The Sister Study
Health, Medical History and Lifestyle
Version DFU5

Instructions:

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

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

Like this: ● Not like this: ⊘ ✓

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

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

1	2	3	4	5	6	7	8	9	0

Version 2

Your continued participation in the Sister Study is completely voluntary and greatly appreciated. If you are not comfortable answering a question, just skip it and go to the next one. All information you share will be kept confidential.

Today's Date: ☐☐ / ☐☐ / 2 0 ☐☐

MONTH DAY YEAR

We ask that the Sister Study participant fill out the form. Sometimes this is not possible...

- ○ Mark here if you are the participant filling this out for yourself. → **GO TO QUESTION 1, BELOW**

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

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

What is the relationship to the participant of the person helping with the questionnaire or completing the questionnaire on behalf of the participant?

- ○ Spouse/partner
- ○ Sister
- ○ Brother
- ○ Daughter
- ○ Son
- ○ Friend
- ○ Other, specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If participant cannot answer the questions for herself and you are completing the questionnaire on her behalf, what are the condition(s) that prevent her from answering the questions for herself?

☐

GENERAL HEALTH

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

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

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

	NO	YES
a. had a routine physical exam?	○	○
b. had a bone density scan or osteoporosis screening?	○	○
c. had a screening colonoscopy or sigmoidoscopy exam?	○	○
d. had a vaccination for shingles (herpes zoster)?	○	○

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

POUNDS

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

FEET INCHES

FAMILY MEDICAL HISTORY

5. Since January 1, 2017, were **any** of your sisters diagnosed with breast cancer **for the first time**?

○ No → **GO TO QUESTION 7 ON NEXT PAGE**

○ Yes

6. Please record breast cancer diagnosis date for each sister diagnosed **for the first time** since January 1, 2017. *Use additional paper if more than two sisters were diagnosed with breast cancer for the first time since January 1, 2017.*

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

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

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

8. Since January 1, 2017, have any **other** close blood relatives of yours been diagnosed with breast cancer **for the first time**?

○ No → **GO TO QUESTION 10**

○ Yes

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

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

10. Since January 1, 2017, have **any** close blood relatives of yours been diagnosed with ovarian cancer **for the first time**?

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

○ Yes

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

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

PERSONAL MEDICAL HISTORY

We are interested in changes to your health in the past few years. Please think about your medical history **since January 1, 2017.**

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2017**	**DIAGNOSED 1/1/2017 OR LATER**	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
12. breast cancer? *Do not include in situ cancer.*	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
13. ductal (breast) carcinoma in situ (DCIS)?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
14. lobular (breast) carcinoma in situ (LCIS)?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
15. lung cancer?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
16. ovarian cancer?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
17. cancer of the uterus or endometrium? *Do not include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.*	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
18. cancer of the colon or rectum?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
19. Hodgkin's disease or Hodgkin's lymphoma?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
20. non-Hodgkin's lymphoma?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR
21. leukemia?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / YEAR
22. thyroid cancer?	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER DIAGNOSED**	**DIAGNOSED BEFORE 1/1/2017**	**DIAGNOSED 1/1/2017 OR LATER**	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
23. melanoma? *Do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.*	○ Never	○ Before January 1, 2017	○ January 1, 2017 or later	☐☐ / MONTH 2 0 ☐☐ YEAR
24. skin cancer (**not** melanoma)?	○ Never	○ Before January 1, 2017 If diagnosed before January 1, 2017, was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?	○ January 1, 2017 or later Was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?	☐☐ / MONTH 2 0 ☐☐ YEAR
25. any other type of cancer not already listed?	○ Never	○ Before January 1, 2017 If diagnosed before January 1, 2017, please specify what type(s) of cancer: 1) ☐ 2) ☐	○ January 1, 2017 or later If you were diagnosed with any other type(s) of cancer January 1, 2017 or later, please specify what type(s) of cancer: 1) ☐ 2) ☐	☐☐ / MONTH 2 0 ☐☐ YEAR ☐☐ / MONTH 2 0 ☐☐ YEAR

The Sister Study enrollment started in 2003 and ended in 2009. ***Since your enrollment in the Sister Study***, have you received any of the following treatments for breast cancer, another cancer, or any other reason?	**NO**	**YES** *(Please mark all that apply.)*	a. When was the **first** treatment?	b. When was the **most recent** treatment?
26. **chemotherapy** *By chemotherapy we mean drugs used to kill cancer cells.* *Examples of chemotherapy include: Adriamycin, Taxol, and Carboplatin. There are many other chemotherapy drugs.*	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	MONTH / 2 0 YEAR OR AGE	MONTH / 2 0 YEAR OR AGE
27. **radiation treatments** *This may involve treatment with high dose x-rays, radioactive implants or seeds, or other ways of delivering radiation to a cancer and nearby tissues.*	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	MONTH / 2 0 YEAR OR AGE	MONTH / 2 0 YEAR OR AGE
28. **immunotherapy treatments** *By immunotherapy, we mean treatments that use your body's immune system to better find and destroy cancer cells.* *Examples of immunotherapy include:* ***Herceptin****, nivolumab (****Opdivo****), atezolizumab (****Tecentriq****),* ***Keytruda****, monoclonal antibodies, immune checkpoint inhibitors, cytokines, cancer vaccines, and adoptive cell transfer.*	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	MONTH / 2 0 YEAR OR AGE	MONTH / 2 0 YEAR OR AGE
29. **bone marrow or stem cell transplant**	○ No	○ Yes, for breast cancer ○ Yes, for a cancer other than breast cancer ○ Yes, for another reason	a. What month and year did you have this treatment? MONTH / 2 0 YEAR OR AGE	

Has a doctor or other health professional **ever** told you that you had...	**NO**	**YES**	b. Have you **ever** used any prescription medications for this condition?	c. If yes, are you currently taking prescription medications?
30. high cholesterol (not borderline)?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes	○ No ○ Yes
31. congestive heart failure?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes	○ No ○ Yes
32. hypertension or high blood pressure?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes	○ No ○ Yes

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

Has a doctor or other health professional **ever** told you that you had...	**NO**	**YES**	b. Have you had this condition in the **past 12 months?**	c. Have you **ever** used any prescription medications for this condition?	d. If yes, are you currently taking prescription medications?
40. cardiac arrhythmia (irregular heartbeat)?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
41. angina?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NO**	**YES**	a. If you had this January 1, 2017 or later, what was the month and year?
42. a heart attack or myocardial infarction?	○ No	○ Yes, my first heart attack was before January 1, 2017 ○ Yes, my first heart attack was January 1, 2017 or later →	MONTH / 2 0 YEAR
43. a stroke (this does not include TIA or "mini-stroke")?	○ No	○ Yes, my first stroke was before January 1, 2017 ○ Yes, my first stroke was January 1, 2017 or later →	MONTH / 2 0 YEAR
44. a mini-stroke or TIA (transient ischemic attack)?	○ No	○ Yes, my first mini-stroke was before January 1, 2017 ○ Yes, my first mini-stroke was January 1, 2017 or later →	MONTH / 2 0 YEAR

Have you **ever** had...	**NEVER OR BEFORE 1/1/2017**	**HAD PROCEDURE 1/1/2017 OR LATER**	a. If you had this procedure January 1, 2017 or later, what was the month and year?
45. a balloon angioplasty, stent placement, or other procedure to open or widen a heart artery? *These procedures are different from the test used to diagnose a blockage.*	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	MONTH / 2 0 YEAR
46. a coronary artery bypass graft surgery?	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NO**	**YES**	b. Do you still have this condition?
47. pre-diabetes, borderline diabetes, or an elevated A1C test **without diabetes**?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. If first diagnosed 1/1/2017 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes
48. diabetes? *Do NOT include pre-diabetes or borderline diabetes.*	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. If first diagnosed 1/1/2017 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes

49. Did you **ever** take insulin for diabetes?

○ No → **GO TO QUESTION 50**

○ Yes

49a. When did you first use insulin? ☐☐ / ☐☐☐☐ MONTH YEAR

49b. Do you **currently** take insulin?

