The Sister Study
Health and Medical History
Version 4

Instructions:

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

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

Like this: ● Not like this: ⊘ ✓

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

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

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

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

1	2	3	4	5	6	7	8	9	0

When writing dates, please follow this example.

EXAMPLE: June 7, 2012 = 0 6 / 0 7 / 2 0 1 2

(month) (day) (year)

Version 4

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

Today's Date: ☐☐ / ☐☐ / 2 0 ☐☐
MONTH DAY YEAR

GENERAL HEALTH

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

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

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

	No	Yes
a. had a routine physical exam?	○	○
b. been to a dentist for a routine check-up or cleaning?	○	○
c. had a Pap smear?	○	○
d. had a breast exam by a doctor or other health professional?	○	○
e. had a screening mammogram?	○	○
f. had a screening ultrasound of the breast?	○	○
g. had a screening MRI of the breast?	○	○
h. had a bone density scan or osteoporosis screening?	○	○
i. had a screening colonoscopy or sigmoidoscopy exam?	○	○
j. had an ultrasound of the uterus?	○	○

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

○ No
○ Yes

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

○ No
○ Yes

5. Since January 1, 2009, have you ever been unable to get screening mammography because your insurance doesn't cover it or you don't have access to screening through your work or other sources?

○ No
○ Yes

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

POUNDS

7. What is your current height?

FEET INCHES

8. Since January 1, 2009, how many times have you lost 20 pounds (9 kilograms) or more and then later gained all the weight back? *(If none, please enter "00".)*

TIMES

Please use a ballpoint pen for this form

9. Have you **ever** been vaccinated for shingles (herpes zoster)?

○ No → **GO TO QUESTION 10**

○ Yes

9a. In what month and year did you have a shingles vaccination? MONTH / YEAR

10. In the past 12 months, did you get vaccinated for the flu (either a flu shot or nasal spray)?

○ No → **GO TO QUESTION 11**

○ Yes

10a. In what month and year did you receive the flu vaccine? MONTH / 2 0 YEAR

11. During the past 12 months, did you have any cold sores?

○ No
○ Yes, 1-2 times
○ Yes, 3 or more times

12. During the past 12 months, did you have any colds?

○ No → **GO TO QUESTION 13**

○ Yes

12a. How many colds did you have?

○ 1-2
○ 3-4
○ 5 or more

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

○ No
○ Yes

FAMILY MEDICAL HISTORY

14. Since January 1, 2009, were **any** of your sisters diagnosed with breast cancer **for the first time**?

○ No
○ Yes

15. Since January 1, 2009, have any **other** close blood relatives of yours been diagnosed with breast cancer **for the first time**?

○ No → **GO TO QUESTION 16**

○ Yes

15a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

16. Since January 1, 2009, have **any** close blood relatives of yours been diagnosed with ovarian cancer **for the first time**?

○ No → **GO TO THE NEXT PAGE, QUESTION 17**

○ Yes

16a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

Please use a ballpoint pen for this form

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

○ No → **GO TO QUESTION 18**

○ Yes

17a. What is/are the relative(s)' relationship to you? *(Please mark all that apply.)*

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

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

○ No → **GO TO QUESTION 19**

○ Yes

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

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

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

○ No → **GO TO THE NEXT PAGE, QUESTION 20**

○ Yes

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

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

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

○ No → **GO TO QUESTION 21**

○ Yes

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

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

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

○ No → **GO TO THE NEXT PAGE, QUESTION 22**

○ Yes

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

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

Please use a ballpoint pen for this form

PERSONAL MEDICAL HISTORY

We are interested in changes to your health in the past few years. Please think about your medical history **since January 1, 2009.**

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
22. breast cancer? Please do **not** include in situ cancer.	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
23. ductal (breast) carcinoma in situ (DCIS)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
24. lobular (breast) carcinoma in situ (LCIS)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
25. lung cancer?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
26. ovarian cancer?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
27. cancer of the uterus or endometrium? Please do **not** include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
28. cancer of the colon or rectum?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
29. Hodgkin's disease or Hodgkin's lymphoma?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
30. non-Hodgkin's lymphoma?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
31. leukemia?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
32. malignant melanoma?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
33. skin cancer (**not** malignant melanoma)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	a. MONTH/YEAR DIAGNOSED MONTH / 2 0 YEAR b. Was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?
34. any other type of cancer not already listed?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	a. MONTH/YEAR DIAGNOSED MONTH / 2 0 YEAR b. Please specify what type of cancer: c. If you were diagnosed with a second **other** type of cancer January 1, 2009 or later, what month and year were you diagnosed? MONTH / 2 0 YEAR d. Please specify what type of cancer:

