixed carotenoids	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
101.	Omega-3 or omega-3 fatty acids	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
102.	Probiotics/acidophilus	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years





In the past 12 months, did you take any of these supplements at least once a month?		NO	YES	a. How frequently did you take this?	b. For how many years in all have you taken this?
103.	Soy isoflavones	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
104.	St. John's Wort	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
105.	Turmeric capsules	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
106.	Valerian	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
107.	Something else	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 3 days per week <input type="radio"/> 3 - 5 days per week <input type="radio"/> 6 - 7 days per week	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years

Please use a ballpoint pen for this form



Have you used any of the following complementary or alternative practices within the past 12 months?		NO	YES	a. How frequently?	b. For how many years in all?
108.	Juicing	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
109.	Acupuncture	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
110.	Yoga	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
111.	Spirituality, meditation, prayer	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
112.	Therapeutic touch/massage	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
113.	Tai chi	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years



Have you used any of the following complementary or alternative practices within the past 12 months?		NO	YES	a. How frequently?	b. For how many years in all?
114.	Qi gong	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
115.	Chiropractic	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
116.	Reiki	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
117.	Biofeedback	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
118.	Homeopathy	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years
119.	Visualization/guided imagery	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years

Please use a ballpoint pen for this form



Have you used any of the following complementary or alternative practices within the past 12 months?	NO	YES	a. How frequently?	b. For how many years in all?
120. Deep breathing exercises	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than once a month <input type="radio"/> 1-4 times a month <input type="radio"/> More than 4 times a month	<input type="radio"/> Less than 1 year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 - 4 years <input type="radio"/> 5 - 9 years <input type="radio"/> 10+ years

121. Typically, how often do you have bowel movements?

- Less than once every other day
- Once every other day
- Once per day
- 2 or more times per day

122. How often do you use laxatives, not including fiber or fiber tabs?

- Never
- Less than once a month
- 1 - 3 times per month
- 1 - 3 times per week
- 4 - 6 times per week
- Daily or more



Some people follow special diets as part of their lifestyle. Others change their diet when there is a change in their life or when they are trying to achieve a goal like losing weight.

Since <b>January 1, 2009</b> , which (if any) of these special diets have you followed for longer than a month, other than during pregnancy?		NO	YES	a. How long did you follow this diet?	b. Have you followed this diet for <b>at least a month in the past year?</b>
123.	High fiber	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
124.	Low fat	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
125.	Restricted calories	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
126.	Liquid/juice	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
127.	Vegetarian	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
128.	Low salt	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
129.	Macrobiotic	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
130.	Diabetic diet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
131.	Atkins	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
132.	Zone (Barry Sears)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No

Please use a ballpoint pen for this form



Since <b>January 1, 2009</b> , which (if any) of these special diets have you followed for longer than a month, other than during pregnancy?		NO	YES	a. How long did you follow this diet?	b. Have you followed this diet for <b>at least a month in the past year</b> ?
133.	Weight Watchers	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
134.	Tried to gain weight	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
135.	Diet with pre-prepared meals	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
136.	Physician-based diet with special supplements such as puddings, beverages or vitamins	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
137.	South Beach diet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
138.	Raw food diet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
139.	HCG diet	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No
140.	Other diet, please specify: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 weeks - 1 year <input type="radio"/> More than 1 year	<input type="radio"/> Yes <input type="radio"/> No

Have you <b>ever</b> had any of the following weight loss procedures?		NO	YES	a. What age did you have this?
141.	Lap band	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
142.	Bariatric surgery	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE



143. Do you have, or have you ever had, a food allergy?

No  
 Don't know
 } **GO TO PAGE 33, QUESTION 156**

Yes



Do you have, or have you ever had, an allergy to the following foods?	NO	YES	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
144. Milk	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
145. Egg	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
146. Peanuts	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
147. Other nuts	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto; display: flex; justify-content: space-between;"><div style="width: 45%;"></div><div style="width: 45%;"></div></div> <div style="text-align: center; margin-top: 5px;">AGE</div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know