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

Please specify: ☐

50. Have you **ever** used any other prescription medications, **not including insulin**, for diabetes?

○ No → **GO TO QUESTION 51 ON NEXT PAGE**

○ Yes

Have you **ever** used the following prescription medications for diabetes?	**NO**	**YES**	a. If yes, are you **currently** taking this medication?
a. **Metformin alone** (not in combination with other medications) *Examples include Metformin (**Glucophage**), Metformin liquid (**Riomet**), or Metformin extended release (**Glucophage XR**, **Fortamet**, **Glumetza**)*	○ No	○ Yes	○ No ○ Yes
b. **Metformin in combination with other medications** *Examples include Pioglitazone & metformin (**Actoplus Met**), Glyburide & metformin (**Glucovance**), Glipizide & metformin (**Metaglip**), Sitagliptin & metformin (**Janumet**), Saxagliptin & metformin (**Kombiglyze**), Repaglinide & metformin (**Prandimet**), Linagliptin and metformin (**Jentadueto**), Empagliflozin and metformin (**Synjardy**), Dapagliflozin and metformin (**Xigduo XR**)*	○ No	○ Yes	○ No ○ Yes
c. **Sulfonylureas** *Examples include Glimepiride (**Amaryl**), Glyburide (**Micronase**, **DiaBeta**), Glipizide (**Glucotrol**), or Micronized glyburide (**Glynase**)*	○ No	○ Yes	○ No ○ Yes
d. **Any other, please specify:** ☐	○ No	○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2017**	**DIAGNOSED 1/1/2017 OR LATER**
51. Parkinson's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR

52. Have you **ever** used any prescription medications for Parkinson's disease? Examples include Levodopa, Sinemet, Parcopa, Stalevo, Mirapex, Requip, Neupro patch, or Azilect.

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

○ Yes

52a. Did your symptoms ever improve after taking any of these medications? ○ No ○ Yes

52b. Are you currently taking any of these medications? ○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2017**	**DIAGNOSED 1/1/2017 OR LATER**
53. osteoarthritis (age-related arthritis)? **Do not include rheumatoid arthritis or psoriatic arthritis.**	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR
54. osteoporosis (bone loss, or bone thinning)?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR
55. osteopenia, or low bone density?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR

56. Have you **ever** used any prescription medications to treat or prevent osteoporosis or osteopenia?

Do not count calcium or Vitamin D.

○ No → **GO TO QUESTION 57 ON NEXT PAGE**

○ Yes

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

Have you **ever** had...	**NEVER OR BEFORE 1/1/2017**	**1/1/2017 OR LATER**	a. What was the month and year that this **first** happened since January 1, 2017?	b. How many times has this happened since January 1, 2017?
57. a hip fracture?	○ Never ○ Before January 1, 2017	○ January 1, 2017 or later	__ / 20__ MONTH YEAR	__ # TIMES
58. a wrist fracture?	○ Never ○ Before January 1, 2017	○ January 1, 2017 or later	__ / 20__ MONTH YEAR	__ # TIMES
59. a spine (vertebral) fracture?	○ Never ○ Before January 1, 2017	○ January 1, 2017 or later	__ / 20__ MONTH YEAR	__ # TIMES
60. a rib fracture?	○ Never ○ Before January 1, 2017	○ January 1, 2017 or later	__ / 20__ MONTH YEAR	__ # TIMES
61. any other fracture?	○ Never ○ Before January 1, 2017	○ January 1, 2017 or later	__ / 20__ MONTH YEAR	__ # TIMES
Please specify type of other fracture before January 1, 2017:		Please specify type of other fracture you had since January 1, 2017:		

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

○ None → **GO TO QUESTION 63 ON NEXT PAGE**

○ Once
○ Twice
○ Three or more

62a. Did you seek medical care as a result of any of your falls? ○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NO**	**YES**	b. Have you had this condition in the **past 12 months?**
63. depression?	○ No	○ Yes, first diagnosed before January 1, 2017 ○ Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? __ __ / 2 0 __ __ MONTH YEAR	○ No ○ Yes c. Have you taken medication for depression in the **past 12 months?** ○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2017**	**DIAGNOSED 1/1/2017 OR LATER**	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
64. emphysema?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	__ __ / 2 0 __ __ MONTH YEAR
65. chronic obstructive pulmonary disease (COPD)?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	__ __ / 2 0 __ __ MONTH YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2017**	**1/1/2017 OR LATER**	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
66. Graves' disease, or hyperthyroidism, or overactive thyroid?	○ Never diagnosed ○ Diagnosed before 1/1/2017	○ Diagnosed 1/1/2017 or later	MONTH / 2 0 YEAR

IF DIAGNOSED ↓

b. Were you treated with radioactive iodine?	○ Never ○ Yes, before 1/1/2017 ○ Yes, 1/1/2017 or later
c. Did you have surgery to remove your thyroid?	○ Never ○ Yes, before 1/1/2017 ○ Yes, 1/1/2017 or later

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2017**	**1/1/2017 OR LATER**	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
67. Hashimoto's thyroiditis, or hypothyroidism, or underactive thyroid?	○ Never diagnosed ○ Diagnosed before 1/1/2017	○ Diagnosed 1/1/2017 or later	MONTH / 2 0 YEAR
68. any other type of thyroid disease or thyroid condition? Do NOT include thyroid cancer.	○ Never diagnosed ○ Diagnosed before 1/1/2017 If diagnosed before January 1, 2017, please specify the condition:	○ Diagnosed 1/1/2017 or later If you were diagnosed January 1, 2017 or later, please specify the condition:	MONTH / 2 0 YEAR

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

○ No
○ Yes

70. Are you **currently** taking levothyroxine (e.g. Levoxyl, Levo-T, Synthroid, Tirosint, Unithroid) for thyroid disease or a thyroid condition?

○ No
○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2017**	**DIAGNOSED 1/1/2017 OR LATER**	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
71. rheumatoid arthritis? ***Do not include osteoarthritis or psoriatic arthritis.***	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
72. psoriatic arthritis? ***Do not include osteoarthritis or rheumatoid arthritis.***	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
73. multiple sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
74. scleroderma or systemic sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
75. systemic lupus erythematosus (SLE)? ***Do not include discoid lupus.***	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR
76. Sjögren's syndrome?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	___ ___ / 2 0 ___ ___ MONTH YEAR

77. Have you **ever** used any prescription medications for autoimmune diseases such as rheumatoid arthritis, multiple sclerosis, scleroderma or systemic sclerosis, systemic lupus erythematosus (SLE; do not include discoid lupus), psoriatic arthritis (do not include psoriasis without arthritis), or Sjögren's syndrome?

