



# The Sister Study Health and Medical History B-Version 1

### Instructions:

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

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

Like this: ●

Not like this: ⊗ ✓

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

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

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

EXAMPLE: June 7, 2012 = 

0	6
---	---

 / 

0	7
---	---

 / 

2	0	1	2
---	---	---	---

(month)                      (day)                      (year)

Version 1

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



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

## 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?	<input type="radio"/>	<input type="radio"/>
b. been to a dentist for a routine check-up or cleaning?	<input type="radio"/>	<input type="radio"/>
c. had a Pap smear?	<input type="radio"/>	<input type="radio"/>
d. had a breast exam by a doctor or other health professional?	<input type="radio"/>	<input type="radio"/>
e. had a screening mammogram?	<input type="radio"/>	<input type="radio"/>
f. had a screening ultrasound of the breast?	<input type="radio"/>	<input type="radio"/>
g. had a screening MRI of the breast?	<input type="radio"/>	<input type="radio"/>
h. had a bone density scan or osteoporosis screening?	<input type="radio"/>	<input type="radio"/>
i. had a screening colonoscopy or sigmoidoscopy exam?	<input type="radio"/>	<input type="radio"/>
j. had an ultrasound of the uterus?	<input type="radio"/>	<input type="radio"/>
k. had an ultrasound of the ovaries?	<input type="radio"/>	<input type="radio"/>
l. had a flu vaccination (either a flu shot or nasal spray)?	<input type="radio"/>	<input type="radio"/>
m. had a vaccination for shingles (herpes zoster)?	<input type="radio"/>	<input type="radio"/>



3. Do you have any form of general health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Medicaid?

- No
- Yes

4. Was there a time in the past 12 months when you needed to see a doctor but did not because of the cost?

- No
- Yes

5. Since January 1, 2012, have you ever been unable to get screening mammography because your insurance doesn't cover it or you don't have access to screening through your work or other sources?

- No
- Yes

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

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POUNDS

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

--	--	--

FEET      INCHES

8. Since January 1, 2012, how many times have you lost 20 pounds (9 kilograms) or more and then later gained all the weight back? (If none, please enter "00".)

--	--

# TIMES



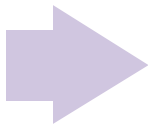
## FAMILY MEDICAL HISTORY

9. Since January 1, 2012, were **any** of your sisters diagnosed with breast cancer **for the first time**?
- No
  - Yes

- 9a. In all, how many of your full or half sisters have ever been diagnosed with breast cancer?
- 1
  - 2
  - 3
  - 4
  - 5 or more

10. Since January 1, 2012, have any **other** close blood relatives of yours been diagnosed with breast cancer **for the first time**?
- No → **GO TO QUESTION 11**

Yes

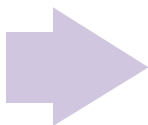


10a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

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

11. Since January 1, 2012, have **any** close blood relatives of yours been diagnosed with ovarian cancer **for the first time**?
- No → **GO TO THE NEXT PAGE, QUESTION 12**

Yes



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

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



In previous questionnaires, we have asked whether any of your grandparents have had cancer. However, we did not ask you which grandparent was diagnosed with cancer.

Were any of the following blood relatives EVER diagnosed with <b>BREAST</b> cancer?		a. If Yes, at what age were they diagnosed?					
12. Grandmother on <u>mother's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table> OR <input type="radio"/> I don't know			AGE	
AGE							
13. Grandmother on <u>father's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table> OR <input type="radio"/> I don't know			AGE	
AGE							
14. Grandfather on <u>mother's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table> OR <input type="radio"/> I don't know			AGE	
AGE							
15. Grandfather on <u>father's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table> OR <input type="radio"/> I don't know			AGE	
AGE							

Were any of the following blood relatives EVER diagnosed with <b>OVARIAN</b> cancer?		a. If Yes, at what age were they diagnosed?					
16. Grandmother on <u>mother's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table> OR <input type="radio"/> I don't know			AGE	
AGE							
17. Grandmother on <u>father's</u> side.	<input type="radio"/> No <input type="radio"/> I don't know	<input type="radio"/> Yes	<table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table> OR <input type="radio"/> I don't know			AGE	
AGE							

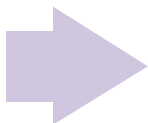
Please use a ballpoint pen for this form



