



# The Sister Study Health and Medical History Version 6



**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.
- Do not write comments on the form.
- Please keep this questionnaire clean, flat, and dry.
- Do not fold or tear any of the pages.

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

Like this: ●

Not like this: ⊗ ⊙

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

Like this: ● ~~YES~~

Not like this: ⊗ ~~YES~~

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

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
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1	2	3	4	5	6	7	8	9	0
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When writing dates, please follow this example.

EXAMPLE: June 7, 2004 = 

0	6
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 / 

0	7
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2	0	0	4
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(month)    (day)    (year)

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





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
- 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"/>

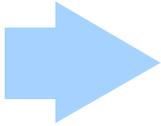
Please use a ballpoint pen for this form



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 → GO TO QUESTION 4

Yes



3a. Does your health care insurance cover all or some of the cost of breast screening exams such as mammograms, digital mammography, breast ultrasound, or breast MRI?

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. What is your current weight (in pounds)?

--	--	--

POUNDS

6. What is your current height?

--

FEET

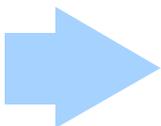
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INCHES

7. In the past 12 months, did you have a flu shot? A flu shot is usually given in the fall and protects against influenza for the flu season.

No → GO TO THE NEXT PAGE, QUESTION 8

Yes



7a. In what month and year did you have a flu shot?

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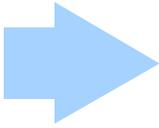
MONTH YEAR



8. In the past 12 months, did you have a flu vaccine sprayed in your nose by a doctor or other health professional? This vaccine is often called FluMist. A health professional may let you spray it yourself. This flu vaccine is usually given in the fall and protects against influenza for the flu season.

No → GO TO QUESTION 9

Yes

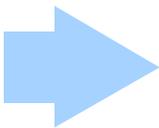


8a. In what month and year did you receive the flu vaccine by nasal spray?	<input type="text"/> / <input type="text"/>
	MONTH YEAR

9. In the past 12 months, did you have the flu? The flu is a respiratory illness with fever. Other symptoms include weakness, fatigue, and muscle aches.

No → GO TO QUESTION 10

Yes



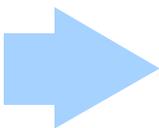
9a. Did a doctor confirm that this was the flu?	<input type="radio"/> No <input type="radio"/> Yes
9b. In what month and year did you have the flu?	<input type="text"/> / <input type="text"/>
	MONTH YEAR

## FAMILY MEDICAL HISTORY

10. Since August 1, 2008, were *any* of your sisters diagnosed with breast cancer *for the first time*?

No → GO TO THE NEXT PAGE, QUESTION 11

Yes



10a. In all, how many sisters who share at least one biological parent with you have <i>ever</i> been diagnosed with breast cancer?	<input type="text"/>
	# SISTERS

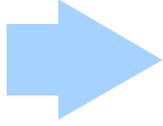
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11. Since August 1, 2008, have any *other* close blood relatives of yours been diagnosed with breast cancer?

No → GO TO QUESTION 12

Yes



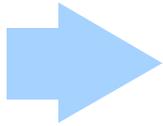
11a. What is/are the relative(s)' relationship to you?  
(Please mark all that apply.)

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

12. Since August 1, 2008, have *any* close blood relatives of yours been diagnosed with ovarian cancer?

No → GO TO QUESTION 13

Yes



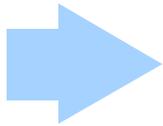
12a. What is/are the relative(s)' relationship to you?  
(Please mark all that apply.)

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

13. Have *any* close blood relatives of yours *ever* been diagnosed with asthma?

No → GO TO THE NEXT PAGE, QUESTION 14

Yes



13a. 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



## PERSONAL MEDICAL HISTORY

We are interested in changes to your health in the few years since you joined the study. Please think about your medical history since August 1, 2008.