○ No → **GO TO QUESTION 78 ON NEXT PAGE**

○ Yes

↓

Have you ever used any of the following types of medications for an autoimmune disease?	**NO**	**YES**	a. If yes, are you **currently** taking this type of medication?
a. **Immune-modifying prescription medications** *Examples: Hydroxychloroquine or chloroquine (**Plaquenil**); Methotrexate (**Rheumatrex or Trexall**); Azathioprine (**Imuran**), Mycophenolate mofetil (**Cellcept**), Cyclophosphamide (**Cytoxan**), and **Cyclosporine***	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
b. **Biologics** *Examples: **Remicade**, **Humira**, **Enbrel**, **Benlysta**, and rituximab **(Rituxan)***	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
c. **Other types of prescription medications, not including immune-modifying prescription medications or biologics** *Do not include corticosteroids/steroids such as prednisone, cortisone or methylprednisolone (Medrol). Also do not include over-the-counter pain relievers such as acetaminophen (Tylenol), aspirin, or non-steroidal anti-inflammatory medications [e.g. ibuprofen (Motrin), naproxen (Naprosyn)].* Specify *first/only* **other type of prescription medication:** 1)	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
Specify any *additional* **other type of prescription medication:** 2)	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed

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

78. Have you **ever** been told by a doctor that you had ***diverticulosis*** (intestinal pouches or pockets called diverticula)?

○ No → **GO TO QUESTION 79**

○ Yes

78a. When were you **first** told you had diverticulosis?

MONTH / YEAR **OR** AGE

79. Have you **ever** been told by a doctor that you had ***diverticulitis*** (inflamed or infected intestinal pouches or pockets (i.e. inflamed or infected diverticula))?

○ No → **GO TO QUESTION 80 ON NEXT PAGE**

○ Yes

↓

a. Thinking back to your **first** episode of diverticulitis, when did your first episode occur?

MONTH / YEAR **OR** AGE

b. How many **total** episodes or attacks of diverticulitis have you had?

EPISODES

c. Have you **ever** been admitted to the hospital for an episode of diverticulitis?

○ No
○ Yes

d. Have you **ever** had a CT scan that was positive or confirmed the diagnosis of diverticulitis?

○ No
○ Yes

e. When was your most recent episode or attack of diverticulitis?

MONTH / YEAR **OR** AGE

For your most recent episode of diverticulitis...	**NO**	**YES**
f. were you seen by a doctor?	○	○
g. did you go to the emergency department?	○	○
h. were you hospitalized?	○	○
i. were you prescribed antibiotics?	○	○
j. did you have a CT scan?	○	○
k. did you have surgery?	○	○

k1. IF YES, when did you have the surgery?

MONTH / YEAR **OR** AGE

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2017**	**DIAGNOSED 1/1/2017 OR LATER**	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
80. Crohn's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
81. ulcerative colitis?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
82. polyps in the colon or rectum?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
83. Alzheimer's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
84. dementia excluding Alzheimer's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2017 **Please specify type of dementia you had before January 1, 2017:**	○ Diagnosed January 1, 2017 or later **Please specify type of dementia you had since January 1, 2017:**	MONTH / 2 0 YEAR
85. cognitive impairment?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
86. pernicious anemia (vitamin B12 anemia)? *Do not include iron-deficiency anemia.*	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
87. hemochromatosis?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
88. shingles?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
89. cataracts?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2017**	**DIAGNOSED 1/1/2017 OR LATER**	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
90. glaucoma?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
91. macular degeneration?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
92. pulmonary embolism?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
93. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / YEAR
94. kidney failure requiring dialysis or transplant?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
95. kidney stones?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
96. gout?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR
97. gallstones or gallbladder disease?	○ Never diagnosed ○ Diagnosed before January 1, 2017	○ Diagnosed January 1, 2017 or later	MONTH / 2 0 YEAR

Have you **ever** had...	**NEVER OR BEFORE 1/1/2017**	**HAD PROCEDURE 1/1/2017 OR LATER**	a. If you had this procedure January 1, 2017 or later, what was the month and year?
98. gallbladder surgery?	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	MONTH / 2 0 YEAR

Since January 1, 2017, has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
99. any other major health condition? *Do not report any cancer or health condition reported elsewhere in this questionnaire.*	○ Never diagnosed ○ Diagnosed before January 1, 2017 If diagnosed before January 1, 2017, please specify what type of major health condition(s): 1) ☐ 2) ☐	○ Diagnosed January 1, 2017 or later If you were diagnosed with any other major health condition(s) January 1, 2017 or later, please specify what type of major health condition(s): 1) ☐ 2) ☐	☐☐ / 20☐☐ MONTH YEAR ☐☐ / 20☐☐ MONTH YEAR

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

○ No → **GO TO QUESTION 101 ON NEXT PAGE**

○ Yes

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

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

○ No
○ Yes, specify:

☐

101. Since January 1, 2017, have you experienced any of the following **medical symptoms**...
(Please mark a response for each item below.)

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

102. Since January 1, 2017, have you had a mammogram, breast ultrasound, or breast MRI?

○ No → **GO TO QUESTION 103 ON NEXT PAGE**

○ Yes

102a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2017? ☐☐ # TIMES

102b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI? ☐☐ / 2 0 ☐☐ MONTH / YEAR

103. Since January 1, 2017, have you had a breast cyst or cysts drained (aspirated) or removed?

○ No
○ Yes

104. Since January 1, 2017, have you had a surgical, needle, or other biopsy to diagnose or rule out a breast condition?

○ No → **GO TO QUESTION 105**

○ Yes

104a. On how many occasions have you had this since January 1, 2017?
OCCASIONS

104b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

104c. On which breast was the most recent biopsy performed?
○ Left breast
○ Right breast
○ Both breasts

105. Since January 1, 2017, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

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

○ Yes

105a. On how many occasions have you had this since January 1, 2017?
OCCASIONS

105b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

105c. On which breast was the most recent lumpectomy or excisional biopsy performed?
○ Left breast
○ Right breast
○ Both breasts

Since January 1, 2017, were you told you had any of the following benign breast conditions after a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy?