Please use a ballpoint pen for this form

Has a doctor or other health professional **ever** told you that you had...	NO	YES	b. Have you experienced any symptoms in the **past 12 months?**
35. hypertension or high blood pressure?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? MONTH / 20 YEAR	○ No ○ Yes
36. angina?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? MONTH / 20 YEAR	○ No ○ Yes
37. cardiac arrhythmia (irregular heartbeat)?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? MONTH / 20 YEAR	○ No ○ Yes
38. congestive heart failure?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? MONTH / 20 YEAR	○ No ○ Yes

Has a doctor or other health professional told you that you had...	NO	YES	b. Have you had another incident since then?
39. a heart attack or myocardial infarction?	○ No	○ Yes, my first heart attack was before January 1, 2009 ○ Yes, my first heart attack was January 1, 2009 or later ↓ a. What month and year was your first heart attack? __ __ / 2 0 __ __ MONTH YEAR	○ No ○ Yes ↓ c. What month and year was your most recent heart attack? __ __ / __ __ __ __ MONTH YEAR
40. a stroke (this does not include TIA or "mini-stroke")?	○ No	○ Yes, my first stroke was before January 1, 2009 ○ Yes, my first stroke was January 1, 2009 or later ↓ a. What month and year was your first stroke? __ __ / 2 0 __ __ MONTH YEAR	○ No ○ Yes ↓ c. What month and year was your most recent stroke? __ __ / __ __ __ __ MONTH YEAR
41. a mini-stroke or TIA (transient ischemic attack)?	○ No	○ Yes, my first mini-stroke was before January 1, 2009 ○ Yes, my first mini-stroke was January 1, 2009 or later ↓ a. What month and year was your first mini-stroke? __ __ / 2 0 __ __ MONTH YEAR	○ No ○ Yes ↓ c. What month and year was your most recent mini-stroke? __ __ / __ __ __ __ MONTH YEAR

Please use a ballpoint pen for this form

Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. How many times has this happened since January 1, 2009?	b. What was the month and year that this **first** happened since January 1, 2009?
42. a hip fracture?	○ Never ○ Before January 1, 2009	○ January 1, 2009 or later	# TIMES	MONTH / 2 0 YEAR
43. a wrist fracture?	○ Never ○ Before January 1, 2009	○ January 1, 2009 or later	# TIMES	MONTH / 2 0 YEAR

44. Since January 1, 2009, have you had any other broken bones?

○ Never
○ Yes, before January 1, 2009

GO TO QUESTION 45

○ Yes, January 1, 2009 or later

What broken bones did you have?

44a. What was the month and year that this happened? MONTH / 2 0 YEAR

44b. FIRST BROKEN BONE

44c. What was the month and year that this happened? MONTH / 2 0 YEAR

44d. SECOND BROKEN BONE

			a. **If yes,** how many times?	b. Age at **first** injury?	c. Age at **most recent** injury?
45. Have you **ever** had a serious head injury that resulted in unconsciousness, coma, or hospitalization?	○ No	○ Yes	# TIMES	AGE	AGE

46. Since January 1, 2009, have you had <u>any other major injury</u> that required hospitalization?

○ Never

○ Yes, <u>before</u> January 1, 2009 → **GO TO QUESTION 47**

○ Yes, January 1, 2009 or later →

If you were injured January 1, 2009 or later, what type of injuries did you have?

46a. What month and year were you injured? ☐☐ / 2 0 ☐☐
MONTH YEAR

46b. ☐
FIRST OTHER MAJOR INJURY

46c. What month and year were you injured? ☐☐ / 2 0 ☐☐
MONTH YEAR

46d. ☐
SECOND OTHER MAJOR INJURY

Has a doctor or other health professional **ever** told you that you had...	**NO**	**YES**
47. diabetes?	○ No	○ Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 ○ Yes, <u>first</u> diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR b. Do you still have this condition? ○ No ○ Yes c. Do you currently take insulin for diabetes? ○ No → **GO TO THE NEXT PAGE, QUESTION 48** ○ Yes d. If yes, when did you **first** use insulin? ☐☐ / ☐☐☐☐ MONTH YEAR

Please use a ballpoint pen for this form

Has a doctor or other health professional **ever** told you that you had...	NO	YES	b. Have you experienced any symptoms in the **past 12 months?**
48. allergic rhinitis, hay fever, or seasonal allergies?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
49. asthma?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
50. depression?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes
51. periodontal (gum) disease?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes

Since January 1, 2009, has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
52. chronic bronchitis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
53. emphysema?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
54. chronic obstructive pulmonary disease (COPD)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
55. Graves' disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
56. other hyperthyroidism (overactive thyroid)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
57. Hashimoto's thyroiditis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
58. other hypothyroidism (underactive thyroid)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
59. an enlarged thyroid or goiter?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
60. thyroid nodules?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
61. another thyroid problem? Please do **not** include thyroid cancer.	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	a. MONTH/YEAR DIAGNOSED MONTH / 2 0 YEAR b. Please specify the problem:

Please use a ballpoint pen for this form

Since January 1, 2009, has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
62. osteoporosis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
63. osteopenia, or low bone density?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
64. osteoarthritis (age-related arthritis)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
65. rheumatoid arthritis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
66. multiple sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
67. scleroderma or systemic sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
68. systemic lupus erythematosus (SLE)?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
69. discoid lupus?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
70. Sjögren's syndrome?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
71. Crohn's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
72. ulcerative colitis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
73. shingles?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	NO	YES
74. migraine headaches?	○ No	○ Yes, first diagnosed before January 1, 2009 ○ Yes, first diagnosed January 1, 2009 or later → a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR b. Was the diagnosis of migraine made by a... *(Please mark all that apply.)* ○ Headache specialist ○ Neurologist ○ Other physician ○ Other health professional c. Which kind of migraines do you get? ○ With visual aura ○ Without visual aura ○ Both types with similar frequency d. During the past 12 months, how often have you had a migraine? ○ Never ○ Monthly or less ○ Biweekly ○ Weekly ○ Daily e. During the past 12 months, how long on average have your migraines usually lasted? ○ A few hours or less ○ About half a day ○ A day ○ Several days ○ One week or longer

Please use a ballpoint pen for this form

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
75. polyps in the colon or rectum?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
76. polycystic ovarian syndrome or PCOS?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
77. ovarian cysts?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
78. endometriosis?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
79. uterine fibroids or fibroid tumors?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
80. gallstones or gallbladder disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
81. Parkinson's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
82. Alzheimer's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
83. mild cognitive impairment?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
84. kidney failure requiring dialysis or transplant?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
85. kidney stones?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
86. other kidney disease?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 1/1/2009	DIAGNOSED 1/1/2009 OR LATER	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
87. gout?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
88. cataracts?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
89. glaucoma?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
90. macular degeneration?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR
91. hearing loss?	○ Never diagnosed ○ Diagnosed before January 1, 2009	○ Diagnosed January 1, 2009 or later	MONTH / 2 0 YEAR

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

Has a doctor or other health professional **ever** told you that you had...	NO	YES	a. If yes, what year were you **first** diagnosed?
91b. pulmonary embolism?	○ No	○ Yes	YEAR
91c. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	○ No	○ Yes	YEAR

Please use a ballpoint pen for this form

92. Since January 1, 2009, 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. daily, persistent, troublesome dry eyes for more than 3 months, or a recurrent feeling of sand or gravel in your eyes, or use of tear substitutes more than 3 times a day?	○	○
d. a daily feeling of dry mouth for more than 3 months, or frequent drinking of liquids to aid in swallowing dry foods, or recurrently or persistently swollen salivary glands?	○	○
e. a tremor or trembling in either of your hands?	○	○
f. walking or other movements getting noticeably slower?	○	○
g. handwriting getting noticeably smaller?	○	○
h. difficulty getting started when walking or making other movements?	○	○
i. wheezing or whistling in your chest?	○	○
j. shortness of breath when hurrying on level ground, or when walking up a slight hill, or when climbing a flight of stairs at your usual pace?	○	○
k. shortness of breath when at rest?	○	○
l. shortness of breath when lying down?	○	○
m. shortness of breath when walking?	○	○
n. swelling (or edema) in your legs?	○	○
o. excessive sweating other than due to menopause?	○	○
p. unexplained and unintentional weight loss of 10 or more pounds?	○	○

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

○ No → **GO TO QUESTION 94**

○ Yes

93a. How old were you the **first** time you noticed this problem?

AGE

93b. Are there any reasons (such as head injury) that explain the decrease in your sense of smell?

○ No
○ Yes, specify:

94. Have you experienced the following **at least once a week in the past year**?
(Please mark a response for each item below.)

a. Heartburn (a burning discomfort behind the breast bone in your chest)

○ No
○ Yes

b. Acid regurgitation/reflux (a bitter or sour tasting fluid coming into your throat or mouth)

○ No
○ Yes

	NO	YES	a. If yes, for how many years have you had this symptom?
95. Since January 1, 2009, have you experienced coughing on most days for three months or more out of a year?	○ No	○ Yes	○ 1 year ○ 2 or more years
96. Since January 1, 2009, have you brought up phlegm on most days for three months or more out of a year (do not count phlegm from the nose)?	○ No	○ Yes	○ 1 year ○ 2 or more years

Please use a ballpoint pen for this form

97. Since January 1, 2009, have you had a mammogram, breast ultrasound, or breast MRI?

○ No → **GO TO THE NEXT PAGE, QUESTION 98**

○ Yes

97a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2009?