18. Have **any** close blood relatives of yours **ever** been diagnosed with Parkinson's disease?

No → **GO TO QUESTION 19**

Yes



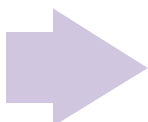
18a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

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

19. Have **any** close blood relatives of yours **ever** been diagnosed with Alzheimer's disease?

No → **GO TO QUESTION 20**

Yes



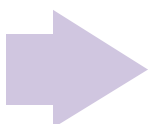
19a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

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

20. Have **any** close blood relatives of yours **ever** been diagnosed with diabetes?

No → **GO TO THE NEXT PAGE, QUESTION 21**

Yes



20a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

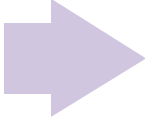
- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Other relative related to you by blood



21. Have any close blood relatives of yours ever been diagnosed with heart disease?

No → GO TO QUESTION 22

Yes



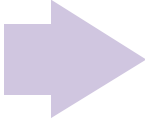
21a. What is/are the relative(s)' relationship to you?  
(Please mark all that apply.)

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

22. Have any close blood relatives of yours ever had a stroke?

No → GO TO THE NEXT PAGE, QUESTION 23

Yes



22a. What is/are the relative(s)' relationship to you?  
(Please mark all that apply.)

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

Please use a ballpoint pen for this form



## PERSONAL MEDICAL HISTORY

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

Has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>DIAGNOSED 1/1/2012 OR LATER</b>	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
23. breast cancer? Please do <b>not</b> include in situ cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
24. ductal (breast) carcinoma in situ (DCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
25. lobular (breast) carcinoma in situ (LCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
26. lung cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
27. ovarian cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
28. cancer of the uterus or endometrium? Please do <b>not</b> include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
29. cancer of the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
30. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
31. non-Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>
32. leukemia?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div>





Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
33. melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> / <input type="text"/> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
34. skin cancer (not melanoma)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012  If diagnosed before January 1, 2012, was it... (Please mark all that apply.)  <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?	<input type="radio"/> Diagnosed January 1, 2012 or later	a. MONTH/YEAR DIAGNOSED <div style="text-align: center;"> <input type="text"/> / <input type="text"/> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> b. Was it... (Please mark all that apply.) <input type="radio"/> basal cell? <input type="radio"/> squamous cell? <input type="radio"/> other?
35. any other type of cancer not already listed?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012  If diagnosed before January 1, 2012, please specify what type(s) of cancer: <input type="text"/> <input type="text"/>	<input type="radio"/> Diagnosed January 1, 2012 or later	a. MONTH/YEAR DIAGNOSED <div style="text-align: center;"> <input type="text"/> / <input type="text"/> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> b. Please specify what type of cancer: <input type="text"/> c. If you were diagnosed with a second <b>other</b> type of cancer January 1, 2012 or later, what month and year were you diagnosed? <div style="text-align: center;"> <input type="text"/> / <input type="text"/> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> d. Please specify what type of cancer: <input type="text"/>

Please use a ballpoint pen for this form



Has a doctor or other health professional ever told you that you had...	NO	YES	b. Have you had this condition in the past 12 months?
36. hypertension or high blood pressure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 10px; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
37. angina?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 10px; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
38. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 10px; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
39. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2012 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2012 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 10px; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes



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

Please use a ballpoint pen for this form



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

		a. If yes, how many times?	b. Age at first injury?	c. Age at most recent injury?
47. Have you <b>ever</b> had a serious head injury that resulted in unconsciousness, coma, or hospitalization?	<input type="radio"/> No	<input type="radio"/> Yes <input type="text"/> # TIMES	<input type="text"/> AGE	<input type="text"/> AGE



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

NO

YES

48. diabetes?

No

Yes, first diagnosed before January 1, 2012

Yes, first diagnosed January 1, 2012 or later →

a. What month and year were you diagnosed?

		/	2	0		
MONTH			YEAR			

b. Do you still have this condition?

No

Yes

c. Do you currently take insulin for diabetes?

No → GO TO 48e

Yes →

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

		/				
MONTH			YEAR			

e. Do you currently take other medications for diabetes?

No

Yes → (Please report medications in question 174.)