Have you **ever** had...	**NEVER OR BEFORE 1/1/2017**	**1/1/2017 OR LATER**	a. If you had this January 1, 2017 or later, what was the month and year?
106. fibrocystic or **benign nonproliferative** changes within normal range? For example, cysts, mild hyperplasia, benign calcifications, fibrosis, etc.	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
107. fibroadenoma?	○ Never ○ Yes, before January 1, 2017 b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know	○ Yes, January 1, 2017 or later	☐☐ / 2 0 ☐☐ MONTH YEAR b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know
108. benign breast disease?	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
109. proliferation **without atypia**? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
110. atypical hyperplasia?	○ Never ○ Yes, before January 1, 2017 b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know	○ Yes, January 1, 2017 or later	☐☐ / 2 0 ☐☐ MONTH YEAR b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know

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

○ No

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

○ Not applicable

Have you **ever** had...	**NEVER OR BEFORE 1/1/2017**	**1/1/2017 OR LATER**	a. If you had this procedure January 1, 2017 or later, what was the month and year?	b. Why was this done?
112. a mastectomy of your **left** breast?	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR	○ To treat breast cancer ○ To prevent breast cancer ○ Both
113. a mastectomy of your **right** breast?	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR	○ To treat breast cancer ○ To prevent breast cancer ○ Both

Have you **ever** had...	**NEVER OR BEFORE 1/1/2017**	**1/1/2017 OR LATER**	a. If you had this procedure January 1, 2017 or later, what was the month and year?	b. Did you have a silicone gel implant?
114. breast reconstruction or enlargement surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR	○ No ○ Yes
115. breast reconstruction or enlargement surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR	○ No ○ Yes
116. a breast implant surgically removed from your **left** breast?	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR	○ No ○ Yes
117. a breast implant surgically removed from your **right** breast?	○ Never ○ Yes, before January 1, 2017	○ Yes, January 1, 2017 or later	MONTH / 2 0 YEAR	○ No ○ Yes

118. Have you had a menstrual period in the past 10 years?

○ No → **GO TO QUESTION 119 ON PAGE 32**

○ Yes

118a. Have you had a menstrual period in the past 12 months?

○ No → **ANSWER BOX A BELOW**

○ Yes → **ANSWER BOX B ON PAGE 30**

BOX A

THIS BOX IS FOR WOMEN WHO HAVE NOT HAD A MENSTRUAL PERIOD IN THE PAST 12 MONTHS. ALL OTHERS GO TO QUESTION 118d ON NEXT PAGE.

118b. 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	

118c. Why did your periods stop? Please choose one response that best describes your situation.

○ My periods stopped on their own (naturally).

○ My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.

○ My periods stopped after my uterus or ovaries were removed

(be sure to answer questions 130 and 131 on page 35).

○ My periods stopped due to radiation or chemotherapy.

○ My periods stopped after having a uterine or endometrial ablation.

○ My periods stopped after having a uterine embolization, also known as a uterine artery embolization or uterine fibroid embolization.

○ My periods stopped due to medicine that causes the ovaries to make less hormones or medicine that has this as a side effect.

○ My periods stopped because I am taking the kind of birth control pills that make me not have periods.

○ My periods stopped for some other reason. Please describe in the box below:

GO TO QUESTION 118g ON PAGE 31

BOX B

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

118d. When was your last menstrual period?

		/	2	0		
MONTH			YEAR			

118e. What statement best describes you?

- ○ My periods have not stopped and I am not taking hormones.
- ○ My periods have not stopped but I am taking hormones.
- ○ My periods stopped temporarily but restarted when I stopped taking birth control pills.
- ○ My periods stopped temporarily, but I have had episodes of bleeding since the time when I started taking hormones.
- ○ My periods stopped temporarily but restarted when I began taking hormone replacement therapy.

GO TO QUESTION 118g ON NEXT PAGE

OR

- ○ My periods stopped sometime in the last 12 months. → **GO TO QUESTION 118f**

118f. Why did your periods stop? Please choose one response that best describes your situation.

- ○ My periods stopped on their own (naturally).
- ○ My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.
- ○ My periods stopped after my uterus or ovaries were removed **(be sure to answer questions 130 and 131 on page 35).**
- ○ My periods stopped due to radiation or chemotherapy.
- ○ My periods stopped after having a uterine or endometrial ablation.
- ○ My periods stopped after having a uterine embolization, also known as a uterine artery embolization or uterine fibroid embolization.
- ○ My periods stopped due to medicine that causes the ovaries to make less hormones or medicine that has this as a side effect.
- ○ My periods stopped because I am taking the kind of birth control pills that make me not have periods.
- ○ My periods stopped for some other reason, please describe in the box below:

118g. Since January 1, 2017, have you used any **hormonal birth control**?

○ No → **GO TO QUESTION 119 ON NEXT PAGE**

○ Yes

Since January 1, 2017, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2017?	b. Do you currently use this?
118h. birth control pills?	○ No	○ Yes	☐☐ # MONTHS	○ No → **GO TO 118i** ○ Yes c. Do you currently take the type of pills that stop your menstrual periods for several months or longer? ○ No ○ Yes
118i. a hormonal IUD (intrauterine device)?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes
118j. any other hormonal birth control? Specify: ☐	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes

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

Since January 1, 2017, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2017?	b. Do you **currently** use this female hormone product(s)?
119. **estrogen and progesterone at the same time**, whether as a combination product (such as Prempro or Combipatch) or as separate medications (for example Premarin plus Provera or a progesterone shot)? *Do not include vaginal creams, rings, or suppositories.*	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes
120. **estrogen alone**, whether as a pill (such as Premarin), patch, or other form (such as a spray, gel, or implant), with no additional progesterone in any form? *Do not include vaginal creams, rings, or suppositories.*	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes
121. **progesterone alone** (not for birth control)?	○ No	○ Yes	☐ # MONTHS	○ No ○ Yes

Since January 1, 2017, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2017?
122. vaginal estrogen creams, rings, or suppositories?	○ No	○ Yes	☐☐ # MONTHS b. Do you currently use this female hormone product(s)? ○ No ○ Yes c. Does this product also contain progesterone? ○ No ○ Yes ○ Don't know d. Did you also take progesterone in another form (e.g., patch, pill) during the time you were using vaginal estrogen creams, rings, or suppositories? ○ No ○ Yes

Since January 1, 2017, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2017?	b. Do you **currently** use this?	c. Why did you use this? *(Please mark all that apply.)*
123. ospemifene or Osphena?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
124. tamoxifen or Nolvadex?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
125. raloxifene or Evista?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
126. any aromatase inhibitors? *Examples include: anastrozole (**Arimidex**), exemestane (**Aromasin**), and letrozole (**Femara**)*	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
127. Herceptin?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	
128. Estratest?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	
129. testosterone?	○ No	○ Yes	☐☐ # MONTHS	○ No ○ Yes	

Have you **ever** had...	**NEVER OR BEFORE 1/1/2017**	**HAD PROCEDURE 1/1/2017 OR LATER**	If you had this procedure January 1, 2017 or later, what was the month and year?
130. a hysterectomy (surgical removal of the uterus)?	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	a. MONTH/YEAR HAD PROCEDURE [ ][ ] / 2 0 [ ][ ] MONTH YEAR b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy? ○ No → **GO TO QUESTION 131** ○ Yes c. Did you have... ○ both ovaries completely removed? ○ one ovary and part of the other ovary removed? ○ one ovary removed? ○ part of one or part of both ovaries removed? d. Did you have all or part of either ovary left after this surgery? ○ No ○ Yes
131. a separate surgery to remove part or all of one or both ovaries (oophorectomy), but not your uterus?	○ Never had procedure ○ Had procedure before January 1, 2017	○ Had procedure January 1, 2017 or later	a. MONTH/YEAR HAD PROCEDURE [ ][ ] / 2 0 [ ][ ] MONTH YEAR b. Did you have... ○ both ovaries completely removed? ○ one ovary and part of the other ovary removed? ○ one ovary removed? ○ part of one or part of both ovaries removed? c. Did you have all or part of either ovary left after this surgery? ○ No ○ Yes