Please use a ballpoint pen for this form



Do you have, or have you <b>ever</b> had, an allergy to the following foods?	NO	YES	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
148. Shellfish	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <div style="display: flex; justify-content: space-between; width: 100px; height: 20px; border-bottom: 1px solid black;"></div> <div style="text-align: center; margin-top: 5px;">AGE</div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
149. Fish	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <div style="display: flex; justify-content: space-between; width: 100px; height: 20px; border-bottom: 1px solid black;"></div> <div style="text-align: center; margin-top: 5px;">AGE</div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
150. Any kind of fruit	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <div style="display: flex; justify-content: space-between; width: 100px; height: 20px; border-bottom: 1px solid black;"></div> <div style="text-align: center; margin-top: 5px;">AGE</div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
151. Wheat	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <div style="display: flex; justify-content: space-between; width: 100px; height: 20px; border-bottom: 1px solid black;"></div> <div style="text-align: center; margin-top: 5px;">AGE</div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
152. Soy	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <div style="display: flex; justify-content: space-between; width: 100px; height: 20px; border-bottom: 1px solid black;"></div> <div style="text-align: center; margin-top: 5px;">AGE</div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know





Do you have, or have you <b>ever</b> had, an allergy to the following foods?	NO	YES	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
153. Rye	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 60px; height: 20px; margin: 5px auto; display: flex; justify-content: space-between;"><span style="width: 40%;"></span><span style="width: 20%;"></span></div> <p style="text-align: center; margin: 0;">AGE</p>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
154. Vegetable(s)	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 60px; height: 20px; margin: 5px auto; display: flex; justify-content: space-between;"><span style="width: 40%;"></span><span style="width: 20%;"></span></div> <p style="text-align: center; margin: 0;">AGE</p>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know
155. Other food, specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input type="radio"/> No	<input type="radio"/> Yes, it started <u>before</u> age 18 <input type="radio"/> Yes, it started age 18 or later → a. Age it started <div style="border: 1px solid black; width: 60px; height: 20px; margin: 5px auto; display: flex; justify-content: space-between;"><span style="width: 40%;"></span><span style="width: 20%;"></span></div> <p style="text-align: center; margin: 0;">AGE</p>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know

156. Do you have lactose intolerance?

- No
- Don't know



**GO TO NEXT PAGE, QUESTION 157**

- Yes



156a. Do you consume any type of dairy products on most days?

No  
 Yes



157. During the past month, did you eat any hot or cold cereals?

No → GO TO NEXT PAGE, QUESTION 158

Yes



157a. During the past month, how often did you eat hot or cold cereals? You can report per day, per week, or per month.

--	--

# TIMES

- Per day  
 Per week  
 Per month

157b. During the past month, what kind of cereal did you usually eat? Please record the name using the enclosed card. If your cereal is not listed, please enter the cereal name.

--

FIRST CEREAL

157c. Was there another cereal that you usually ate?

- No → GO TO NEXT PAGE, QUESTION 158  
 Yes

157d. During the past month, what second kind of cereal did you usually eat? Please record the name using the enclosed card. If your cereal is not listed, please enter the cereal name.

--

SECOND CEREAL



158. During the past month, did you have any **milk** (either to drink or on cereal)? Include regular milks, chocolate or other flavored milks, lactose-free milk, buttermilk. Do not include soy milk or small amounts of milk in coffee or tea.

- No
- Don't know

} GO TO NEXT PAGE, QUESTION 159

- Yes



158a. During the past month, how often did you have any **milk** (either to drink or on cereal)? You can report per day, per week, or per month.

--	--

# TIMES

- Per day
- Per week
- Per month

158b. During the past month, what kind of milk did you usually drink? Pick one.

