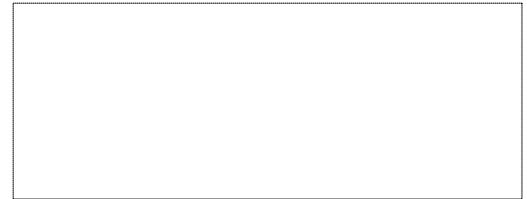




# The Sister Study Health and Medical History Version 4



### 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

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



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

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

## GENERAL HEALTH

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

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

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

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



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



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

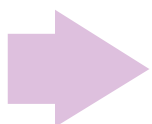
14. Since January 1, 2009, were **any** of your sisters diagnosed with breast cancer **for the first time**?

- 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



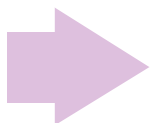
15a. What is/are the relative(s)' relationship to you?  
(Please mark all that apply.)

- 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

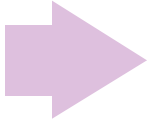
Please use a ballpoint pen for this form



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

No → **GO TO QUESTION 18**

Yes



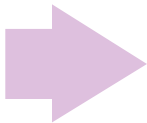
17a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

- 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



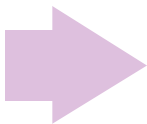
18a. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

- 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.)*

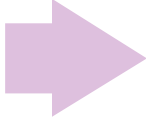
- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Other relative related to you by blood



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

No → GO TO QUESTION 21

Yes



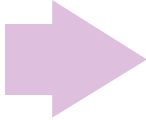
20a. What is/are the relative(s)' relationship to you?  
(Please mark all that apply.)

- 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...	<b>NEVER OR BEFORE 1/1/2009</b>	<b>DIAGNOSED 1/1/2009 OR LATER</b>	a. If diagnosed January 1, 2009 or later, what month and year were you diagnosed?
22. breast cancer? Please do <b>not</b> include in situ cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
23. ductal (breast) carcinoma in situ (DCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
24. lobular (breast) carcinoma in situ (LCIS)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
25. lung cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
26. ovarian cancer?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
27. cancer of the uterus or endometrium? Please do <b>not</b> include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
28. cancer of the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
29. Hodgkin's disease or Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
30. non-Hodgkin's lymphoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
31. leukemia?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin-left: 5px;">YEAR</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>





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?
32. malignant melanoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
33. skin cancer (not malignant melanoma)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<p>a. MONTH/YEAR DIAGNOSED</p> <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> <p>b. Was it... (Please mark all that apply.)</p> <p><input type="radio"/> basal cell?</p> <p><input type="radio"/> squamous cell?</p> <p><input type="radio"/> other?</p>
34. any other type of cancer not already listed?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<p>a. MONTH/YEAR DIAGNOSED</p> <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> <p>b. Please specify what type of cancer:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>c. If you were diagnosed with a second <b>other</b> type of cancer January 1, 2009 or later, what month and year were you diagnosed?</p> <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div> <p>d. Please specify what type of cancer:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <span>/</span> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span><span>YEAR</span></div> </div>	<input type="radio"/> No <input type="radio"/> Yes
36. angina?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <span>/</span> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span><span>YEAR</span></div> </div>	<input type="radio"/> No <input type="radio"/> Yes
37. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <span>/</span> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span><span>YEAR</span></div> </div>	<input type="radio"/> No <input type="radio"/> Yes
38. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; display: inline-block;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <span>/</span> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; padding: 2px 5px; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span><span>YEAR</span></div> </div>	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional told you that you had...	NO	YES	
39. a heart attack or myocardial infarction?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> heart attack was <u>before</u> January 1, 2009  <input type="radio"/> Yes, my <u>first</u> heart attack was January 1, 2009 or later ↓  a. What month and year was your first heart attack?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	b. Have you had another incident since then?  <input type="radio"/> No  <input type="radio"/> Yes ↓ c. What month and year was your most recent heart attack?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
40. a stroke (this does not include TIA or "mini-stroke")?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> stroke was <u>before</u> January 1, 2009  <input type="radio"/> Yes, my <u>first</u> stroke was January 1, 2009 or later ↓  a. What month and year was your first stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ c. What month and year was your most recent stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
41. a mini-stroke or TIA (transient ischemic attack)?	<input type="radio"/> No	<input type="radio"/> Yes, my <u>first</u> mini-stroke was <u>before</u> January 1, 2009  <input type="radio"/> Yes, my <u>first</u> mini-stroke was January 1, 2009 or later ↓  a. What month and year was your first mini-stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No  <input type="radio"/> Yes ↓ c. What month and year was your most recent mini-stroke?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>