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

○ No, not regularly → **GO TO QUESTION 140 ON PAGE 38**

○ Yes, fairly regularly

During the **past 12 months**, have you taken...		NO	YES	a. How often?	b. For how many years in all have you taken this?	c. Did you usually take types that...
133.	One A Day, Centrum, or Thera type multivitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ contain minerals, iron, zinc, etc.? ○ do not contain minerals? ○ Don't know
134.	Stress-tabs or B-Complex type multivitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	
135.	Antioxidant combination-type multivitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	

During the **past 12 months**, have you taken...		NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
136.	Calcium *without vitamin D*?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	Calcium: ○ Less than 600 mg ○ 600 mg ○ More than 600 mg
137.	Calcium *plus vitamin D*?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	Calcium: ○ Less than 600 mg ○ 600 mg ○ More than 600 mg Vitamin D: ○ Less than 2000 IU ○ 2000 IU ○ More than 2000 IU
138.	Vitamin D alone?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	Vitamin D: ○ Less than 2000 IU ○ 2000 IU ○ More than 2000 IU
139.	an Iron supplement?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 65 mg ○ 65 mg ○ More than 65 mg

During the **past 12 months**, have you taken any of the following **at least 4 days a week**...	**NO**	**YES**
140. Vitamin A (not beta-carotene)?	○	○
141. Beta-carotene?	○	○
142. Vitamin B12?	○	○
143. Vitamin C?	○	○
144. Vitamin E?	○	○
145. Folic acid, folate?	○	○
146. Magnesium?	○	○
147. Manganese?	○	○
148. Zinc, alone or combined with something else?	○	○
149. Selenium?	○	○

In the **past 12 months**, did you take any of these supplements at least once a month?		NO	YES	a. How frequently did you take this?	b. For how many years in all have you taken this?
150.	Fish oil	○ No	○ Yes	○ Less than 1 day per week but at least once a month ○ 1 - 2 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
151.	Omega-3 or omega-3 fatty acids	○ No	○ Yes	○ Less than 1 day per week but at least once a month ○ 1 - 2 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
152.	Flax seed/flax seed oil	○ No	○ Yes	○ Less than 1 day per week but at least once a month ○ 1 - 2 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
153.	Melatonin	○ No	○ Yes	○ Less than 1 day per week but at least once a month ○ 1 - 2 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
154.	Probiotics/acidophilus	○ No	○ Yes	○ Less than 1 day per week but at least once a month ○ 1 - 2 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Since January 1, 2017, have you regularly (at least once a week for at least three months in a row) taken...		NO	YES	a. If yes, for about how long have you taken this regularly (at least once a week for at least three months in a row) since January 1, 2017?
155.	antibiotics?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
156.	acetaminophen (Tylenol)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
157.	"baby aspirin" or low-dose aspirin (100 mg/tablet or less)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
158.	aspirin or other aspirin containing products (325 mg/tablet or more)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
159.	ibuprofen (such as Advil, Motrin, Nuprin, etc.)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
160.	Celebrex or other COX-2 inhibitors?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
161.	Aleve or Naprosyn (naproxen)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
162.	Relafen, Ketoprofen, Anaprox, or other non-steroidal anti-inflammatories?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years

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

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

Do not include:

- Vitamins, minerals or supplements already reported in previous questions
- Aspirin or other pain medications already reported in previous questions

○ No → **GO TO QUESTION 164 ON PAGE 46**

○ Yes

TOTAL #

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

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

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

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

164. Which of the following best describes your **current** marital status? Please choose the **one** response that best describes your current situation.

- ○ Never married
- ○ Widowed
- ○ Divorced
- ○ Separated

GO TO QUESTION 165

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

164a. How many years have you been married or living as though married with this spouse/partner?

☐☐ # YEARS OR ○ Less than 1 year

164b. Is your spouse/partner a man or a woman?

- ○ Man
- ○ Woman

165. Thinking about last year, which of the following best describes your total family income from all household members before taxes? Please include income from all sources such as annuities, social security, stocks, alimony, and child support earned in the past year.

- ○ Less than $20,000
- ○ $20,000 to $49,999
- ○ $50,000 to $99,999
- ○ $100,000 to $200,000
- ○ More than $200,000

166. Last year, how many people, including yourself, were supported by that income?

- ○ 1
- ○ 2
- ○ 3-4
- ○ 5-6
- ○ 7-8
- ○ More than 8

Since January 1, 2017...	NO	YES	a. IF YES, in which years did you smoke? *(Please mark all that apply.)*	*During the years you smoked,* b. How many days per week do/did you smoke?	c. How many cigarettes do/did you usually smoke per day on the days you smoked?
167. did you smoke 10 cigarettes or more?	○ No	○ Yes	○ 2017 ○ 2018 ○ 2019 ○ 2020 ○ 2021 ○ 2022	○ Less than one day per week ○ 1-3 days per week ○ 4-6 days per week ○ Every day	☐☐☐ # CIGARETTES

168. Since January 1, 2017, have you used an electronic cigarette or e-cigarette, such as Juul, NJOY, Blu, or Smoking Everywhere, even one or two times?

○ No → **GO TO QUESTION 169 ON NEXT PAGE**

○ Yes

168a. Do you now use e-cigarettes…
- ○ Every day
- ○ Some days
- ○ Not at all

168b. What brand of e-cigarette do/did you use?

BRAND

168c. About how many disposable e-cigarettes or e-cigarette cartridges have you used in the past year?
- ○ None
- ○ 1 or more puffs but never a whole one
- ○ 1-10
- ○ 11-20
- ○ 21-50
- ○ 51-99
- ○ 100 or more

169. Have you **ever** used marijuana? Please include smoking or ingesting marijuana and using cannabis oil. *Do not include products that contain only cannabidiol, also called CBD.*

○ No → **GO TO QUESTION 170 ON PAGE 50**

○ Yes

169a. How old were you the **first or only** time you used marijuana?

☐☐ AGE

169b. How old were you when you **last** used marijuana?

☐☐ AGE

169c. Have you used marijuana in the **last 12 months**?