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2008	DIAGNOSED 8/1/2008 OR LATER	a. If diagnosed August 1, 2008 or later, what month and year were you diagnosed?
14. breast cancer? Please do <b>not</b> include in situ cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
15. ductal (breast) carcinoma in situ (DCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
16. lobular (breast) carcinoma in situ (LCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
17. lung cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
18. ovarian cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
19. cancer of the uterus or endometrium?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
20. cancer of the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
21. malignant melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
22. skin cancer ( <i>not</i> malignant melanoma)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
23. leukemia?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
24. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
25. non-Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR

Please use a ballpoint pen for this form



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2008	DIAGNOSED 8/1/2008 OR LATER	a. If diagnosed August 1, 2008 or later, what month and year were you diagnosed?
26. any other type of cancer not already listed?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	a. MONTH/YEAR DIAGNOSED <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> b. Please specify what type of cancer: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> c. If you were diagnosed with a second <b>other</b> type of cancer August 1, 2008 or later, what month and year were you diagnosed? <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> d. Please specify what type of cancer: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
27. a heart attack or myocardial infarction?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>



Has a doctor or other health professional <i>ever</i> told you that you had...	NO	YES	b. Do you still have this condition?														
28. hypertension or high blood pressure?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
29. angina?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
30. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
31. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2008	DIAGNOSED 8/1/2008 OR LATER	a. If diagnosed August 1, 2008 or later, what month and year were you diagnosed?
32. a stroke (this does not include TIA or "mini-stroke")?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
33. a mini-stroke or TIA (transient ischemic attack)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR

Have you had...	NEVER OR BEFORE 8/1/2008	8/1/2008 OR LATER	a. How many times has this happened since August 1, 2008?	b. What was the month and year that this <i>first</i> happened since August 1, 2008?
34. a hip fracture?	<input type="radio"/> Never <input type="radio"/> <u>Before</u> August 1, 2008	<input type="radio"/> Occurred August 1, 2008 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> MONTH                      YEAR
35. a wrist fracture?	<input type="radio"/> Never <input type="radio"/> <u>Before</u> August 1, 2008	<input type="radio"/> Occurred August 1, 2008 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> MONTH                      YEAR

	NO	YES	a. If yes, how many hip replacements have you <i>ever</i> had?	b. What was the month and year of your <i>first</i> hip replacement surgery?
36. Have you <i>ever</i> had hip replacement surgery?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> one hip <input type="radio"/> both hips	<input type="text"/> / <input type="text"/> MONTH                      YEAR



		NO	YES																												
37.	Has a doctor or other health professional <i>ever</i> told you that you had diabetes?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-left: 20px;">             a. What month and year were you diagnosed?  <table style="border-collapse: collapse; margin: 0 auto;"> <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="font-size: 24px; 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> b. Do you still have this condition? <input type="radio"/> No <input type="radio"/> Yes  c. Do you currently take insulin for diabetes? <input type="radio"/> No → GO TO QUESTION 38 <input type="radio"/> Yes  d. If yes, when did you first use insulin? <table style="margin-left: 20px;"> <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="font-size: 24px; padding: 0 5px;">/</td> <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: 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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table>			/	2	0			MONTH			YEAR						/					MONTH			YEAR			
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MONTH			YEAR																												

Has a doctor or other health professional <i>ever</i> told you that you had...		NO	YES	b. Have you experienced any symptoms in the <i>past 12 months</i> ?														
38.	allergic rhinitis, hay fever, or seasonal allergies?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-left: 20px;">             a. What month and year were you diagnosed?  <table style="border-collapse: collapse; margin: 0 auto;"> <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="font-size: 24px; 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															
39.	asthma?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-left: 20px;">             a. What month and year were you diagnosed?  <table style="border-collapse: collapse; margin: 0 auto;"> <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="font-size: 24px; 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															



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2008	DIAGNOSED 8/1/2008 OR LATER	a. If diagnosed August 1, 2008 or later, what month and year were you diagnosed?
40. chronic bronchitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
41. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
42. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
43. Graves' disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
44. other hyperthyroidism (overactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
45. Hashimoto's thyroiditis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
46. other hypothyroidism (underactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2008	DIAGNOSED 8/1/2008 OR LATER	a. If diagnosed August 1, 2008 or later, what month and year were you diagnosed?
47. an enlarged thyroid or goiter?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
48. thyroid nodules?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
49. another thyroid problem? Please do <i>not</i> include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	a. MONTH/YEAR DIAGNOSED <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR  b. Please specify the problem: <input type="text"/>
50. osteoporosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
51. osteopenia, or low bone density?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
52. rheumatoid arthritis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
53. other arthritis (for example, age or injury related)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
54. multiple sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
55. scleroderma or systemic sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
56. systemic lupus erythematosus (SLE)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
57. discoid lupus?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR
58. Crohn's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> MONTH                      YEAR