☐☐ # TIMES

97b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI?

☐☐ / 2 0 ☐☐
MONTH YEAR

97c. Since January 1, 2009, have you been told you had abnormal findings on a mammogram, breast ultrasound, or breast MRI?

○ No → **GO TO THE NEXT PAGE, QUESTION 98**

○ Yes ↓

97d. What was the month and year of your most recent test with abnormal findings?

☐☐ / 2 0 ☐☐
MONTH YEAR

97e. Which breast showed abnormal findings at the most recent test?

○ Left breast
○ Right breast
○ Both breasts

97f. After completing the work-up for this abnormal test, what was the doctors' recommendation? Did they tell you to...

○ Come back in 12 months or more for usual follow-up
○ Come back in 6-11 months
○ Come back in 3-5 months
○ Come back in less than 3 months
○ Have a breast biopsy, surgery, or other treatment
○ Don't know

97g. Were you told this test showed any of the following? *(Please mark all that apply.)*

○ Breast cysts
○ Fibrocystic breasts
○ Breast calcifications
○ Dense breasts
○ Uneven or one-sided densities
○ Fibroadenoma
○ Other
○ Don't know

98. Since January 1, 2009, have you had a breast cyst or cysts drained (aspirated) or removed?

○ No → **GO TO QUESTION 99**

○ Yes

98a. On how many occasions have you had this since January 1, 2009?
OCCASIONS

98b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

98c. On which breast was the most recent cyst aspiration or removal performed?
- ○ Left breast
- ○ Right breast
- ○ Both breasts

98d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...
- ○ Come back in 12 months or more for usual follow-up
- ○ Come back in 6-11 months
- ○ Come back in 3-5 months
- ○ Come back in less than 3 months
- ○ Have a breast biopsy, surgery, or other treatment
- ○ Don't know

99. Since January 1, 2009, have you had a needle biopsy to diagnose or rule out a breast condition?

○ No → **GO TO THE NEXT PAGE, QUESTION 100**

○ Yes

99a. On how many occasions have you had this since January 1, 2009?
OCCASIONS

99b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

99c. On which breast was the most recent needle biopsy performed?
- ○ Left breast
- ○ Right breast
- ○ Both breasts

99d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...
- ○ Come back in 12 months or more for usual follow-up
- ○ Come back in 6-11 months
- ○ Come back in 3-5 months
- ○ Come back in less than 3 months
- ○ Have a different type of breast biopsy, surgery, or other treatment
- ○ Don't know

Please use a ballpoint pen for this form

100. Since January 1, 2009, have you had a surgical biopsy or a biopsy other than a needle biopsy to diagnose or rule out a breast condition?

○ No → **GO TO THE NEXT PAGE, QUESTION 101**

○ Yes

100a. On how many occasions have you had this since January 1, 2009?

[ ][ ] # OCCASIONS

100b. What was the month and year of your most recent procedure?

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

100c. On which breast was the most recent biopsy performed?

○ Left breast
○ Right breast
○ Both breasts

100d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...

○ Come back in 12 months or more for usual follow-up
○ Come back in 6-11 months
○ Come back in 3-5 months
○ Come back in less than 3 months
○ Have a different type of breast biopsy, surgery, or other treatment
○ Don't know

101. Since January 1, 2009, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

○ No → **GO TO QUESTION 102**

○ Yes

101a. On how many occasions have you had this since January 1, 2009? ☐☐ # OCCASIONS

101b. What was the month and year of your most recent procedure? ☐☐ / 2 0 ☐☐ MONTH / YEAR

101c. On which breast was the most recent lumpectomy or excisional biopsy performed?
- ○ Left breast
- ○ Right breast
- ○ Both breasts

101d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...
- ○ Come back in 12 months or more for usual follow-up
- ○ Come back in 6-11 months
- ○ Come back in 3-5 months
- ○ Come back in less than 3 months
- ○ Have a different type of biopsy, surgery, or other treatment
- ○ Don't know

Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. Why was this done?	b. If you had this procedure January 1, 2009 or later, what was the month and year?
102. a mastectomy of your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	○ To treat breast cancer ○ To prevent breast cancer ○ Both	☐☐ / 2 0 ☐☐ MONTH / YEAR
103. a mastectomy of your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	○ To treat breast cancer ○ To prevent breast cancer ○ Both	☐☐ / 2 0 ☐☐ MONTH / YEAR

Please use a ballpoint pen for this form

Since January 1, 2009, were you told you had any of the following after a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy?