○ No → **GO TO 169e ON NEXT PAGE**

○ Yes

169d. Please list the reason(s) you used marijuana in the **last 12 months.** *(Please mark all that apply.)*

○ Pleasure
○ Relaxation
○ Pain relief
○ Other symptom relief
(For example, relief of treatment-related nausea)
○ Other reason

Did you use marijuana...	NO	YES	a. On average, how frequently did you use marijuana?	b. How did you use it? *(Please mark all that apply.)*
169e. in your teens?	○ No	○ Yes	○ Once a year or less ○ Less than once a month ○ Once a month or more, but less than once a week ○ Once a week or more	○ Smoking ○ Ingesting ○ Other, specify:
169f. in your 20s?	○ No	○ Yes	○ Once a year or less ○ Less than once a month ○ Once a month or more, but less than once a week ○ Once a week or more	○ Smoking ○ Ingesting ○ Other, specify:
169g. in your 30s?	○ No	○ Yes	○ Once a year or less ○ Less than once a month ○ Once a month or more, but less than once a week ○ Once a week or more	○ Smoking ○ Ingesting ○ Other, specify:
169h. in your 40s?	○ No	○ Yes	○ Once a year or less ○ Less than once a month ○ Once a month or more, but less than once a week ○ Once a week or more	○ Smoking ○ Ingesting ○ Other, specify:
169i. in your 50s?	○ No ○ Haven't reached this age	○ Yes	○ Once a year or less ○ Less than once a month ○ Once a month or more, but less than once a week ○ Once a week or more	○ Smoking ○ Ingesting ○ Other, specify:
169j. in your 60s?	○ No ○ Haven't reached this age	○ Yes	○ Once a year or less ○ Less than once a month ○ Once a month or more, but less than once a week ○ Once a week or more	○ Smoking ○ Ingesting ○ Other, specify:
169k. in your 70s or above?	○ No ○ Haven't reached this age	○ Yes	○ Once a year or less ○ Less than once a month ○ Once a month or more, but less than once a week ○ Once a week or more	○ Smoking ○ Ingesting ○ Other, specify:

170. Have you **ever** used cannabidiol, also called CBD?

○ No → **GO TO QUESTION 171 ON NEXT PAGE**

○ Yes

170a. When did you **first** use cannabidiol, also called CBD? ☐☐ / ☐☐☐☐ MONTH YEAR

170b. When did you **last** use cannabidiol, also called CBD? ☐☐ / ☐☐☐☐ MONTH YEAR

170c. Are you **currently** using cannabidiol, also called CBD?

○ No → **GO TO 171 ON NEXT PAGE**

○ Yes

170d. When you use cannabidiol (CBD), what forms of CBD do you typically use? *(Please mark all that apply.)*

- ○ Oral, prescription medication (examples: Epidiolex, Sativex)
- ○ Oral, non-prescription, swallowed immediately (may be an oil, capsule, edible, tincture, or powder)
- ○ Oral, non-prescription, held in the mouth while being absorbed (may be a spray or a liquid, often placed under the tongue)
- ○ Inhaled, may use vaporizer or vaping device (e.g. a vape pen)
- ○ Topical, as a cream or lotion
- ○ Other non-prescription form, including sprays, suppositories, and applicators

Since January 1, 2017...	NO	YES	a. If yes, in which years since January 1, 2017 did you drink alcohol? *(Please mark all that apply.)*	b. About how often did you drink alcohol?	c. On average, how many drinks did you have on the days that you drank alcohol?
171. have you drunk **alcoholic beverages?**	○ No	○ Yes	○ 2017 ○ 2018 ○ 2019 ○ 2020 ○ 2021 ○ 2022	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

172. Since January 1, 2017, did you **ever** drink four or more alcoholic beverages in a row, in one sitting?

○ No → **GO TO QUESTION 173**

○ Yes

172a. How often has this happened since January 1, 2017?

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

173. Since January 1, 2017, has a doctor or other health professional told you that your drinking was hurting your health?

○ No
○ Yes

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

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

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

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

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

Have you **ever**...		NO	YES	a. What does/did it measure? *(Please mark all that apply.)*	b. Do you **currently** use it?
180.	worn a fitness tracker or fitbit-type device?	○ No	○ Yes	○ Physical activity ○ Sleep ○ Other	○ No ○ Yes
181.	used a smart phone to track your activities?	○ No	○ Yes	○ Physical activity ○ Sleep ○ Other	○ No ○ Yes

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

Since January 1, 2017, which (if any) of these special diets have you followed for longer than a month, other than during pregnancy?		NO	YES	a. How long did you follow this diet?	b. Have you followed this diet for **at least a month in the past year?**
182.	Vegetarian	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ No ○ Yes
183.	Vegan	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ No ○ Yes
184.	Pescatarian (includes fish and seafood)	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ No ○ Yes
185.	Gluten-free	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ No ○ Yes
186.	Ketogenic ("keto") diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ No ○ Yes

187. Have you **ever** had a chemical relaxer or straightener applied to your hair?

○ No → **GO TO QUESTION 188 ON NEXT PAGE**

○ Yes

187a. In the **last 12 months**, have you had a chemical relaxer or straightener applied to your hair?
○ No
○ Yes → **Q187c**

187b. If No, how old were you when you **last** had a chemical relaxer or straightener applied to your hair?
☐☐ AGE

Did you use or apply chemical relaxers or straighteners to your hair...	NO	YES	a. On average, how frequently did you use or apply chemical relaxers or straighteners?	b. Did the chemical relaxer(s) you used contain lye?
187c. in your teens?	○ No	○ Yes	○ 1-2 times a year ○ Every 3-4 months ○ Every 5-8 weeks ○ 1 or more times a month	○ No, never or rarely contained lye ○ Yes, always or usually contained lye
187d. in your 20s?	○ No	○ Yes	○ 1-2 times a year ○ Every 3-4 months ○ Every 5-8 weeks ○ 1 or more times a month	○ No, never or rarely contained lye ○ Yes, always or usually contained lye
187e. in your 30s?	○ No	○ Yes	○ 1-2 times a year ○ Every 3-4 months ○ Every 5-8 weeks ○ 1 or more times a month	○ No, never or rarely contained lye ○ Yes, always or usually contained lye
187f. in your 40s?	○ No	○ Yes	○ 1-2 times a year ○ Every 3-4 months ○ Every 5-8 weeks ○ 1 or more times a month	○ No, never or rarely contained lye ○ Yes, always or usually contained lye
187g. in your 50s or above?	○ No	○ Yes	○ 1-2 times a year ○ Every 3-4 months ○ Every 5-8 weeks ○ 1 or more times a month	○ No, never or rarely contained lye ○ Yes, always or usually contained lye

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

	Not at all	Less than 30 minutes per day	30 minutes or more per day
a. Winter season	○	○	○
b. Spring season	○	○	○
c. Summer season	○	○	○
d. Fall season	○	○	○

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

		AND		PER WEEK
HOURS			MINUTES	

190. Since January 1, 2017, have you had a full-time or part-time job other than homemaking that you held for at least 12 months (at least 9 months if it was a teaching job)?

○ No

190a. Which of the following **best** describes your current situation?

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

GO TO QUESTION 202 ON PAGE 59

○ Yes → **GO TO QUESTION 191 ON NEXT PAGE**

IF YOU DID NOT HAVE A JOB SINCE JANUARY 1, 2017, GO TO QUESTION 202 ON PAGE 59

191. How many different jobs have you had since January 1, 2017? ☐☐ # OF JOBS

Please tell us about the jobs you have had since January 1, 2017, starting with the most recent and working backwards. **PLEASE DO NOT REPORT JOBS YOU STOPPED WORKING BEFORE 2017.**