Please use a ballpoint pen for this form

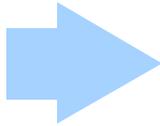


Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2008	DIAGNOSED 8/1/2008 OR LATER	a. If diagnosed August 1, 2008 or later, what month and year were you diagnosed?
59. ulcerative colitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR
60. shingles?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<input type="text"/> / <input type="text"/> MONTH                      YEAR

61. Has a doctor or other health professional *ever* told you that you had migraine headaches?

No → GO TO THE NEXT PAGE, QUESTION 62

Yes



61a. Were you diagnosed with migraine headaches <i>before</i> August 1, 2008?	<input type="radio"/> No <input type="radio"/> Yes
61b. Were you [also] diagnosed with migraines August 1, 2008 or <i>later</i> ?	<input type="radio"/> No → GO TO 61d <input type="radio"/> Yes
61c. If you were diagnosed August 1, 2008 or later, what month and year were you diagnosed?	<input type="text"/> / <input type="text"/> MONTH                      YEAR
61d. Was the diagnosis of migraine made by a... (Please mark all that apply.)	<input type="radio"/> Headache specialist <input type="radio"/> Neurologist <input type="radio"/> Other physician <input type="radio"/> Other health professional
61e. Before a migraine attacks, do you usually have aura symptoms?	<input type="radio"/> No <input type="radio"/> Yes
61f. <i>During the past 12 months</i> , how often have you had a migraine?	<input type="radio"/> Never <input type="radio"/> 1-2 times <input type="radio"/> 3-5 times <input type="radio"/> 6-11 times <input type="radio"/> Once per month <input type="radio"/> 2-3 times per month <input type="radio"/> Once per week <input type="radio"/> 2-4 times per week <input type="radio"/> 5 or more times per week



Has a doctor or other health professional <i>ever</i> told you that you had...	NO	YES	b. Do you still have this condition?														
62. depression?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
63. periodontal or gum disease?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed <u>before</u> August 1, 2008 <input type="radio"/> Yes, first diagnosed August 1, 2008 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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 8/1/2008	DIAGNOSED 8/1/2008 OR LATER	a. If diagnosed August 1, 2008 or later, what month and year were you diagnosed?														
64. polyps in the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
65. polycystic ovaries or PCOS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
66. endometriosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
67. uterine fibroids or fibroid tumors?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
68. gallstones or gallbladder disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> August 1, 2008	<input type="radio"/> Diagnosed August 1, 2008 or later	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="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="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														



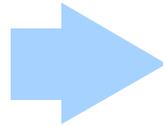
The following are some conditions we have not asked about in the past. Please tell us if you have ever been diagnosed with any of these conditions and when you were first diagnosed.

Has a doctor or other health professional ever told you that you had...	NO	YES	a. If yes, what year were you <i>first</i> diagnosed?								
69. Sjögren's syndrome?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
70. Parkinson's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
71. Alzheimer's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
72. kidney failure requiring dialysis or transplant?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
73. kidney stones?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
74. other kidney disease?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
75. cataracts?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
76. glaucoma?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
77. macular degeneration?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
78. doctor-diagnosed hearing loss?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											
78x. gout?	<input type="radio"/> No	<input type="radio"/> Yes	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px; height: 20px;"></td> </tr> <tr> <td colspan="4">YEAR</td> </tr> </table>					YEAR			
YEAR											

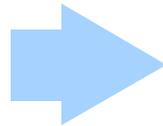


79. Since August 1, 2008, has a doctor or other health professional told you that you had any other major illness?

- Never diagnosed
- Diagnosed before August 1, 2008
- Diagnosed August 1, 2008 or later



GO TO QUESTION 80



79a. If you were diagnosed August 1, 2008 or later, what month and year were you diagnosed?  /  2 0    
MONTH YEAR

79b. Please specify the problem:   
FIRST OTHER MAJOR ILLNESS

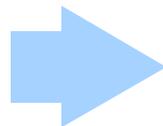
79c. If you were diagnosed with a second *other* major illness August 1, 2008 or later, what month and year were you diagnosed?  /  2 0    
MONTH YEAR