Please use a ballpoint pen for this form



Has a doctor or other health professional ever told you that you had...	NO	YES	b. Have you had this condition in the past 12 months?														
49. asthma?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2012 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2012 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
50. depression?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2012 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2012 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
51. periodontal (gum) disease?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2012 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2012 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
52. lost any adult teeth due to disease or decay (please do not count wisdom teeth extractions, or teeth lost due to accidents, violence, or orthodontistry)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2012 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2012 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">YEAR</td> <td colspan="2"></td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														



Since January 1, 2012, has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>DIAGNOSED 1/1/2012 OR LATER</b>	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
53. allergic rhinitis, hay fever, or seasonal allergies?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
54. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
55. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
56. Graves' disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
57. other hyperthyroidism (overactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
58. Hashimoto's thyroiditis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
59. other hypothyroidism (underactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
60. an enlarged thyroid or goiter?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR

Please use a ballpoint pen for this form



Since January 1, 2012, has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>DIAGNOSED 1/1/2012 OR LATER</b>	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
61. thyroid nodules?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
62. another thyroid problem? Please do <b>not</b> include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	a. MONTH/YEAR DIAGNOSED <input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR  b. Please specify the problem: <input type="text"/>
63. osteoporosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
64. osteopenia, or low bone density?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
65. osteoarthritis (age-related arthritis)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
66. rheumatoid arthritis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
67. multiple sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR
68. scleroderma or systemic sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/> MONTH YEAR





Since January 1, 2012, has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>DIAGNOSED 1/1/2012 OR LATER</b>	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
69. systemic lupus erythematosus (SLE)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
70. discoid lupus?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
71. Sjögren's syndrome?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
72. Crohn's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
73. ulcerative colitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
74. shingles?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>

Please use a ballpoint pen for this form



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2012	DIAGNOSED 1/1/2012 OR LATER	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
75. polyps in the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
76. polycystic ovarian syndrome or PCOS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
77. ovarian cysts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
78. uterine fibroids or fibroid tumors?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
79. gallstones or gallbladder disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
80. Parkinson's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
81. Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
82. cognitive impairment?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR
83. kidney failure requiring dialysis or transplant?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> MONTH YEAR



Has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>DIAGNOSED 1/1/2012 OR LATER</b>	a. If diagnosed January 1, 2012 or later, what month and year were you diagnosed?
84. kidney stones?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
85. gout?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
86. cataracts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
86a. detached retina?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
87. glaucoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
88. macular degeneration?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
89. pulmonary embolism?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
90. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2012	<input type="radio"/> Diagnosed January 1, 2012 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR

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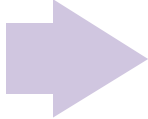


Endometriosis is a health problem in women in which tissue that looks and acts like the lining of the uterus grows outside of the uterus. Endometriosis is different from endometrial polyps or endometrial cancer.

91. Has any doctor told you that you have endometriosis?

No → GO TO THE NEXT PAGE, QUESTION 94

Yes



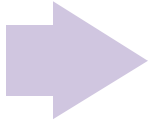
92. How old were you when you were first diagnosed with endometriosis?		<input type="text"/> <input type="text"/> AGE	
Was your endometriosis confirmed by...			Age at procedure?
93a. Laparoscopy (insertion of a thin, lighted tube through a small incision in the abdomen to examine organs)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93b. Laparotomy (traditional abdominal surgery, which requires a larger incision)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93c. Ultrasound?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93d. Magnetic Resonance Imaging (MRI)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93e. Hysterectomy for suspected endometriosis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93f. Hysterectomy for other reason?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93g. Other, please specify: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE



94. Some people experience problems with urinary incontinence, the leakage of urine. In the past 12 months, have you accidentally leaked urine?

- No → **GO TO THE NEXT PAGE, QUESTION 95**
- I don't know

Yes



- |   |  |
|---|--|
| 94a. How frequently does this happen?   | <input type="radio"/> Every day<br><input type="radio"/> 3 - 6 times per week<br><input type="radio"/> Once or twice per week<br><input type="radio"/> 2 - 3 times per month<br><input type="radio"/> Once per month<br><input type="radio"/> A few times per year |
| 94b. How much of a problem, if any, is/was the urine leakage for you?   | <input type="radio"/> A big problem<br><input type="radio"/> A small problem<br><input type="radio"/> Not a problem  |
| 94c. Have you talked with your doctor or other health provider about your urine leakage?                        | <input type="radio"/> No<br><input type="radio"/> Yes  |
| 94d. Have you taken any medications for your urinary incontinence?  | <input type="radio"/> No<br><input type="radio"/> Yes  |
| 94e. Have you had any other treatments for your urinary incontinence?   | <input type="radio"/> No → <b>GO TO QUESTION 95</b><br><input type="radio"/> Yes   |
| 94f. If so, what treatments have you had for your urinary incontinence?<br><i>(Please mark all that apply.)</i> | <input type="radio"/> Bladder training<br><input type="radio"/> Exercises<br><input type="radio"/> Surgery<br><input type="radio"/> Other, specify:  |

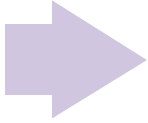
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95. Have you been told that you have pelvic prolapse? You may have heard it called "cystocele," "rectocele," "urethrocele," or "dropped bladder."