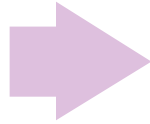
Please use a ballpoint pen for this form



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 <b>first</b> happened since January 1, 2009?
42. a hip fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2009	<input type="radio"/> January 1, 2009 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
43. a wrist fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2009	<input type="radio"/> January 1, 2009 or later	<input type="text"/> # TIMES	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR

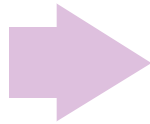
44. Since January 1, 2009, have you had any other broken bones?

- 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?  /  2 0   
MONTH YEAR

44b.   
FIRST BROKEN BONE

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

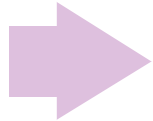
44d.   
SECOND BROKEN BONE

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

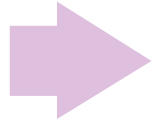


46. Since January 1, 2009, have you had any other major injury that required hospitalization?

- Never
- Yes, before January 1, 2009
- Yes, January 1, 2009 or later



**GO TO QUESTION 47**



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

Please use a ballpoint pen for this form

Has a doctor or other health professional <b>ever</b> told you that you had...	<b>NO</b>	<b>YES</b>
47. diabetes?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later → <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">             a. What month and year were you diagnosed?  <input type="text"/> / <input type="text"/> 2 0 <input type="text"/> <input type="text"/>  <small>MONTH YEAR</small> </div> <p>b. Do you still have this condition?</p> <ul style="list-style-type: none"> <li><input type="radio"/> No</li> <li><input type="radio"/> Yes</li> </ul> <p>c. Do you currently take insulin for diabetes?</p> <ul style="list-style-type: none"> <li><input type="radio"/> No → <b>GO TO THE NEXT PAGE, QUESTION 48</b></li> <li><input type="radio"/> Yes</li> </ul> <p>d. If yes, when did you <b>first</b> use insulin?</p> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>MONTH YEAR</small>



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?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2009 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2009 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
49. asthma?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2009 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2009 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
50. depression?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2009 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2009 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														
51. periodontal (gum) disease?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2009 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2009 or later → a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="4" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														



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?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
53. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
54. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
55. Graves' disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
56. other hyperthyroidism (overactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
57. Hashimoto's thyroiditis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
58. other hypothyroidism (underactive thyroid)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
59. an enlarged thyroid or goiter?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
60. thyroid nodules?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
61. another thyroid problem? Please do <b>not</b> include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<p>a. MONTH/YEAR DIAGNOSED</p> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> <p>b. Please specify the problem:</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Please use a ballpoint pen for this form



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





<p>Has a doctor or other health professional ever told you that you had...</p>	<p><b>NO</b></p>	<p><b>YES</b></p>														
<p>74. migraine headaches?</p>	<p><input type="radio"/> No</p>	<p><input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2009</p> <p><input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2009 or later →</p> <div data-bbox="1101 527 1474 737" style="border: 1px solid black; padding: 5px;"> <p>a. What month and year were you diagnosed?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; text-align: center; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td colspan="5" style="text-align: center; font-size: 8px;">YEAR</td> </tr> </table> </div> <p>b. Was the diagnosis of migraine made by a... (Please mark all that apply.)</p> <ul style="list-style-type: none"> <li><input type="radio"/> Headache specialist</li> <li><input type="radio"/> Neurologist</li> <li><input type="radio"/> Other physician</li> <li><input type="radio"/> Other health professional</li> </ul> <p>c. Which kind of migraines do you get?</p> <ul style="list-style-type: none"> <li><input type="radio"/> With visual aura</li> <li><input type="radio"/> Without visual aura</li> <li><input type="radio"/> Both types with similar frequency</li> </ul> <p>d. During the past 12 months, how often have you had a migraine?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Never</li> <li><input type="radio"/> Monthly or less</li> <li><input type="radio"/> Biweekly</li> <li><input type="radio"/> Weekly</li> <li><input type="radio"/> Daily</li> </ul> <p>e. During the past 12 months, how long on average have your migraines usually lasted?</p> <ul style="list-style-type: none"> <li><input type="radio"/> A few hours or less</li> <li><input type="radio"/> About half a day</li> <li><input type="radio"/> A day</li> <li><input type="radio"/> Several days</li> <li><input type="radio"/> One week or longer</li> </ul>			/	2	0			MONTH		YEAR				
		/	2	0												
MONTH		YEAR														