Since January 1, 2009, have you had...		NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. If you had this January 1, 2009 or later, what was the month and year?
104.	fibrocystic or **benign nonproliferative** changes within normal range? For example, cysts, mild hyperplasia, benign calcifications, fibrosis, etc.	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
105.	fibroadenoma?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know
106.	proliferation **without atypia**? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
107.	atypical hyperplasia?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know
108.	ductal carcinoma in situ (DCIS)?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
109.	lobular carcinoma in situ (LCIS)?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
110.	breast cancer?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR
111.	other changes?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR

112. 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

113. Other than during breastfeeding or pregnancy, were you ever diagnosed with mastitis?

○ No

○ Yes

Since January 1, 2009, have you had...		**NEVER OR BEFORE 1/1/2009**	**1/1/2009 OR LATER**	a. If you had this procedure January 1, 2009 or later, what was the month and year?
114.	breast reduction surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
115.	breast reduction surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	☐☐ / 2 0 ☐☐ MONTH YEAR

Please use a ballpoint pen for this form

Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. If you had this procedure January 1, 2009 or later, what was the month and year?	b. Did you have a silicone gel implant?
116. breast reconstruction surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes
117. breast reconstruction surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes
118. breast enlargement surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes
119. breast enlargement surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes

Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. If you had this procedure January 1, 2009 or later, what was the month and year?	b. Was this a silicone gel implant?
120. a breast implant surgically removed from your **left** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes
121. a breast implant surgically removed from your **right** breast?	○ Never ○ Yes, before January 1, 2009	○ Yes, January 1, 2009 or later	MONTH / 2 0 YEAR	○ No ○ Yes

122. Since January 1, 2009, have you had <u>any other major health condition</u>?

○ Never diagnosed

○ Diagnosed <u>before</u> January 1, 2009

GO TO QUESTION 123

○ Diagnosed January 1, 2009 or later

If you were diagnosed January 1, 2009 or later, what other major health conditions did you have?

122a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐
MONTH YEAR

122b. ☐
FIRST OTHER MAJOR HEALTH CONDITION

122c. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐
MONTH YEAR

122d. ☐
SECOND OTHER MAJOR HEALTH CONDITION

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MENSTRUAL HISTORY

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

○ No → **GO TO PAGE 34, QUESTION 132**

○ Yes → **GO TO PAGE 30, QUESTION 124**

124. Are you currently pregnant or breastfeeding?

○ No → **GO TO NEXT QUESTION, 124a**

○ Yes → **GO TO PAGE 32, QUESTION 125**

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

○ No → **ANSWER BOX A BELOW**

○ Yes → **ANSWER BOX B ON THE NEXT PAGE**

BOX A

THIS BOX IS FOR WOMEN WHO HAVE NOT HAD A MENSTRUAL PERIOD IN THE PAST 12 MONTHS AND ARE NOT PREGNANT OR BREASTFEEDING. ALL OTHERS GO TO QUESTION 124d.

124b. Why did your periods stop?

○ My periods stopped on their own (naturally).

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

○ My periods stopped after my uterus or ovaries were removed **(be sure to answer questions 163 and 164).**

○ My periods stopped due to radiation or chemotherapy.

○ 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:

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

		/					**OR**		
MONTH			YEAR					AGE	

GO TO PAGE 32, QUESTION 125

BOX B

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

124d. When was your last menstrual period?

		/	2	0		
MONTH			YEAR			

124e. What statement best describes you?

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

GO TO PAGE 32, QUESTION 125

OR

- O My periods stopped sometime in the last 12 months. → **GO TO QUESTION 124f**

124f. Why did your periods stop?

- O My periods stopped on their own (naturally).
- O My periods stopped on their own but I began taking hormone replacement therapy before my periods fully stopped.
- O My periods stopped after my uterus or ovaries were removed **(be sure to answer questions 163 and 164).**
- O My periods stopped due to radiation or chemotherapy.
- O My periods stopped due to medicine that causes the ovaries to make less hormones or medicine that has this as a side effect.
- O My periods stopped because I am taking the kind of birth control pills that make me not have periods.
- O My periods stopped for some other reason, please describe:

Please use a ballpoint pen for this form

REPRODUCTIVE HISTORY AND HORMONES

125. Have you had a pregnancy since January 1, 2009?

○ No → **GO TO PAGE 34, QUESTION 132**

○ Yes

125a. Are you currently pregnant?
○ No
○ Yes

125b. How many times have you been pregnant since January 1, 2009 (including your current pregnancy, if you are pregnant now)?
☐ # TIMES

THIS SECTION IS FOR WOMEN WHO HAVE BEEN PREGNANT SINCE JANUARY 1, 2009. ALL OTHERS GO TO THE NEXT PAGE, QUESTION 132.