No → GO TO THE NEXT PAGE, QUESTION 96

Yes



95a. Have you had surgery to correct pelvic prolapse?	<input type="radio"/> No → GO TO QUESTION 96 <input type="radio"/> Yes
95b. How many surgeries have you had to correct pelvic prolapse?	<input type="text"/> # SURGERIES
95c. How old were you when you had your <b>first</b> surgery?	<input type="text"/> AGE
95d. How old were you when you had your <b>second</b> surgery?	<input type="text"/> AGE
95e. How old were you when you had your <b>third</b> surgery?	<input type="text"/> AGE



## SURGERIES

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	HAD PROCEDURE 1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?
96. gallbladder surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
97. 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.	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
98. coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>

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99. Since January 1, 2012, 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 <b>lasting six or more weeks</b> ?	<input type="radio"/>	<input type="radio"/>
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)?	<input type="radio"/>	<input type="radio"/>
c. daily, persistent, troublesome dry eyes for more than 3 months, or a recurrent feeling of sand or gravel in your eyes, or use of tear substitutes more than 3 times a day?	<input type="radio"/>	<input type="radio"/>
d. a daily feeling of dry mouth for more than 3 months, or frequent drinking of liquids to aid in swallowing dry foods, or recurrently or persistently swollen salivary glands?	<input type="radio"/>	<input type="radio"/>
e. a tremor or trembling in either of your hands?	<input type="radio"/>	<input type="radio"/>
f. walking or other movements getting noticeably slower?	<input type="radio"/>	<input type="radio"/>
g. handwriting getting noticeably smaller?	<input type="radio"/>	<input type="radio"/>
h. difficulty getting started when walking or making other movements?	<input type="radio"/>	<input type="radio"/>
i. wheezing or whistling in your chest?	<input type="radio"/>	<input type="radio"/>
j. 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?	<input type="radio"/>	<input type="radio"/>
k. shortness of breath when at rest?	<input type="radio"/>	<input type="radio"/>
l. shortness of breath when lying down?	<input type="radio"/>	<input type="radio"/>
m. shortness of breath when walking?	<input type="radio"/>	<input type="radio"/>
n. swelling (or edema) in your legs?	<input type="radio"/>	<input type="radio"/>
o. excessive sweating other than due to menopause?	<input type="radio"/>	<input type="radio"/>
p. unexplained and unintentional weight loss of 10 or more pounds?	<input type="radio"/>	<input type="radio"/>
q. A problem with sneezing or a runny nose or blocked nose when you did not have a cold or the flu?	<input type="radio"/>	<input type="radio"/>





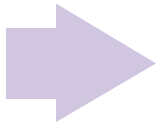
99. Since January 1, 2012, have you experienced any of the following medical symptoms? (Please mark a response for each item below.)

	No	Yes
r. feeling light-headed, dizzy, or weak when standing from sitting or lying down?	<input type="radio"/>	<input type="radio"/>
s. getting up regularly at night to pass urine?	<input type="radio"/>	<input type="radio"/>
t. unexplained pains (not due to known conditions such as arthritis)?	<input type="radio"/>	<input type="radio"/>
u. dribbling of saliva during daytime?	<input type="radio"/>	<input type="radio"/>

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

No → **GO TO QUESTION 101**

Yes



100a. How old were you the **first time** you noticed this problem?

--	--

  
 AGE

100b. Are there any reasons (such as head injury) that explain the decrease in your sense of smell?

No

Yes, specify:

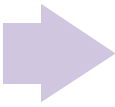
	NO	YES	a. If yes, for how many years have you had this symptom?
101. Since January 1, 2012, have you experienced coughing on most days for three months or more out of a year?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 1 year <input type="radio"/> 2 or more years
102. Since January 1, 2012, have you brought up phlegm on most days for three months or more out of a year (do not count phlegm from the nose)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 1 year <input type="radio"/> 2 or more years

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103. Since January 1, 2012, have you had a mammogram, breast ultrasound, or breast MRI?