Please use a ballpoint pen for this form



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 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?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
76. polycystic ovarian syndrome or PCOS?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
77. ovarian cysts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
78. endometriosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
79. uterine fibroids or fibroid tumors?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
80. gallstones or gallbladder disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
81. Parkinson's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
82. Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
83. mild cognitive impairment?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
84. kidney failure requiring dialysis or transplant?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
85. kidney stones?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR
86. other kidney disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR



Has a doctor or other health professional told you that you had...	NEVER OR BEFORE 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?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
88. cataracts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
89. glaucoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
90. macular degeneration?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
91. hearing loss?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2009	<input type="radio"/> Diagnosed January 1, 2009 or later	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR

Please use a ballpoint pen for this form

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 <b>ever</b> told you that you had...	NO	YES	a. If yes, what year were you <b>first</b> diagnosed?
91b. pulmonary embolism?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR
91c. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YEAR



92. Since January 1, 2009, have you experienced any of the following medical symptoms? (Please mark a response for each item below.)

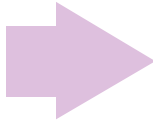
	No	Yes
a. swelling in your wrist, finger, elbow, or knee joints <b>lasting six or more weeks</b> ?	<input type="radio"/>	<input type="radio"/>
b. joint stiffness in the mornings, lasting at least one hour, and for more than six weeks (do not include stiffness related or due to an injury or surgery)?	<input type="radio"/>	<input type="radio"/>
c. daily, persistent, troublesome dry eyes for more than 3 months, or a recurrent feeling of sand or gravel in your eyes, or use of tear substitutes more than 3 times a day?	<input type="radio"/>	<input type="radio"/>
d. a daily feeling of dry mouth for more than 3 months, or frequent drinking of liquids to aid in swallowing dry foods, or recurrently or persistently swollen salivary glands?	<input type="radio"/>	<input type="radio"/>
e. a tremor or trembling in either of your hands?	<input type="radio"/>	<input type="radio"/>
f. walking or other movements getting noticeably slower?	<input type="radio"/>	<input type="radio"/>
g. handwriting getting noticeably smaller?	<input type="radio"/>	<input type="radio"/>
h. difficulty getting started when walking or making other movements?	<input type="radio"/>	<input type="radio"/>
i. wheezing or whistling in your chest?	<input type="radio"/>	<input type="radio"/>
j. shortness of breath when hurrying on level ground, or when walking up a slight hill, or when climbing a flight of stairs at your usual pace?	<input type="radio"/>	<input type="radio"/>
k. shortness of breath when at rest?	<input type="radio"/>	<input type="radio"/>
l. shortness of breath when lying down?	<input type="radio"/>	<input type="radio"/>
m. shortness of breath when walking?	<input type="radio"/>	<input type="radio"/>
n. swelling (or edema) in your legs?	<input type="radio"/>	<input type="radio"/>
o. excessive sweating other than due to menopause?	<input type="radio"/>	<input type="radio"/>
p. unexplained and unintentional weight loss of 10 or more pounds?	<input type="radio"/>	<input type="radio"/>



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 <b>first</b> time you noticed this problem?	<table border="1" style="display: inline-table;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> AGE		
93b.	Are there any reasons (such as head injury) that explain the decrease in your sense of smell?			
	<input type="radio"/> No <input type="radio"/> Yes, specify:			

Please use a ballpoint pen for this form

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

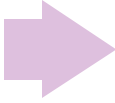
	NO	YES	a. If yes, for how many years have you had this symptom?
95. Since January 1, 2009, have you experienced coughing on most days for three months or more out of a year?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 1 year <input type="radio"/> 2 or more years
96. Since 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 1 year <input type="radio"/> 2 or more years



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.)