79d. Please specify the problem:   
SECOND OTHER MAJOR ILLNESS

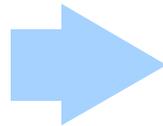
Please use a ballpoint pen for this form

80. Since August 1, 2008, have you had any other major injury?

- Never had a major injury
- Injured before August 1, 2008
- Injured August 1, 2008 or later



GO TO THE NEXT PAGE, QUESTION 81



80a. If you were injured August 1, 2008 or later, what month and year were you injured?  /  2 0    
MONTH YEAR

80b. Please specify what type of injury:   
FIRST OTHER MAJOR INJURY

80c. If you were injured with a second *other* major injury August 1, 2008 or later, what month and year were you injured?  /  2 0    
MONTH YEAR

80d. Please specify what type of injury:   
SECOND OTHER MAJOR INJURY



81. Since August 1, 2008, 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 <i>lasting six or more weeks</i> ?	<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, or a recurrent feeling of sand or gravel in your eyes, or use of tear substitutes more than 3 times a day for at least 3 months?	<input type="radio"/>	<input type="radio"/>
d. a daily feeling of dry mouth, or frequent drinking of liquids to aid in swallowing dry foods, or recurrently or persistently swollen salivary glands for more than 3 months?	<input type="radio"/>	<input type="radio"/>
e. a tremor or trembling in either of your hands that is worse when you are not using the hand compared to when you are using it?	<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"/>

82. Have you experienced the following *at least once a week in the past year*?

	No	Yes
a. heartburn (a burning discomfort behind the breast bone in your chest)?	<input type="radio"/>	<input type="radio"/>
b. acid regurgitation (a bitter or sour tasting fluid coming into your throat or mouth)?	<input type="radio"/>	<input type="radio"/>

	NO	YES	a. If yes, for how many years have you had this symptom?
83. Since August 1, 2008, 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
84. Since August 1, 2008, 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

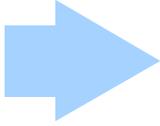


For the next few questions, please think about your breast health over your lifetime.

85. Have you *ever* been told you had abnormal findings on your mammogram, breast ultrasound, or breast MRI?

No → GO TO THE NEXT PAGE, QUESTION 86

Yes



85a. On how many occasions did this happen?	<input type="text"/> <input type="text"/> # OCCASIONS
85b. How old were you when you had your first abnormal mammogram, breast ultrasound, or breast MRI?	<input type="text"/> <input type="text"/> AGE
85c. 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
85d. 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
85e. After completing the work-up for this abnormal test, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a breast biopsy, surgery, or other treatment <input type="radio"/> Don't know
85f. Were you told this test showed any of the following? <i>(Please mark all that apply.)</i>	<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

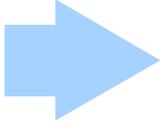
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86. Have you *ever* had a breast cyst or cysts drained (aspirated) or removed?

No → GO TO THE NEXT PAGE, QUESTION 87

Yes



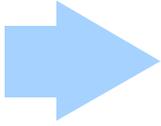
86a. On how many occasions have you had this?	<input type="text"/> <input type="text"/>	# OCCASIONS
86b. How old were you the first time you had this?	<input type="text"/> <input type="text"/>	AGE
86c. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MONTH YEAR
86d. On which breast was the most recent cyst aspiration or removal performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts	
86e. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a breast biopsy, surgery, or other treatment <input type="radio"/> Don't know	



87. Have you *ever* had a needle biopsy to diagnose or rule out a breast condition?

No → GO TO THE NEXT PAGE, QUESTION 88

Yes



87a. On how many occasions have you had this?	<input type="text"/> <input type="text"/> # OCCASIONS
87b. How old were you the first time you had this?	<input type="text"/> <input type="text"/> AGE
87c. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
87d. On which breast was the most recent needle biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
87e. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a different type of breast biopsy, surgery, or other treatment <input type="radio"/> Don't know

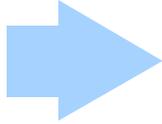
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88. Have you *ever* had a surgical biopsy or a biopsy other than a needle biopsy to diagnose or rule out a breast condition?