No → GO TO THE NEXT PAGE, QUESTION 104

Yes 

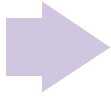
103a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2012?	<input type="text"/> <input type="text"/> # TIMES
103b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
103c. Since January 1, 2012, have you been told you had abnormal findings on a mammogram, breast ultrasound, or breast MRI?	<input type="radio"/> No → GO TO THE NEXT PAGE, QUESTION 104 <input type="radio"/> Yes ↓
103d. What was the month and year of your most recent test with abnormal findings?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
103e. Which breast showed abnormal findings at the most recent test?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
103f. Were you told this test showed any of the following? (Please mark all that apply.)	<input type="radio"/> Breast cysts <input type="radio"/> Fibrocystic breasts <input type="radio"/> Breast calcifications <input type="radio"/> Dense breasts <input type="radio"/> Uneven or one-sided densities <input type="radio"/> Fibroadenoma <input type="radio"/> Other <input type="radio"/> Don't know



104. Since January 1, 2012, have you had a breast cyst or cysts drained (aspirated) or removed?

No → GO TO QUESTION 105

Yes



104a. On how many occasions have you had this since January 1, 2012?

--	--

# OCCASIONS

104b. What was the month and year of your most recent procedure?

		/	2	0		
MONTH			YEAR			

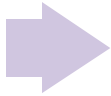
104c. On which breast was the most recent cyst aspiration or removal performed?

- Left breast
- Right breast
- Both breasts

105. Since January 1, 2012, have you had a needle biopsy to diagnose or rule out a breast condition?

No → GO TO THE NEXT PAGE, QUESTION 106

Yes



105a. On how many occasions have you had this since January 1, 2012?

--	--

# OCCASIONS

105b. What was the month and year of your most recent procedure?

		/	2	0		
MONTH			YEAR			

105c. On which breast was the most recent needle biopsy performed?

- Left breast
- Right breast
- Both breasts

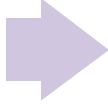
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106. Since January 1, 2012, have you had a surgical biopsy or a biopsy other than a needle biopsy to diagnose or rule out a breast condition?

No → GO TO QUESTION 107

Yes



106a. On how many occasions have you had this since January 1, 2012?

--	--

# OCCASIONS

106b. What was the month and year of your most recent procedure?

		/	2	0		
MONTH			YEAR			

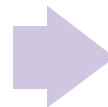
106c. On which breast was the most recent biopsy performed?

- Left breast
- Right breast
- Both breasts

107. Since January 1, 2012, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

No → GO TO THE NEXT PAGE, QUESTION 108

Yes



107a. On how many occasions have you had this since January 1, 2012?

--	--

# OCCASIONS

107b. What was the month and year of your most recent procedure?

		/	2	0		
MONTH			YEAR			

107c. On which breast was the most recent lumpectomy or excisional biopsy performed?

- Left breast
- Right breast
- Both breasts



Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. Why was this done?	b. If you had this procedure January 1, 2012 or later, what was the month and year?
108. a mastectomy of your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px;">  </div> <div style="margin-left: 5px;">MONTH</div> <div style="margin-left: 20px;">YEAR</div> </div>
109. a mastectomy of your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px;">  </div> <div style="margin-left: 5px;">MONTH</div> <div style="margin-left: 20px;">YEAR</div> </div>

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Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?	b. Did you have a silicone gel implant?
110. breast reconstruction surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px;">  </div> <div style="margin-left: 5px;">MONTH</div> <div style="margin-left: 20px;">YEAR</div> </div>	<input type="radio"/> No <input type="radio"/> Yes
111. breast reconstruction surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px;">  </div> <div style="margin-left: 5px;">MONTH</div> <div style="margin-left: 20px;">YEAR</div> </div>	<input type="radio"/> No <input type="radio"/> Yes



Since January 1, 2012, were you told you had any of the following after a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy?

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this January 1, 2012 or later, what was the month and year?
112. fibrocystic or <b>benign nonproliferative</b> changes within normal range? For example, cysts, mild hyperplasia, benign calcifications, fibrosis, etc.	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
113. fibroadenoma?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div> <p>b. What type?</p> <input type="radio"/> Simple fibroadenoma <input type="radio"/> Complex fibroadenoma <input type="radio"/> Both <input type="radio"/> Don't know
114. benign breast disease?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
115. proliferation <b>without atypia</b> ? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div>



Since January 1, 2012, were you told you had any of the following after a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy?