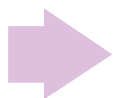
- Breast cysts
- Fibrocystic breasts
- Breast calcifications
- Dense breasts
- Uneven or one-sided densities
- Fibroadenoma
- Other
- Don't know



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

No → GO TO QUESTION 99

Yes

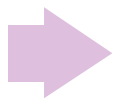


98a. On how many occasions have you had this since January 1, 2009?	<input type="text"/> <input type="text"/> # OCCASIONS
98b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
98c. On which breast was the most recent cyst aspiration or removal performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
98d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a breast biopsy, surgery, or other treatment <input type="radio"/> Don't know

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?	<input type="text"/> <input type="text"/> # OCCASIONS
99b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
99c. On which breast was the most recent needle biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts
99d. Following the most recent procedure, what was the doctors' recommendation? Did they tell you to...	<input type="radio"/> Come back in 12 months or more for usual follow-up <input type="radio"/> Come back in 6-11 months <input type="radio"/> Come back in 3-5 months <input type="radio"/> Come back in less than 3 months <input type="radio"/> Have a different type of breast biopsy, surgery, or other treatment <input type="radio"/> Don't know

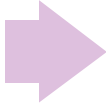
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100. Since January 1, 2009, have you had a surgical biopsy or a biopsy other than a needle biopsy to diagnose or rule out a breast condition?

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

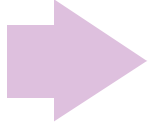




101. Since January 1, 2009, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

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

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. 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?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
103. a mastectomy of your right breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR



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 <b>benign nonproliferative</b> changes within normal range? For example, cysts, mild hyperplasia, benign calcifications, fibrosis, etc.	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	MONTH / YEAR [ ][ ] / 2 0 [ ][ ]
105. fibroadenoma?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	MONTH / YEAR [ ][ ] / 2 0 [ ][ ] b. What type? <input type="radio"/> Simple fibroadenoma <input type="radio"/> Complex fibroadenoma <input type="radio"/> Both <input type="radio"/> Don't know
106. proliferation <b>without atypia</b> ? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	MONTH / YEAR [ ][ ] / 2 0 [ ][ ]
107. atypical hyperplasia?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	MONTH / YEAR [ ][ ] / 2 0 [ ][ ] b. What type? <input type="radio"/> Atypical ductal hyperplasia <input type="radio"/> Atypical lobular hyperplasia <input type="radio"/> Both <input type="radio"/> Don't know
108. ductal carcinoma in situ (DCIS)?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	MONTH / YEAR [ ][ ] / 2 0 [ ][ ]
109. lobular carcinoma in situ (LCIS)?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	MONTH / YEAR [ ][ ] / 2 0 [ ][ ]
110. breast cancer?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	MONTH / YEAR [ ][ ] / 2 0 [ ][ ]
111. other changes?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	MONTH / YEAR [ ][ ] / 2 0 [ ][ ]



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

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?
114. breast reduction surgery on your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;"> </div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
115. breast reduction surgery on your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;"> </div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center; margin-right: 5px;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>



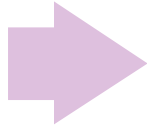
Since January 1, 2009, have you had...	NEVER OR BEFORE 1/1/2009	1/1/2009 OR LATER	a. If you had this procedure January 1, 2009 or later, what was the month and year?	b. Did you have a silicone gel implant?
116. breast reconstruction surgery on your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
117. breast reconstruction surgery on your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
118. breast enlargement surgery on your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
119. breast enlargement surgery on your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> 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 <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
121. a breast implant surgically removed from your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2009	<input type="radio"/> Yes, January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes



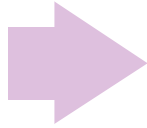
122. Since January 1, 2009, have you had any other major health condition?

- Never diagnosed
- Diagnosed before 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

Please use a ballpoint pen for this form

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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?

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

124e. 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 PAGE 32,  
QUESTION 125

OR

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

124f. 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:

Please use a ballpoint pen for this form

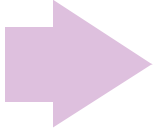


**REPRODUCTIVE HISTORY AND HORMONES**

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.**

Please use a ballpoint pen for this form

	<b>FIRST PREGNANCY (since January 1, 2009)</b>	<b>SECOND PREGNANCY (since January 1, 2009)</b>
126. How did this pregnancy end?	<input type="radio"/> Still pregnant now <input type="radio"/> Single live birth <input type="radio"/> Twins, live births <input type="radio"/> Other multiple live births → <input type="text"/> # BABIES <input type="radio"/> Stillbirth(s) <input type="radio"/> Miscarriage <input type="radio"/> Induced abortion <input type="radio"/> Molar or ectopic pregnancy	<input type="radio"/> Still pregnant now <input type="radio"/> Single live birth <input type="radio"/> Twins, live births <input type="radio"/> Other multiple live births → <input type="text"/> # BABIES <input type="radio"/> Stillbirth(s) <input type="radio"/> Miscarriage <input type="radio"/> Induced abortion <input type="radio"/> Molar or ectopic pregnancy
127. How many weeks did this pregnancy last (or has it lasted so far, if now pregnant)?	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 to 12 weeks <input type="radio"/> 13 to 16 weeks <input type="radio"/> 17 to 24 weeks <input type="radio"/> 25 to 36 weeks <input type="radio"/> 37 to 41 weeks <input type="radio"/> 42 weeks or more	<input type="radio"/> Less than 8 weeks <input type="radio"/> 8 to 12 weeks <input type="radio"/> 13 to 16 weeks <input type="radio"/> 17 to 24 weeks <input type="radio"/> 25 to 36 weeks <input type="radio"/> 37 to 41 weeks <input type="radio"/> 42 weeks or more
128. What month and year did this pregnancy end?	<div style="display: flex; justify-content: center; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <p style="text-align: center;">MONTH                      YEAR</p> <p style="text-align: center;"><b>OR</b></p> <input type="radio"/> Still pregnant now	<div style="display: flex; justify-content: center; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <p style="text-align: center;">MONTH                      YEAR</p> <p style="text-align: center;"><b>OR</b></p> <input type="radio"/> Still pregnant now
129. What was the sex of the baby or babies?	<input type="radio"/> Single male <input type="radio"/> Single female <input type="radio"/> Multiple → <input type="text"/> # MALES <input type="text"/> # FEMALES <input type="radio"/> Don't know	<input type="radio"/> Single male <input type="radio"/> Single female <input type="radio"/> Multiple → <input type="text"/> # MALES <input type="text"/> # FEMALES <input type="radio"/> Don't know
130. How long did you breastfeed (or have you been breastfeeding)?	<input type="radio"/> Less than one month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> 13-24 months <input type="radio"/> More than 24 months 	<input type="radio"/> Less than one month <input type="radio"/> 1-3 months <input type="radio"/> 4-6 months <input type="radio"/> 7-12 months <input type="radio"/> 13-24 months <input type="radio"/> More than 24 months 
	<div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">}</div> <div> <p style="margin: 0;"><b>GO TO 131</b></p> </div> </div> <input type="radio"/> Did not breastfeed/ not applicable → <b>GO TO NEXT PREGNANCY OR QUESTION 132</b>	<div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">}</div> <div> <p style="margin: 0;"><b>GO TO 131</b></p> </div> </div> <input type="radio"/> Did not breastfeed/ not applicable → <b>GO TO NEXT PREGNANCY OR QUESTION 132</b>
131. Are you still breastfeeding?	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> 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.**



132. Since January 1, 2009, have you used any hormonal birth control?

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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
134. birth control patches?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
135. a hormonal IUD (intrauterine device)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
136. a Norplant implant?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
137. a Nuva Ring?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
138. Depo Provera?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
139. any other hormonal birth control?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes

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 any fertility medications?

No → **GO TO QUESTION 145**

Yes



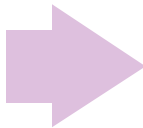
Since January 1, 2009, have you taken...	<b>NO</b>	<b>YES</b>	a. If yes, how many months or menstrual cycles in all have you used this since January 1, 2009?
143. Clomiphene, Clomid, or Serophene?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES
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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS/CYCLES

Please use a ballpoint pen for this form

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

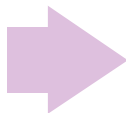
145c. When did the last such pregnancy end?  
  /   /      
 MONTH DAY YEAR



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

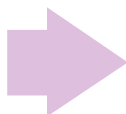


146a. How many times?	<input type="text"/> <input type="text"/>
	# TIMES
146b. When did the first such pregnancy end?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	MONTH DAY YEAR
146c. When did the last such pregnancy end?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	MONTH DAY YEAR