	JOB 1	JOB 2
192. When did you first start this job?	○ Before 2017 ○ 2017 ○ 2018 ○ 2019 ○ 2020 ○ 2021 ○ 2022	○ Before 2017 ○ 2017 ○ 2018 ○ 2019 ○ 2020 ○ 2021 ○ 2022
193. When did you last have this job?	○ 2017 ○ 2018 ○ 2019 ○ 2020 ○ 2021 ○ 2022 ○ I still work there	○ 2017 ○ 2018 ○ 2019 ○ 2020 ○ 2021 ○ 2022 ○ I still work there
194. Where did/do you work? Please write down the name of the company you worked for and the **full street address** of this workplace. Knowing the name and addresses of the places you work will allow us to evaluate the impact of air pollution and other factors in the general environment on your health. We will never use this information for any other purpose and will never contact your employer.	NAME OF COMPANY/PLACE OF WORK STREET # STREET NAME SUITE # CITY OR TOWN STATE ZIP CODE COUNTY	NAME OF COMPANY/PLACE OF WORK STREET # STREET NAME SUITE # CITY OR TOWN STATE ZIP CODE COUNTY

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

		JOB 1			JOB 2		
200.	How many times per month did/do you work at night? "Work at night" means any shift that includes at least one hour between midnight and 2:00 AM.	○ Never ○ 1-2 times/month ○ 3-5 times/month ○ 6-10 times/month ○ 11-15 times/month ○ More than 15 times per month			○ Never ○ 1-2 times/month ○ 3-5 times/month ○ 6-10 times/month ○ 11-15 times/month ○ More than 15 times per month		
			NO	**YES**		**NO**	**YES**
201.	While working at this job did/do you regularly...	a. work in dusty conditions?	○	○	a. work in dusty conditions?	○	○
		b. breathe in chemical vapors or fumes?	○	○	b. breathe in chemical vapors or fumes?	○	○
		c. get chemicals or oils on your skin or clothing?	○	○	c. get chemicals or oils on your skin or clothing?	○	○
		d. come in contact with solvents or degreasers?	○	○	d. come in contact with solvents or degreasers?	○	○
		e. come in contact with metal chips, dust, or fumes?	○	○	e. come in contact with metal chips, dust, or fumes?	○	○
		f. come in contact with pesticides?	○	○	f. come in contact with pesticides?	○	○
		g. use cleaning solutions (not counting dish or laundry detergents)?	○	○	g. use cleaning solutions (not counting dish or laundry detergents)?	○	○
		h. travel in a vehicle?	○	○	h. travel in a vehicle?	○	○

SPACE IS PROVIDED FOR TWO JOBS. IF YOU HAVE HAD MORE THAN TWO JOBS LASTING 12 MONTHS OR MORE SINCE JANUARY 1, 2017, PLEASE ANSWER THE SAME QUESTIONS FOR EACH JOB AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.

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

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

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

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

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

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

○ No
○ Yes

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

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

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

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

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

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

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

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

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

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

Have you ever been ***treated unfairly***…	NO	YES	a. Has this happened in the **past five years**?	b. If yes, about how often has this happened in the **past five years**?	c. What do you think is the **main reason** for these experiences? *(Please mark all that apply.)*
210. in home renting, buying, or mortgage?	○ No	○ Yes	○ No ○ Yes	○ Less than once a year ○ A few times a year ○ A few times a month ○ At least once a week ○ Almost daily	○ Race or ethnicity ○ Sexual orientation ○ Age ○ Gender ○ Religion ○ Weight ○ Education/income level ○ Disability or illness ○ Other, specify:
211. in being stopped, searched, or threatened by police?	○ No	○ Yes	○ No ○ Yes	○ Less than once a year ○ A few times a year ○ A few times a month ○ At least once a week ○ Almost daily	○ Race or ethnicity ○ Sexual orientation ○ Age ○ Gender ○ Religion ○ Weight ○ Education/income level ○ Disability or illness ○ Other, specify:
212. in receiving service at a store, restaurant, or other business?	○ No	○ Yes	○ No ○ Yes	○ Less than once a year ○ A few times a year ○ A few times a month ○ At least once a week ○ Almost daily	○ Race or ethnicity ○ Sexual orientation ○ Age ○ Gender ○ Religion ○ Weight ○ Education/income level ○ Disability or illness ○ Other, specify:
213. in job hiring, promotion, or firing?	○ No ○ Not applicable (See below)	○ Yes	○ No ○ Yes	○ Less than once a year ○ A few times a year ○ A few times a month ○ At least once a week ○ Almost daily	○ Race or ethnicity ○ Sexual orientation ○ Age ○ Gender ○ Religion ○ Weight ○ Education/income level ○ Disability or illness ○ Other, specify:

*If you have never held a job other than homemaking that took at least 10 hours a week, where you worked for one year or longer, please answer **Not Applicable**.*

Have you **ever**…		NO	YES	a. Has this happened in the **past five years**?	b. If yes, about how often has this happened in the **past five years**?	c. What do you think is the **main reason** for these experiences? *(Please mark all that apply.)*
214.	been treated as though you were less intelligent, worthy, or honest than others?	○ No	○ Yes	○ No ○ Yes	○ Less than once a year ○ A few times a year ○ A few times a month ○ At least once a week ○ Almost daily	○ Race or ethnicity ○ Sexual orientation ○ Age ○ Gender ○ Religion ○ Weight ○ Education/income level ○ Disability or illness ○ Other, specify:
215.	experienced people acting as if they are afraid of you?	○ No	○ Yes	○ No ○ Yes	○ Less than once a year ○ A few times a year ○ A few times a month ○ At least once a week ○ Almost daily	○ Race or ethnicity ○ Sexual orientation ○ Age ○ Gender ○ Religion ○ Weight ○ Education/income level ○ Disability or illness ○ Other, specify:
216.	felt discriminated against?	○ No	○ Yes	○ No ○ Yes	○ Less than once a year ○ A few times a year ○ A few times a month ○ At least once a week ○ Almost daily	○ Race or ethnicity ○ Sexual orientation ○ Age ○ Gender ○ Religion ○ Weight ○ Education/income level ○ Disability or illness ○ Other, specify:

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

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

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

○ No
○ Yes
○ Don't know

Please answer the following questions about sleep. We are interested in what time you go to bed and when you wake up. Please consider a typical 24 hour period which may include sleeping during the day if you are working at night. Questions ask about your usual bedtimes and waking times when you are working (work days) or on non-work days. If you are not working, think about your usual patterns on weekdays versus weekends.

219. What time do you usually go to bed on weekdays or workdays?

		:		*(mark one)*
				○ AM
				○ PM
(hr)			*(min)*	

220. What time do you usually wake up on weekdays or workdays?

		:		*(mark one)*
				○ AM
				○ PM
(hr)			*(min)*	

221. What time do you usually go to bed on weekends or non-workdays?

		:		*(mark one)*
				○ AM
				○ PM
(hr)			*(min)*	

222. What time do you usually wake up on weekends or non-workdays?

		:		*(mark one)*
				○ AM
				○ PM
(hr)			*(min)*	

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

HOURS

For the following question only consider your **main sleep period**. For most people this will be at night, but may be different for you. *Example: A nurse working night shift would have her main sleep period during the day.*

224. In the **past year**, how many hours of actual sleep, on average, did you typically get during your **main sleep period**? *(This may be different than the number of hours you spent in bed.)*

HOURS

224a. On average, what time of day do you eat your last meal before going to bed for your main sleep period?

		:		○ AM
				○ PM

HOUR MINUTES

224b. On average, how much time passes between when you last eat anything before going to bed and when you first eat anything when you wake up from your main sleep period? *(Include snacks.)*

HOURS

For the following question consider **all sleep in a typical 24 hour day**, including naps.