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this January 1, 2012 or later, what was the month and year?
116. atypical hyperplasia?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div> <p>b. What type?</p> <input type="radio"/> Atypical ductal hyperplasia <input type="radio"/> Atypical lobular hyperplasia <input type="radio"/> Both <input type="radio"/> Don't know
117. ductal carcinoma in situ (DCIS)?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
118. lobular carcinoma in situ (LCIS)?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
119. breast cancer?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
120. other changes?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text" value="2"/> <input type="text" value="0"/> <input type="text"/> <input type="text"/>              MONTH YEAR           </div>

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121. 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



Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?
122. breast reduction surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
123. breast reduction surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?	b. Did you have a silicone gel implant?
124. breast enlargement surgery on your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
125. breast enlargement surgery on your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes

Since January 1, 2012, have you had...	NEVER OR BEFORE 1/1/2012	1/1/2012 OR LATER	a. If you had this procedure January 1, 2012 or later, what was the month and year?	b. Was this a silicone gel implant?
126. a breast implant surgically removed from your left breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
127. a breast implant surgically removed from your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2012	<input type="radio"/> Yes, January 1, 2012 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes





127a1. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

/        OR       
 MONTH                      YEAR                      AGE

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

Since January 1, 2012, have you used...		NO	YES	a. If yes, how many months in all have you used this since January 1, 2012?	b. Do you currently use this female hormone product(s)?
128.	a combined pill containing both estrogen and progesterone (such as Prempro)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
129.	an estrogen-only pill (such as Premarin) with no additional progesterone in any form?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
130.	an estrogen pill (such as Premarin) and a separate progesterone pill (such as Provera) or progesterone shot?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
131.	an estrogen-only patch with no additional progesterone in any form?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
132.	a patch containing both estrogen and progesterone (such as Combipatch)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
133.	an estrogen-only patch and a separate progesterone pill or progesterone shot?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
134.	progesterone alone (not for birth control)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes

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Since January 1, 2012, have you used...	NO	YES	If yes, how many months in all have you used this since January 1, 2012?
135. vaginal estrogen creams, rings, or suppositories?	<input type="radio"/> No	<input type="radio"/> Yes	<p>a. <input type="text"/> <input type="text"/> # MONTHS</p> <p>b. Do you currently use this female hormone product(s)?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Does this product also contain progesterone?</p> <p><input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Don't know</p> <p>d. Did you also take progesterone in another form (e.g., patch, pill) during the time you were using vaginal estrogen creams, rings, or suppositories?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p>
136. any other estrogen products, including "natural" estrogens?	<input type="radio"/> No	<input type="radio"/> Yes	<p>a. <input type="text"/> <input type="text"/> # MONTHS</p> <p>b. Do you currently use this female hormone product(s)?</p> <p><input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Which of the following products have you used since January 1, 2012? (Please mark all that apply.)</p> <p><input type="radio"/> Capsules <input type="radio"/> Gel or cream applied to the skin <input type="radio"/> Injection <input type="radio"/> Liquid <input type="radio"/> Troche or lozenge (dissolved under the tongue) <input type="radio"/> Other</p>



Since January 1, 2012, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2012?	b. Do you currently use this?	c. Why did you use this?
137. tamoxifen or Nolvadex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
138. ospemifene or Osphena?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
139. raloxifene or Evista?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
<b>Aromatase inhibitors:</b>					
140. anastrozole or Arimidex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> Treat breast cancer <input type="radio"/> Prevent breast cancer <input type="radio"/> Another reason
141. exemestane or Aromasin?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
142. letrozole or Femara?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
143. other aromatase inhibitor?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
Please specify: <input type="text"/>					
144. Herceptin?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
145. testosterone?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	
146. Estratest?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes	