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?	<input type="text"/> <input type="text"/>
	# TIMES
147b. What was the month and year of your most recent mastitis?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	MONTH YEAR
147c. Were you ever given antibiotics to treat mastitis?	<input type="radio"/> No <input type="radio"/> Yes
147d. Were you ever given pain medication to treat mastitis?	<input type="radio"/> No <input type="radio"/> Yes
147e. Did you ever stop breastfeeding sooner than planned because of mastitis?	<input type="radio"/> No <input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
149.	an estrogen-only pill (such as Premarin) with no additional progesterone in any form?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
150.	an estrogen pill (such as Premarin) <b>and</b> a separate progesterone pill (such as Provera) or progesterone shot?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
151.	an estrogen-only patch with no additional progesterone in any form?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
152.	a patch containing both estrogen and progesterone (such as Combipatch)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
153.	an estrogen-only patch <b>and</b> a separate progesterone pill or progesterone shot?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
154.	progesterone alone (not for birth control)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="text"/> <input type="text"/> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes

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Since January 1, 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?	<input type="radio"/> No	<input type="radio"/> Yes	a. <input type="text"/> <input type="text"/> # MONTHS b. Do you currently use this female hormone product(s)? <input type="radio"/> No <input type="radio"/> Yes c. Does this product also contain progesterone? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> No <input type="radio"/> Yes
156. any other estrogen products, including "natural" estrogens?	<input type="radio"/> No	<input type="radio"/> Yes	a. <input type="text"/> <input type="text"/> # MONTHS b. Do you currently use this female hormone product(s)? <input type="radio"/> No <input type="radio"/> Yes c. Which of the following products have you used since January 1, 2009? (Please mark all that apply.) <input type="radio"/> Capsules <input type="radio"/> Gel or cream applied to the skin <input type="radio"/> Injection <input type="radio"/> Liquid <input type="radio"/> Troche or lozenge (dissolved under the tongue) <input type="radio"/> Other



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?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
158. raloxifene or Evista?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
159. Herceptin?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
<b>Aromatase inhibitors:</b>				
160a. anastrozole or Arimidex?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
160b. exemestane or Aromasin?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
160c. letrozole or Femara?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
160d. other aromatase inhibitor? Please specify: <div style="border: 1px solid black; width: 280px; height: 25px; margin-top: 5px;"></div>	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
161. testosterone supplements?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
162. Estratest?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes

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Since January 1, 2009, have you had...	<b>NEVER OR BEFORE 1/1/2009</b>	<b>HAD PROCEDURE 1/1/2009 OR LATER</b>	If you had this procedure January 1, 2009 or later, what was the month and year?														
163. a hysterectomy (surgical removal of the uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	<p>If you had this procedure January 1, 2009 or later, what was the month and year?</p> <p>a. MONTH/YEAR HAD PROCEDURE</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">/</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center;">MONTH</td> <td colspan="4" style="text-align: center;">YEAR</td> </tr> </table> <p>b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy?</p> <p><input type="radio"/> No → <b>GO TO QUESTION 164</b>  <input type="radio"/> Yes</p> <p>c. Did you have...</p> <p><input type="radio"/> both ovaries completely removed?  <input type="radio"/> one ovary and part of the other ovary removed?  <input type="radio"/> one ovary removed?  <input type="radio"/> part of one or part of both ovaries removed?</p> <p>d. Did you have all or part of either ovary left after this surgery?</p> <p><input type="radio"/> No  <input type="radio"/> Yes</p>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
164. a separate surgery to remove part or all of one or both ovaries (but not your uterus)?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	<p>a. MONTH/YEAR HAD PROCEDURE</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">/</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="3" style="text-align: center;">MONTH</td> <td colspan="4" style="text-align: center;">YEAR</td> </tr> </table> <p>b. Did you have...</p> <p><input type="radio"/> both ovaries completely removed?  <input type="radio"/> one ovary and part of the other ovary removed?  <input type="radio"/> one ovary removed?  <input type="radio"/> part of one or part of both ovaries removed?</p> <p>c. Did you have all or part of either ovary left after this surgery?</p> <p><input type="radio"/> No  <input type="radio"/> Yes</p>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														