		FIRST PREGNANCY (since January 1, 2009)	SECOND PREGNANCY (since January 1, 2009)
126.	How did this pregnancy end?	○ Still pregnant now ○ Single live birth ○ Twins, live births ○ Other multiple live births → [ ] # BABIES ○ Stillbirth(s) ○ Miscarriage ○ Induced abortion ○ Molar or ectopic pregnancy	○ Still pregnant now ○ Single live birth ○ Twins, live births ○ Other multiple live births → [ ] # BABIES ○ Stillbirth(s) ○ Miscarriage ○ Induced abortion ○ Molar or ectopic pregnancy
127.	How many weeks did this pregnancy last (or has it lasted so far, if now pregnant)?	○ Less than 8 weeks ○ 8 to 12 weeks ○ 13 to 16 weeks ○ 17 to 24 weeks ○ 25 to 36 weeks ○ 37 to 41 weeks ○ 42 weeks or more	○ Less than 8 weeks ○ 8 to 12 weeks ○ 13 to 16 weeks ○ 17 to 24 weeks ○ 25 to 36 weeks ○ 37 to 41 weeks ○ 42 weeks or more
128.	What month and year did this pregnancy end?	[ ][ ] / [2][0][ ][ ] MONTH YEAR **OR** ○ Still pregnant now	[ ][ ] / [2][0][ ][ ] MONTH YEAR **OR** ○ Still pregnant now
129.	What was the sex of the baby or babies?	○ Single male ○ Single female ○ Multiple → [ ] # MALES [ ] # FEMALES ○ Don't know	○ Single male ○ Single female ○ Multiple → [ ] # MALES [ ] # FEMALES ○ Don't know
130.	How long did you breastfeed (or have you been breastfeeding)?	○ Less than one month ○ 1-3 months ○ 4-6 months ○ 7-12 months ○ 13-24 months ○ More than 24 months → **GO TO 131** ○ Did not breastfeed/ not applicable → **GO TO NEXT PREGNANCY OR QUESTION 132**	○ Less than one month ○ 1-3 months ○ 4-6 months ○ 7-12 months ○ 13-24 months ○ More than 24 months → **GO TO 131** ○ Did not breastfeed/ not applicable → **GO TO NEXT PREGNANCY OR QUESTION 132**
131.	Are you still breastfeeding?	○ No ○ Yes	○ No ○ Yes

IF YOU HAVE HAD MORE THAN 2 PREGNANCIES SINCE JANUARY 1, 2009, PLEASE ANSWER THE SAME QUESTIONS FOR EACH PREGNANCY AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.

Please use a ballpoint pen for this form

132. Since January 1, 2009, have you used <u>any hormonal birth control</u>?

○ No → **GO TO QUESTION 140**

○ Yes

Since January 1, 2009, have you used...		NO	YES	a. If yes, how many months in all have you used this since January 1, 2009?	b. Are you currently using this?
133.	birth control pills?	○ No	○ Yes	# MONTHS	○ No ○ Yes
134.	birth control patches?	○ No	○ Yes	# MONTHS	○ No ○ Yes
135.	a hormonal IUD (intrauterine device)?	○ No	○ Yes	# MONTHS	○ No ○ Yes
136.	a Norplant implant?	○ No	○ Yes	# MONTHS	○ No ○ Yes
137.	a Nuva Ring?	○ No	○ Yes	# MONTHS	○ No ○ Yes
138.	Depo Provera?	○ No	○ Yes	# MONTHS	○ No ○ Yes
139.	any other hormonal birth control?	○ No	○ Yes	# MONTHS	○ No ○ Yes

140. Have you **ever** tried for more than one year to become pregnant and did not get pregnant?

○ No

○ Yes

141. Since January 1, 2009, have you visited a doctor, clinic, or hospital to seek help for you to become pregnant?

○ No

○ Yes

142. Since January 1, 2009, have you used <u>any fertility medications</u>?

○ No → **GO TO QUESTION 145**

○ Yes

Since January 1, 2009, have you taken...		NO	YES	a. If yes, how many months or menstrual cycles in all have you used this since January 1, 2009?
143.	Clomiphene, Clomid, or Serophene?	○ No	○ Yes	# MONTHS/CYCLES
144.	drugs that contain follicle-stimulating hormones (FSH) — Follistim, Puregon, Gonal-F, Urofollitropin, Metrodin, Fertinex, Bravelle, human menopausal gonadotropin (hMG), menotropin, Pergonal, Humegon, or Repronex?	○ No	○ Yes	# MONTHS/CYCLES

145. Have you **ever** conceived a pregnancy in a menstrual cycle where you were treated with the fertility drug Clomiphene, Clomid, or Serophene?