No → GO TO THE NEXT PAGE, QUESTION 89

Yes



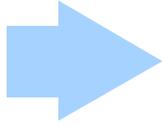
88a. On how many occasions have you had this?	<input type="text"/> <input type="text"/> # OCCASIONS
88b. How old were you the first time you had this?	<input type="text"/> <input type="text"/> AGE
88c. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
88d. On which breast was the most recent biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
88e. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a different type of breast biopsy, surgery, or other treatment <input type="radio"/> Don't know



89. Have you ever had a breast lump or lumps removed (lumpectomy)?

No → GO TO THE NEXT PAGE, QUESTION 90

Yes



89a. On how many occasions have you had this?	<input type="text"/> <input type="text"/> # OCCASIONS
89b. How old were you the first time you had this?	<input type="text"/> <input type="text"/> AGE
89c. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
89d. On which breast was the most recent lumpectomy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
89e. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a different type of biopsy, surgery, or other treatment <input type="radio"/> Don't know

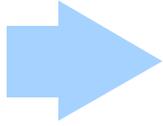
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90. Have you *ever* had a mastectomy of your *left* breast?

No → GO TO QUESTION 91

Yes

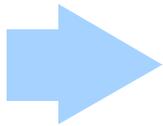


90a. Why was this done?	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both														
90b. When was this done?	<input type="radio"/> Before August 1, 2008 → GO TO 91 <input type="radio"/> August 1, 2008 or later														
90c. If you had this procedure August 1, 2008 or later, what was the month and year?	<table border="1"><tr><td></td><td></td><td>/</td><td>2</td><td>0</td><td></td><td></td></tr><tr><td colspan="3">MONTH</td><td colspan="4">YEAR</td></tr></table>			/	2	0			MONTH			YEAR			
		/	2	0											
MONTH			YEAR												

91. Have you *ever* had a mastectomy of your *right* breast?

No → GO TO THE NEXT PAGE, QUESTION 92

Yes



91a. Why was this done?	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both														
91b. When was this done?	<input type="radio"/> Before August 1, 2008 → GO TO 92 <input type="radio"/> August 1, 2008 or later														
91c. If you had this procedure August 1, 2008 or later, what was the month and year?	<table border="1"><tr><td></td><td></td><td>/</td><td>2</td><td>0</td><td></td><td></td></tr><tr><td colspan="3">MONTH</td><td colspan="4">YEAR</td></tr></table>			/	2	0			MONTH			YEAR			
		/	2	0											
MONTH			YEAR												



Were you *ever* told you had any of the following after a cyst aspiration, cyst removal, biopsy, lumpectomy, or mastectomy?

	NO	YES	a. IF YES, how old were you when you were <i>first</i> told you had this?
92. fibrocystic or benign changes (within normal range)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
93. fibroadenoma	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
94. proliferative changes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
95. ductal hyperplasia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
96. lobular hyperplasia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
97. ductal carcinoma in situ (DCIS)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
98. lobular carcinoma in situ (LCIS)	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
99. breast cancer	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE
100. other changes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> AGE

Please use a ballpoint pen for this form

101. Did you keep a copy of the pathology report(s) from the cyst aspiration, cyst removal, biopsy, lumpectomy, or mastectomy that you are willing to share with us?

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



Have you <i>ever</i> had...	NEVER OR BEFORE 8/1/2008	8/1/2008 OR LATER	a. If you had this procedure August 1, 2008 or later, what was the month and year?
102. breast reduction surgery of your <i>left</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2008	<input type="radio"/> Yes, August 1, 2008 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>
103. breast reduction surgery of your <i>right</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2008	<input type="radio"/> Yes, August 1, 2008 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>

Have you <i>ever</i> had...	NEVER OR BEFORE 8/1/2008	8/1/2008 OR LATER	a. If you had this procedure August 1, 2008 or later, what was the month and year?	b. Did you have a silicone gel implant?
104. breast reconstruction surgery of your <i>left</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2008	<input type="radio"/> Yes, August 1, 2008 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
105. breast reconstruction surgery of your <i>right</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2008	<input type="radio"/> Yes, August 1, 2008 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
106. breast enlargement surgery of your <i>left</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2008	<input type="radio"/> Yes, August 1, 2008 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
107. breast enlargement surgery of your <i>right</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2008	<input type="radio"/> Yes, August 1, 2008 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



Have you ever had...	NEVER OR BEFORE 8/1/2008	8/1/2008 OR LATER	a. If you had this procedure August 1, 2008 or later, what was the month and year?	b. Was this a silicone gel implant?
108. a breast implant surgically removed from your <i>left</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2008	<input type="radio"/> Yes, August 1, 2008 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
109. a breast implant surgically removed from your <i>right</i> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> August 1, 2008	<input type="radio"/> Yes, August 1, 2008 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



110. Are you currently pregnant or breastfeeding?

- No → GO TO NEXT QUESTION, 110a
- Yes → GO TO PAGE 30, QUESTION 111

110a. Have you had a menstrual period in the past 12 months?