Please use a ballpoint pen for this form



Since January 1, 2012, have you had...	<b>NEVER OR BEFORE 1/1/2012</b>	<b>HAD PROCEDURE 1/1/2012 OR LATER</b>	If you had this procedure January 1, 2012 or later, what was the month and year?														
147. a hysterectomy (surgical removal of the uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 or later	<p>a. MONTH/YEAR HAD PROCEDURE</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">/</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center;">MONTH</td> <td colspan="4" style="text-align: center;">YEAR</td> </tr> </table> <p>b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy?</p> <p><input type="radio"/> No → <b>GO TO QUESTION 148</b>  <input type="radio"/> Yes</p> <p>c. Did you have...</p> <p><input type="radio"/> both ovaries completely removed?  <input type="radio"/> one ovary and part of the other ovary removed?  <input type="radio"/> one ovary removed?  <input type="radio"/> part of one or part of both ovaries removed?</p> <p>d. Did you have all or part of either ovary left after this surgery?</p> <p><input type="radio"/> No  <input type="radio"/> Yes</p>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
148. a separate surgery to remove part or all of one or both ovaries (but not your uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2012	<input type="radio"/> Had procedure January 1, 2012 or later	<p>a. MONTH/YEAR HAD PROCEDURE</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">/</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center;">MONTH</td> <td colspan="4" style="text-align: center;">YEAR</td> </tr> </table> <p>b. Did you have...</p> <p><input type="radio"/> both ovaries completely removed?  <input type="radio"/> one ovary and part of the other ovary removed?  <input type="radio"/> one ovary removed?  <input type="radio"/> part of one or part of both ovaries removed?</p> <p>c. Did you have all or part of either ovary left after this surgery?</p> <p><input type="radio"/> No  <input type="radio"/> Yes</p>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														



**SYMPTOMS OF MENOPAUSE OR PRE-MENOPAUSE**

Have you ever experienced any of the following menopausal symptoms?		NO	YES	a. On average, how would you rate the severity of your symptom?	b. Have you experienced any symptoms in the past 12 months?
149.	vaginal dryness	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
150.	night sweats	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes

Have you ever experienced any of the following menopausal symptoms?		NO	YES	a. On average, how would you rate the severity of your symptom?	b. How often did/do these occur in a typical week?	
151.	hot flashes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> 1 time or less <input type="radio"/> 2-3 times <input type="radio"/> 4 or more times <input type="radio"/> Don't know	c. For about how many total months or years did you have hot flashes?  <input type="radio"/> Less than 3 months <input type="radio"/> 3 to less than 6 months <input type="radio"/> 6 months to less than 1 year <input type="radio"/> 1 to less than 2 years <input type="radio"/> 2 to less than 3 years <input type="radio"/> 3 or more years  d. Have you experienced any symptoms in the past 12 months?  <input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



## MEDICATIONS

Since January 1, 2012, have you used any prescription medicines to treat or to prevent...		NO	YES	a. If yes, are you currently taking this?
152.	hypertension (high blood pressure)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
153.	high cholesterol?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
154.	cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
155.	congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
155a.	angina?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
156.	diabetes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
157.	thyroid disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
158.	osteoporosis (bone loss, or bone thinning)? Do not count calcium or Vitamin D.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed



Since January 1, 2012, have you used any prescription medicines to treat or to prevent...		NO	YES	a. If yes, are you currently taking this?
159.	rheumatoid arthritis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
160.	osteoarthritis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
161.	migraines?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
162.	depression?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
163.	asthma?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
164.	Parkinson's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
165.	anxiety?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed

Please use a ballpoint pen for this form



Since January 1, 2012, 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, 2012?	
166.	acetaminophen (Tylenol)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
167.	“baby aspirin” or low-dose aspirin (100mg/tablet or less)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
168.	aspirin or other aspirin containing products (325 mg/tablet or more)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
169.	ibuprofen (such as Advil, Motrin, Nuprin, etc.)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
170.	Celebrex or other COX-2 inhibitors?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
171.	Aleve or Naprosyn?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
172.	Relafen, Ketoprofen, Anaprox, or other non-steroidal anti-inflammatories?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
173.	antibiotics?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years