225. In the **past year**, how many hours of actual sleep, on average, did you typically get **in 24 hours, including naps**? *(This may be different than the number of hours you spent in bed.)*

HOURS

226. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be?

○ Definitely a "morning" type
○ Rather more a "morning" than an "evening" type
○ Rather more an "evening" than a "morning" type
○ Definitely an "evening" type

227. If there is a specific time at which you have to get up in the morning, to what extent are you dependent on being woken by an alarm clock?

○ Not at all dependent
○ Slightly dependent
○ Fairly dependent
○ Very dependent

228. In the **past 7 days**...

	Not At All	A Little Bit	Some-what	Quite A Bit	Very Much
a. my sleep was restless.	○	○	○	○	○
b. I was satisfied with my sleep.	○	○	○	○	○
c. my sleep was refreshing.	○	○	○	○	○
d. I had difficulty falling asleep.	○	○	○	○	○
e. I had trouble staying asleep.	○	○	○	○	○

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

○ No → **GO TO QUESTION 230**

○ Yes

229a. In the **past month,** about how often did you feel **excessively** sleepy during the day?

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

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

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. feel too cold?	○	○	○	○
b. feel too hot?	○	○	○	○
c. have bad dreams?	○	○	○	○
d. have pain?	○	○	○	○
e. have to go to the bathroom?	○	○	○	○
f. other reason(s), please specify:	○	○	○	○

231. During the **past month**, how often have you taken medicine (prescription or over the counter) to help you sleep?

- ○ Not during the past month
- ○ Less than once a week
- ○ Once or twice a week
- ○ Three or more times a week

232. During the **past month**, how would you rate your sleep quality overall?

- ○ Very good
- ○ Fairly good
- ○ Fairly bad
- ○ Very bad

Have you **ever** been told...	**NEVER OR BEFORE 1/1/2017**	**1/1/2017 OR LATER**	a. If yes, has this happened more than 3 times since 1/1/2017?	b. If you first knew this after 1/1/2017, what was the year, or how old were you?
233. or suspected yourself, that you seem to **"act out your dreams" while asleep?** *For example, punching or flailing arms in the air, making running movements, shouting, or screaming.*	○ Never ○ Yes, first knew this before 1/1/2017	○ Yes, first knew this after 1/1/2017	○ No ○ Yes (more than 3 times)	2 0 ☐ ☐ YEAR **OR** ☐ ☐ AGE

234. Have you **ever** been told that you sleepwalk?

- ○ No → **GO TO QUESTION 235 ON NEXT PAGE**
- ○ Yes

234a. What was the first year (or age) you knew you did this? ☐☐☐☐ YEAR OR ☐☐ AGE

234b. Since January 1, 2017, how many times (that you are aware of) has this happened?

- ○ No times since 1/1/2017
- ○ 1-3 times
- ○ More than 3 times

235. Has a doctor or other health professional **ever** told you that you had sleep apnea?

○ No → **GO TO QUESTION 236**

○ Yes

235a. When were you **first** told you had sleep apnea? ☐☐ / ☐☐☐☐ MONTH / YEAR

235b. Do you **currently** have this condition? ○ No ○ Yes

235c. Do you **currently** use a continuous positive airway pressure machine (CPAP)? *Please include BiPAP (bi-level PAP), VPAP (variable PAP), and APAP (auto-titrating PAP) machines.* ○ No ○ Yes

		NO	YES
236.	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	○	○
237.	Has anyone observed you stop breathing during your sleep?	○	○

238. In the **past 5 years**, approximately how frequently have you donated blood?

○ More than once a year
○ Once a year
○ Less than once a year
○ Never

239. Since January 1, 2017, have **any close relatives** of yours died of **cancer or another cause**? *Include close relatives related by blood, marriage, or adoption.*

○ No → **GO TO QUESTION 240 ON NEXT PAGE**

○ Yes

↓

What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*	Cause of Death *(Please mark all that apply.)*
○ Mother	○ Cancer ○ Other
○ Father	○ Cancer ○ Other
○ Sister(s)	○ Cancer ○ Other
○ Brother(s)	○ Cancer ○ Other
○ Daughter(s)	○ Cancer ○ Other
○ Son(s)	○ Cancer ○ Other
○ Spouse or partner(s)	○ Cancer ○ Other
○ Other relative(s) whether related to you by blood, marriage, or adoption, etc.	○ Cancer ○ Other

240. Have you moved since January 1, 2017?

○ No → **GO TO QUESTION 241 ON NEXT PAGE**

○ Yes

240a. What month and year did you move into your current residence?

MONTH / 2 0 YEAR

240b. Please write down your current address.

STREET #

STREET NAME

APT #

CITY OR TOWN STATE ZIP CODE

COUNTY

240c. Please write down the name of the nearest cross street (the street that intersects with the street where you live):

NAME OF NEAREST CROSS STREET

241. Have you received a COVID-19 vaccine?

○ No → **GO TO QUESTION 242 ON NEXT PAGE**

○ Yes

↓

241a. Which of the following applies? I have received...

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

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

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

241a1. Have you received a booster vaccine shot?

○ No → **GO TO QUESTION 242 ON NEXT PAGE**

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

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

242. Have you ever been sick with suspected or confirmed COVID-19, whether or not you were tested for active COVID-19 infection at that time?

- ○ I had a positive COVID-19 test but never felt sick
- ○ No, I have not been sick with COVID-19
- ○ Probably not: I was sick with some of the same symptoms but don't think it was COVID-19

GO TO QUESTION 243 ON PAGE 75

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

↓

242a. What was the approximate date you started feeling sick? *If you had this more than once, report for the time <u>when you were the most sick</u>.*

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

242a1. When you were sick with COVID-19 or symptoms similar to COVID-19, which of the following symptoms did you experience? (*If you were sick **with COVID-19 symptoms** more than once, please report for the <u>time you were the most sick</u>.) Please mark all that apply.*

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

[ ]

- ○ I did not have any symptoms → **GO TO Q243, Pg75**

242b. How many days until you recovered? That is, how many days until you felt well enough to resume your normal activities?

[ ][ ][ ] # DAYS

OR ○ Not yet recovered →

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

[ ][ ][ ] # DAYS

242c. Were you admitted to the hospital? *Do NOT include visit(s) to the Emergency Department only.*

○ No

○ Yes →

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

DAYS

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

○ No
○ Yes

242d. Are you still experiencing symptoms due to COVID-19?

○ No → **GO TO QUESTION 243 ON NEXT PAGE**

○ Yes

↓

242d1. Which symptoms have you continued to experience? *(Please mark all that apply.)*

HEAD/SENSORY

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

PAIN

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

OTHERS

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

Please specify other symptoms:

29070

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

○ No → **GO TO QUESTION 244**

○ Yes

243a. What was the sample collection date of the first positive test?

		/	2	0		
MONTH			YEAR			

243b. Was it confirmed with a second test?

○ No

○ Yes

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

○ No

○ Yes

↓

Please specify:

If you have a pathology report from a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy that you are willing to share with us, please include a copy with your completed questionnaire.

Thank you!

Please check to see that all questions are answered.

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

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

The Sister Study, 4505 Emperor Blvd, Suite 400, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org