○ No → **GO TO THE NEXT PAGE, QUESTION 146**

○ Yes

145a. How many times? # TIMES

145b. When did the first such pregnancy end? MONTH / DAY / YEAR

145c. When did the last such pregnancy end? MONTH / DAY / YEAR

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146. Have you **ever** conceived a pregnancy in a menstrual cycle where you were treated with drugs that contain follicle-stimulating hormone (FSH) (Metrodin, human menopausal gonadotropin (hMG), Pergonal, menotropin, Follistim, Puregon, Gonal-F, Urofollitropin, Fertinex, Bravelle, Repronex, Humegon)?

○ No → **GO TO QUESTION 147**

○ Yes

146a. How many times? ☐☐ # TIMES

146b. When did the first such pregnancy end? ☐☐ / ☐☐ / ☐☐☐☐ MONTH / DAY / YEAR

146c. When did the last such pregnancy end? ☐☐ / ☐☐ / ☐☐☐☐ MONTH / DAY / YEAR

147. Has a doctor or other health professional ever told you that you had mastitis while you were breastfeeding (postnatal or lactational mastitis)?

○ No → **GO TO THE NEXT PAGE, QUESTION 148**

○ Yes

147a. How many times have you had this? ☐☐ # TIMES

147b. What was the month and year of your most recent mastitis? ☐☐ / ☐☐☐☐ MONTH / YEAR

147c. Were you ever given antibiotics to treat mastitis? ○ No ○ Yes

147d. Were you ever given pain medication to treat mastitis? ○ No ○ Yes

147e. Did you ever stop breastfeeding sooner than planned because of mastitis? ○ No ○ Yes

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

Since January 1, 2009, have you used...		NO	YES	a. If yes, how many months in all have you used this since January 1, 2009?	b. Do you currently use this female hormone product(s)?
148.	a combined pill containing both estrogen and progesterone (such as Prempro)?	○ No	○ Yes	# MONTHS	○ No ○ Yes
149.	an estrogen-only pill (such as Premarin) with no additional progesterone in any form?	○ No	○ Yes	# MONTHS	○ No ○ Yes
150.	an estrogen pill (such as Premarin) **and** a separate progesterone pill (such as Provera) or progesterone shot?	○ No	○ Yes	# MONTHS	○ No ○ Yes
151.	an estrogen-only patch with no additional progesterone in any form?	○ No	○ Yes	# MONTHS	○ No ○ Yes
152.	a patch containing both estrogen and progesterone (such as Combipatch)?	○ No	○ Yes	# MONTHS	○ No ○ Yes
153.	an estrogen-only patch **and** a separate progesterone pill or progesterone shot?	○ No	○ Yes	# MONTHS	○ No ○ Yes
154.	progesterone alone (not for birth control)?	○ No	○ Yes	# MONTHS	○ No ○ Yes

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Since January 1, 2009, have you used...	NO	YES	If yes, how many months in all have you used this since January 1, 2009?
155. vaginal estrogen creams, rings, or suppositories?	○ No	○ Yes	a. ☐☐ # 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
156. any other estrogen products, including "natural" estrogens?	○ No	○ Yes	a. ☐☐ # MONTHS b. Do you currently use this female hormone product(s)? ○ No ○ Yes c. Which of the following products have you used since January 1, 2009? *(Please mark all that apply.)* ○ Capsules ○ Gel or cream applied to the skin ○ Injection ○ Liquid ○ Troche or lozenge (dissolved under the tongue) ○ Other

Since January 1, 2009, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2009?	b. Do you currently use this?
157. tamoxifen or Nolvadex?	○ No	○ Yes	# MONTHS	○ No ○ Yes
158. raloxifene or Evista?	○ No	○ Yes	# MONTHS	○ No ○ Yes
159. Herceptin?	○ No	○ Yes	# MONTHS	○ No ○ Yes
Aromatase inhibitors:				
160a. anastrozole or Arimidex?	○ No	○ Yes	# MONTHS	○ No ○ Yes
160b. exemestane or Aromasin?	○ No	○ Yes	# MONTHS	○ No ○ Yes
160c. letrozole or Femara?	○ No	○ Yes	# MONTHS	○ No ○ Yes
160d. other aromatase inhibitor? Please specify:	○ No	○ Yes	# MONTHS	○ No ○ Yes
161. testosterone supplements?	○ No	○ Yes	# MONTHS	○ No ○ Yes
162. Estratest?	○ No	○ Yes	# MONTHS	○ No ○ Yes