- No → ANSWER BOX A BELOW
- Yes → ANSWER BOX B ON THE NEXT PAGE

### BOX A

FOR WOMEN WHO HAVE NOT HAD A MENSTRUAL PERIOD IN THE PAST 12 MONTHS. ALL OTHERS GO TO QUESTION 110d.

110b. Why did your periods stop?

- My periods stopped on their own (naturally).
- My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.
- My periods stopped after my uterus or ovaries were removed (be sure to answer questions 151 and 152).
- My periods stopped due to radiation or chemotherapy.
- My periods stopped due to medicine that suppresses ovarian function.
- My periods stopped because I am taking the kind of birth control pills that eliminate periods.
- My periods stopped for some other reason, please describe:

110c. 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	

GO TO PAGE 30, QUESTION 111



## BOX B

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

110d. When was your last menstrual period?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MONTH			DAY			YEAR			

110e. What statement best describes you?

- My periods have not stopped and I am not taking hormones.
- My periods have not stopped but I am taking hormones.
- My periods stopped temporarily, but restarted when I began hormone replacement therapy.



GO TO PAGE 30,  
QUESTION 111

OR

- My periods stopped sometime in the last 12 months. → GO TO QUESTION 110f

110f. Why did your periods stop?

- My periods stopped on their own (naturally).
- My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.
- My periods stopped after my uterus or ovaries were removed (be sure to answer questions 151 and 152).
- My periods stopped due to radiation or chemotherapy.
- My periods stopped due to medicine that suppresses ovarian function.
- My periods stopped because I am taking the kind of birth control pills that eliminate periods.
- My periods stopped for some other reason, please describe:

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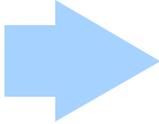


REPRODUCTIVE HISTORY AND HORMONES

111. Have you been pregnant since August 1, 2008?

No → GO TO PAGE 32, QUESTION 118

Yes



111a. Are you currently pregnant?	<input type="radio"/> No <input type="radio"/> Yes
111b. How many times have you been pregnant since August 1, 2008 (including your current pregnancy, if applicable)?	<input type="text"/> # TIMES



THIS SECTION IS FOR WOMEN WHO HAVE BEEN PREGNANT SINCE AUGUST 1, 2008. ALL OTHERS GO TO THE NEXT PAGE, QUESTION 118.

	FIRST PREGNANCY (since August 1, 2008)	SECOND PREGNANCY (since August 1, 2008)
112. How did this pregnancy end?	<input type="radio"/> Still pregnant now <input type="radio"/> Single live birth <input type="radio"/> Twins, live births <input type="radio"/> Other multiple live births → <input type="text"/> # BABIES <input type="radio"/> Stillbirth(s) <input type="radio"/> Miscarriage <input type="radio"/> Induced abortion <input type="radio"/> Molar or ectopic pregnancy	<input type="radio"/> Still pregnant now <input type="radio"/> Single live birth <input type="radio"/> Twins, live births <input type="radio"/> Other multiple live births → <input type="text"/> # BABIES <input type="radio"/> Stillbirth(s) <input type="radio"/> Miscarriage <input type="radio"/> Induced abortion <input type="radio"/> Molar or ectopic pregnancy
113. How many weeks did this pregnancy last (or has it lasted, if now pregnant)?	<input type="radio"/> less than 8 weeks <input type="radio"/> 8 to 12 weeks <input type="radio"/> 13 to 16 weeks <input type="radio"/> 17 to 24 weeks <input type="radio"/> 25 to 36 weeks <input type="radio"/> 37 to 41 weeks <input type="radio"/> 42 weeks or more	<input type="radio"/> less than 8 weeks <input type="radio"/> 8 to 12 weeks <input type="radio"/> 13 to 16 weeks <input type="radio"/> 17 to 24 weeks <input type="radio"/> 25 to 36 weeks <input type="radio"/> 37 to 41 weeks <input type="radio"/> 42 weeks or more
114. What month and year did this pregnancy end?	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR OR <input type="radio"/> Still pregnant now	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR OR <input type="radio"/> Still pregnant now
115. What was the sex of the baby or babies?	<input type="radio"/> Single male <input type="radio"/> Single female <input type="radio"/> Multiple → <input type="text"/> # MALES <input type="text"/> # FEMALES <input type="radio"/> Don't know	<input type="radio"/> Single male <input type="radio"/> Single female <input type="radio"/> Multiple → <input type="text"/> # MALES <input type="text"/> # FEMALES <input type="radio"/> Don't know
116. How long did you breastfeed (or have you been breastfeeding)?	<input type="radio"/> less than one month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> 13-24 months <input type="radio"/> more than 24 months } GO TO 117 <input type="radio"/> did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 118	<input type="radio"/> less than one month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> 13-24 months <input type="radio"/> more than 24 months } GO TO 117 <input type="radio"/> did not breastfeed/ not applicable → GO TO NEXT PREGNANCY OR QUESTION 118
117. Are you still breastfeeding?	<input type="radio"/> no <input type="radio"/> yes	<input type="radio"/> no <input type="radio"/> yes