- Whole or regular milk
- Fat-free, skim, or non-fat milk
- 2% fat or reduced-fat milk
- Soy milk
- 1%, ½%, or low-fat milk
- Other, specify:

Please use a ballpoint pen for this form



During the past month, did you...	NO	YES	a. How often?	
159. drink any <b>regular soda or pop</b> that contains sugar? Do <b>not</b> include diet soda.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
160. drink any <b>100% pure fruit juices</b> such as orange, mango, apple, grape and pineapple juices? Do <b>not</b> include fruit-flavored drinks with added sugar or fruit juice you made at home and added sugar to.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
161. drink any <b>coffee or tea</b> that had <b>sugar or honey</b> added to it? Include coffee and tea you sweetened yourself and presweetened tea and coffee drinks such as Arizona Iced Tea and Frappuccino. Do <b>not</b> include artificially sweetened coffee or diet tea.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
162. drink any <b>sweetened</b> fruit drinks, sports or energy drinks, such as Kool-aid, lemonade, Hi-C, cranberry drink, Gatorade, Red Bull, or Vitamin Water? Include fruit juices you made at home and added sugar to. Do <b>not</b> include diet drinks or artificially sweetened drinks.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
163. eat any <b>fruit</b> ? Include fresh, frozen, or canned fruit. Do <b>not</b> include juices.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
164. eat a green leafy or lettuce <b>salad</b> , with or without other vegetables?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
165. eat any kind of <b>fried potatoes</b> including french fries, home fries, or hash brown potatoes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
166. eat any <b>other kind of potatoes</b> , such as baked, boiled, mashed potatoes, sweet potatoes, or potato salad?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
167. eat any <b>refried beans, baked beans, beans in soup, pork and beans or other cooked dried beans</b> ? Do <b>not</b> include green beans.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
168. eat any <b>brown rice</b> or other cooked whole grains, such as bulgur, cracked wheat, or millet? Do <b>not</b> include white rice.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month



During the past month, did you...	NO	YES	a. How often?
169. eat <b>any other vegetables</b> ? Do <b>not</b> include green salads, potatoes, and cooked dried beans.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
170. eat any Mexican-type <b>salsa</b> made with tomato?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
171. eat any <b>pizza</b> ? Include frozen pizza, fast food pizza, and homemade pizza.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
172. have any <b>tomato sauces</b> such as with spaghetti or noodles or mixed into foods such as lasagna? Do <b>not</b> count tomato sauce on pizza.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
173. eat any kind of <b>cheese</b> ? Include cheese as a snack, cheese on burgers, sandwiches, and cheese in foods such as lasagna, quesadillas, or casseroles. Do <b>not</b> include cheese on pizza.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
174. eat any <b>red meat</b> , such as beef, pork, ham, or sausage? Do <b>not</b> include chicken, turkey or seafood. Include red meat you had in sandwiches, lasagna, stew, and other mixtures. Red meats may also include veal, lamb, and any lunch meats made with these meats.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
175. eat any <b>processed meat</b> , such as bacon, lunch meats, or hot dogs? Include processed meats you had in sandwiches, soups, pizza, casseroles, and other mixtures.  Processed meats are those preserved by smoking, curing, or salting, or by the addition of preservatives. Examples are: ham, bacon, pastrami, salami, sausages, bratwursts, frankfurters, hot dogs, and spam.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
176. eat any <b>whole grain bread</b> including toast, rolls and in sandwiches? Whole grain breads include whole wheat, rye, oatmeal and pumpernickel. Do <b>not</b> include white bread.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
177. eat any <b>chocolate</b> or any other types of <b>candy</b> ? Do <b>not</b> include sugar-free candy.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES <input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month



During the past month, did you...	NO	YES	a. How often?	
178. eat any <b>doughnuts</b> , sweet rolls, Danish, muffins, <i>pan dulce</i> or pop-tarts? Do <b>not</b> include sugar-free items.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
179. eat any <b>cookies, cake, pie, or brownies</b> ? Do <b>not</b> include sugar-free kinds.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
180. eat any ice cream or other <b>frozen desserts</b> ? Do <b>not</b> include sugar-free kinds.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month
181. eat any <b>popcorn</b> ?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # TIMES	<input type="radio"/> Per day <input type="radio"/> Per week <input type="radio"/> Per month





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Please check to see that all questions are answered.

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

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

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

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