<p>b.</p> <p>On average, how many days per week have you taken this?</p>	<p>c.</p> <p>On days when you take it, how many times do you take it?</p>	<p>d.</p> <p>Are you currently taking this?</p>
<p><input type="radio"/> 1 day per week</p> <p><input type="radio"/> 2-3 days per week</p> <p><input type="radio"/> 4-5 days per week</p> <p><input type="radio"/> 6-7 days per week</p>	<p><input type="radio"/> 1 time per day</p> <p><input type="radio"/> 2 times per day</p> <p><input type="radio"/> 3 times per day</p> <p><input type="radio"/> 4 times per day</p> <p><input type="radio"/> 5 or more times per day</p>	<p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p><input type="radio"/> 1 day per week</p> <p><input type="radio"/> 2-3 days per week</p> <p><input type="radio"/> 4-5 days per week</p> <p><input type="radio"/> 6-7 days per week</p>	<p><input type="radio"/> 1 time per day</p> <p><input type="radio"/> 2 times per day</p> <p><input type="radio"/> 3 times per day</p> <p><input type="radio"/> 4 times per day</p> <p><input type="radio"/> 5 or more times per day</p>	<p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p><input type="radio"/> 1 day per week</p> <p><input type="radio"/> 2-3 days per week</p> <p><input type="radio"/> 4-5 days per week</p> <p><input type="radio"/> 6-7 days per week</p>	<p><input type="radio"/> 1 time per day</p> <p><input type="radio"/> 2 times per day</p> <p><input type="radio"/> 3 times per day</p> <p><input type="radio"/> 4 times per day</p> <p><input type="radio"/> 5 or more times per day</p>	<p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p><input type="radio"/> 1 day per week</p> <p><input type="radio"/> 2-3 days per week</p> <p><input type="radio"/> 4-5 days per week</p> <p><input type="radio"/> 6-7 days per week</p>	<p><input type="radio"/> 1 time per day</p> <p><input type="radio"/> 2 times per day</p> <p><input type="radio"/> 3 times per day</p> <p><input type="radio"/> 4 times per day</p> <p><input type="radio"/> 5 or more times per day</p>	<p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p><input type="radio"/> 1 day per week</p> <p><input type="radio"/> 2-3 days per week</p> <p><input type="radio"/> 4-5 days per week</p> <p><input type="radio"/> 6-7 days per week</p>	<p><input type="radio"/> 1 time per day</p> <p><input type="radio"/> 2 times per day</p> <p><input type="radio"/> 3 times per day</p> <p><input type="radio"/> 4 times per day</p> <p><input type="radio"/> 5 or more times per day</p>	<p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
<p><input type="radio"/> 1 day per week</p> <p><input type="radio"/> 2-3 days per week</p> <p><input type="radio"/> 4-5 days per week</p> <p><input type="radio"/> 6-7 days per week</p>	<p><input type="radio"/> 1 time per day</p> <p><input type="radio"/> 2 times per day</p> <p><input type="radio"/> 3 times per day</p> <p><input type="radio"/> 4 times per day</p> <p><input type="radio"/> 5 or more times per day</p>	<p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>
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<p>c. How often do you take it?</p>	<p>d. On days when you take it, how many times do you take it?</p>	<p>e. In what form did you take this? (Please mark all that apply.)</p>	
<ul style="list-style-type: none"> <li><input type="radio"/> Once a month or less</li> <li><input type="radio"/> Less than once a week</li> <li><input type="radio"/> Once a week</li> <li><input type="radio"/> 2-3 days a week</li> <li><input type="radio"/> 4-5 days a week</li> <li><input type="radio"/> 6-7 days a week</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> 1 time per day</li> <li><input type="radio"/> 2 times per day</li> <li><input type="radio"/> 3 times per day</li> <li><input type="radio"/> 4 times per day</li> <li><input type="radio"/> 5 or more times per day</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Pill</li> <li><input type="radio"/> Inhaler</li> <li><input type="radio"/> Cream</li> <li><input type="radio"/> Liquid</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Patch</li> <li><input type="radio"/> Spray</li> <li><input type="radio"/> Shot</li> <li><input type="radio"/> Other</li> </ul>
<ul style="list-style-type: none"> <li><input type="radio"/> Once a month or less</li> <li><input type="radio"/> Less than once a week</li> <li><input type="radio"/> Once a week</li> <li><input type="radio"/> 2-3 days a week</li> <li><input type="radio"/> 4-5 days a week</li> <li><input type="radio"/> 6-7 days a week</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> 1 time per day</li> <li><input type="radio"/> 2 times per day</li> <li><input type="radio"/> 3 times per day</li> <li><input type="radio"/> 4 times per day</li> <li><input type="radio"/> 5 or more times per day</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Pill</li> <li><input type="radio"/> Inhaler</li> <li><input type="radio"/> Cream</li> <li><input type="radio"/> Liquid</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Patch</li> <li><input type="radio"/> Spray</li> <li><input type="radio"/> Shot</li> <li><input type="radio"/> Other</li> </ul>
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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? <i>(Please mark all that apply.)</i>	
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
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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)

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!***