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Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	HAD PROCEDURE 1/1/2009 OR LATER	If you had this procedure January 1, 2009 or later, what was the month and year?
163. a hysterectomy (surgical removal of the uterus)?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 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 164** ○ 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
164. a separate surgery to remove part or all of one or both ovaries (but not your uterus)?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 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

SYMPTOMS OF MENOPAUSE OR PRE-MENOPAUSE

Have you **ever** experienced any of the following menopausal symptoms?		NO	YES	a. On average, how would you rate the severity of your symptom?	b. Have you experienced any symptoms in the **past 12 months?**
165.	Hot flashes	○ No	○ Yes	○ Mild ○ Moderate ○ Severe How often did/do these occur in a typical week? ○ 1 time or less ○ 2-3 times ○ 4 or more times ○ Don't know For about how many total months or years did you have hot flashes? ○ Less than 3 months ○ 3 to less than 6 months ○ 6 months to less than 1 year ○ 1 to less than 2 years ○ 2 to less than 3 years ○ 3 or more years	○ No ○ Yes
166.	Night sweats	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
167.	Other excessive sweating	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
168.	Vaginal dryness	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes

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Have you **ever** experienced any of the following menopausal symptoms?		NO	YES	a. On average, how would you rate the severity of your symptom?	b. Have you experienced any symptoms in the **past 12 months?**
169.	Pain with intercourse	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
170.	Irregular menstrual bleeding	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
171.	Bladder problems	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
172.	Depression, anxiety, or emotional distress	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes
173.	Insomnia	○ No	○ Yes	○ Mild ○ Moderate ○ Severe	○ No ○ Yes

SURGERIES

Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	HAD PROCEDURE 1/1/2009 OR LATER	a. If you had this procedure January 1, 2009 or later, what was the month and year?
174. gallbladder surgery?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 or later	MONTH / 2 0 YEAR
175. a procedure to open or widen a heart artery, such as a balloon angioplasty or stent placement? These procedures are different from the test used to diagnose a blockage.	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 or later	MONTH / 2 0 YEAR
176. coronary artery bypass graft surgery?	○ Never had procedure ○ Had procedure before January 1, 2009	○ Had procedure January 1, 2009 or later	MONTH / 2 0 YEAR

Please use a ballpoint pen for this form

MEDICATIONS

Since January 1, 2009, have you used any prescription medicines to treat or to prevent...		NO	YES	a. If yes, are you currently taking this?
177.	hypertension (high blood pressure)?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
178.	high cholesterol?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
179.	cardiac arrhythmia (irregular heartbeat)?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
180.	congestive heart failure?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
181.	diabetes?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
182.	thyroid disease?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
183.	osteoporosis (bone loss, or bone thinning)? Do not count calcium or vitamin D.	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed

Since January 1, 2009, have you used any prescription medicines to treat or to prevent...	NO	YES	a. If yes, are you currently taking this?
184. rheumatoid arthritis?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
185. osteoarthritis?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
186. migraines?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
187. depression?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
188. asthma?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
189. Parkinson's disease?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
190. anxiety?	○ No	○ Yes	○ No ○ Yes, regularly ○ Yes, as needed

Please use a ballpoint pen for this form

Since January 1, 2009, 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, 2009?	
191.	acetaminophen (Tylenol)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
192.	"baby aspirin" or low-dose aspirin (100mg/tablet or less)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
193.	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
194.	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
195.	Celebrex or other COX-2 inhibitors?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
196.	Aleve or Naprosyn?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years	○ 3 years ○ 4 years ○ More than 4 years
197.	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
198.	antibiotics?	○ 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

Please use a ballpoint pen for this form

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

Do not include:

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

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

○ No → **GO TO END, PAGE 52**

○ Yes

TOTAL #

a. What is/are the name(s) of the prescription or non-prescription medication(s) that you **currently take regularly?**	b. For how long have you used this regularly?
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 or more times per day	○ 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 or more times per day	○ 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 or more times per day	○ 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 or more times per day	○ 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 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other

Please use a ballpoint pen for this form

a. What is/are the name(s) of the prescription or non-prescription medication(s) that you **currently take regularly?** (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?
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 or more times per day	○ 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 or more times per day	○ 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 or more times per day	○ 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 or more times per day	○ 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 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other
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○ 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 or more times per day	○ Pill ○ Inhaler ○ Cream ○ Liquid	○ Patch ○ Spray ○ Shot ○ Other

Please use a ballpoint pen for this form

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Please check to see that all questions are answered.

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

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

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

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!