Please use a ballpoint pen for this form

IF YOU HAVE HAD MORE THAN 2 PREGNANCIES SINCE AUGUST 1, 2008, PLEASE ANSWER THE SAME QUESTIONS FOR EACH PREGNANCY AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.



Since August 1, 2008, have you used...				a. If yes, how many months in all have you used this since August 1, 2008?	b. Are you currently using this?
			NO	YES	
118.	birth control pills?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text" value=""/> <input type="text" value=""/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
119.	birth control patches?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text" value=""/> <input type="text" value=""/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
120.	a hormonal IUD (intrauterine device)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text" value=""/> <input type="text" value=""/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
121.	a Norplant implant?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text" value=""/> <input type="text" value=""/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
122.	a Nuva Ring?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text" value=""/> <input type="text" value=""/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
123.	Depo Provera?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text" value=""/> <input type="text" value=""/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
124.	any other hormonal birth control?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text" value=""/> <input type="text" value=""/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes



125. Since August 1, 2008, have you taken any fertility medications?

No → GO TO THE NEXT PAGE, QUESTION 135

Yes



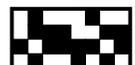
Since August 1, 2008, have you taken...		NO	YES	a. If yes, how many months or cycles in all have you used this since August 1, 2008?
126.	Clomiphene, Clomid, Serophene?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
127.	Follicle-stimulating hormones (FSH) - Follistim, Puregon, Gonal-F?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
128.	Urofollitropin, Metrodin, Fertinex, Bravelle?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
129.	Human menopausal gonadotropin (hMG) - menotropin, Pergonal, Humegon, Repronex?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
130.	Human chorionic gonadotropin (hCG) - Pregnyl, Novarel, Profasi, A.P.L.?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
131.	Gonadotropin-releasing hormone (GnRH) - gonadorelin, Factrel, Lutrepulse, Synarel, nafarelin acetate; and related drugs such as Lupron, leuprolide?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
132.	Gonadotropin inhibitors - Danocrine, Danazol, Antagon, ganirelix acetate?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
133.	Prolactin reducers - Bromocriptine, Parlodel?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
134.	Other: <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES

Please use a ballpoint pen for this form



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

Since August 1, 2008, have you used...		NO	YES	a. If yes, how many months in all have you used this since August 1, 2008?	b. Do you currently use this female hormone product(s)?
135.	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
136.	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
137.	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
138.	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
139.	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
140.	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



<p>Since August 1, 2008, have you used...</p>	<p>NO</p>	<p>YES</p> <p>a. If yes, how many months in all have you used this since August 1, 2008?</p>
<p>141. vaginal estrogen creams, rings, or suppositories?</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p> <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>
<p>142. any other estrogen products, including "natural" estrogens?</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p> <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 August 1, 2008? (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 August 1, 2008, have you used...		NO	YES	a. If yes, how many months in all have you used this since August 1, 2008?	b. Do you currently use this?
143.	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
144.	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
145.	Herceptin?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
146.	aromatase inhibitors such as Arimidex, Aromasin, 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
147.	testosterone supplements?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes

## SURGERIES

Have you <i>ever</i> had...	NEVER OR BEFORE 8/1/2008	HAD PROCEDURE 8/1/2008 OR LATER	a. If you had this procedure August 1, 2008 or later, what was the month and year?
148. gallbladder surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2008	<input type="radio"/> Had procedure August 1, 2008 or later	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
149. angioplasty?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2008	<input type="radio"/> Had procedure August 1, 2008 or later	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
150. coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2008	<input type="radio"/> Had procedure August 1, 2008 or later	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR



Have you <i>ever</i> had...	NEVER OR BEFORE 8/1/2008	HAD PROCEDURE 8/1/2008 OR LATER	a. If you had this procedure August 1, 2008 or later, what was the month and year?
151. a hysterectomy (surgical removal of the uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> August 1, 2008	<input type="radio"/> Had procedure August 1, 2008 or later	a. MONTH/YEAR HAD PROCEDURE <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy?  <input type="radio"/> No → GO TO QUESTION 152 <input type="radio"/> Yes  c. Did you have... <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  d. Did you have all or part of either ovary left after this surgery?  <input type="radio"/> No <input type="radio"/> Yes
152. 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> August 1, 2008	<input type="radio"/> Had procedure August 1, 2008 or later	a. MONTH/YEAR HAD PROCEDURE <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> b. Did you have... <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  c. Did you have all or part of either ovary left after this surgery?  <input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



## SYMPTOMS OF MENOPAUSE

	No	Yes
153. Have you had <u>hot flashes</u> at any time since August 1, 2008?	<input type="radio"/>	<input type="radio"/>
154. Have you had <u>night sweats</u> at any time since August 1, 2008?	<input type="radio"/>	<input type="radio"/>
155. Have you had <u>any other symptoms of menopause</u> since August 1, 2008, such as poor sleeping, irritability or depression?	<input type="radio"/>	<input type="radio"/>



## MEDICATIONS

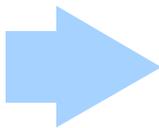
Since August 1, 2008, have you used any prescription medicines to treat or to prevent...	NO	YES	a. If yes, are you currently using this?
156. hypertension (high blood pressure)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
157. high cholesterol?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
158. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
159. diabetes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
160. thyroid disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
161. 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
162. arthritis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
163. migraines?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
164. depression?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
165. asthma?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
166. Parkinson's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
167. anxiety?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form

168. Have you had allergy shots since August 1, 2008?

No → GO TO THE NEXT PAGE, QUESTION 169

Yes



168a. Are you still getting these allergy shots?

No

Yes



Since August 1, 2008, 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 used this regularly (at least once a week for at least three months in a row) since August 1, 2008?
169.	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
170.	"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
171.	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
172.	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
173.	Celebrex, Vioxx, Bextra, 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
174.	Aleve, Naprosyn, 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
175.	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



Please use a ballpoint pen for this form

b. On average, how many days per week have you taken this?	c. On days when you take it, how many times do you take it?	d. Are you currently using this?
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per 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"/> No <input type="radio"/> Yes



These last questions are about prescription and non-prescription medications that you *currently take regularly*. This includes all pills, patches, shots, inhaled medicines, vitamins, and herbal supplements. Please include inhalers, even if you use them occasionally and include all medicines prescribed in once a month or once a year doses such as some medicines to prevent osteoporosis.

**Do not include:**

- Medicines used only occasionally, such as a pain reliever once in a while for a headache
- Aspirin or other pain medications already reported in previous questions

176. Do you *currently* take any prescription or non-prescription medications *regularly or seasonally*? Please include inhalers that you currently use as needed.

No → GO TO END, PAGE 47

Yes

--	--

TOTAL #

a.	b.
What is/are the name(s) of the prescription or non-prescription medication(s) that you <i>currently take regularly</i> ?	For how long have you used this regularly?
1. <table border="1" style="width: 100%; height: 25px;"></table>	<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
2. <table border="1" style="width: 100%; height: 25px;"></table>	<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
3. <table border="1" style="width: 100%; height: 25px;"></table>	<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
4. <table border="1" style="width: 100%; height: 25px;"></table>	<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
5. <table border="1" style="width: 100%; height: 25px;"></table>	<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



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>(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 use a ballpoint pen for this form







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Please check to see that all questions are answered.

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

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

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

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