## SYMPTOMS OF MENOPAUSE OR PRE-MENOPAUSE

Have you <b>ever</b> 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe  How often did/do these occur in a typical week? <input type="radio"/> 1 time or less <input type="radio"/> 2-3 times <input type="radio"/> 4 or more times <input type="radio"/> Don't know  For about how many total months or years did you have hot flashes? <input type="radio"/> Less than 3 months <input type="radio"/> 3 to less than 6 months <input type="radio"/> 6 months to less than 1 year <input type="radio"/> 1 to less than 2 years <input type="radio"/> 2 to less than 3 years <input type="radio"/> 3 or more years	<input type="radio"/> No <input type="radio"/> Yes
166.	Night sweats	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
167.	Other excessive sweating	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
168.	Vaginal dryness	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes

Please use a ballpoint pen for this form



Have you <b>ever</b> 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	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
170.	Irregular menstrual bleeding	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
171.	Bladder problems	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
172.	Depression, anxiety, or emotional distress	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes
173.	Insomnia	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	<input type="radio"/> No <input type="radio"/> Yes



**SURGERIES**

Since January 1, 2009, have you had...	<b>NEVER OR BEFORE 1/1/2009</b>	<b>HAD PROCEDURE 1/1/2009 OR LATER</b>	a. If you had this procedure January 1, 2009 or later, what was the month and year?
174. gallbladder surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
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.	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
176. coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2009	<input type="radio"/> Had procedure January 1, 2009 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center; margin-right: 5px;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>

Please use a ballpoint pen for this form



## 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
178.	high cholesterol?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
179.	cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
180.	congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
181.	diabetes?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
182.	thyroid disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
183.	osteoporosis (bone loss, or bone thinning)? Do not count calcium or vitamin D.	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed

Since January 1, 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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
185. osteoarthritis?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
186. migraines?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
187. depression?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
188. asthma?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
189. Parkinson's disease?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed
190. anxiety?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes, regularly <input type="radio"/> Yes, as needed

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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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
192.	“baby aspirin” or low-dose aspirin (100mg/tablet or less)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
193.	aspirin or other aspirin containing products (325 mg/tablet or more)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
194.	ibuprofen (such as Advil, Motrin, Nuprin, etc.)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
195.	Celebrex or other COX-2 inhibitors?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
196.	Aleve or Naprosyn?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
197.	Relafen, Ketoprofen, Anaprox, or other non-steroidal anti-inflammatories?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years
198.	antibiotics?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Less than 12 months <input type="radio"/> 1 year <input type="radio"/> 2 years	<input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> More than 4 years



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?
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes
<input type="radio"/> 1 day per week <input type="radio"/> 2-3 days per week <input type="radio"/> 4-5 days per week <input type="radio"/> 6-7 days per week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> No <input type="radio"/> Yes



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

**Do not include:**

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

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

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TOTAL #

a.	b.
What is/are the name(s) of the prescription or non-prescription medication(s) that you <b>currently take regularly</b> ?	For how long have you used this regularly?
<p>1. <table border="1" style="width: 100%; height: 25px;"></table></p>	<p><input type="radio"/> Less than 12 months  <input type="radio"/> 1 year  <input type="radio"/> 2 years  <input type="radio"/> 3 years  <input type="radio"/> 4 years  <input type="radio"/> More than 4 years</p>
<p>2. <table border="1" style="width: 100%; height: 25px;"></table></p>	<p><input type="radio"/> Less than 12 months  <input type="radio"/> 1 year  <input type="radio"/> 2 years  <input type="radio"/> 3 years  <input type="radio"/> 4 years  <input type="radio"/> More than 4 years</p>
<p>3. <table border="1" style="width: 100%; height: 25px;"></table></p>	<p><input type="radio"/> Less than 12 months  <input type="radio"/> 1 year  <input type="radio"/> 2 years  <input type="radio"/> 3 years  <input type="radio"/> 4 years  <input type="radio"/> More than 4 years</p>
<p>4. <table border="1" style="width: 100%; height: 25px;"></table></p>	<p><input type="radio"/> Less than 12 months  <input type="radio"/> 1 year  <input type="radio"/> 2 years  <input type="radio"/> 3 years  <input type="radio"/> 4 years  <input type="radio"/> More than 4 years</p>
<p>5. <table border="1" style="width: 100%; height: 25px;"></table></p>	<p><input type="radio"/> Less than 12 months  <input type="radio"/> 1 year  <input type="radio"/> 2 years  <input type="radio"/> 3 years  <input type="radio"/> 4 years  <input type="radio"/> More than 4 years</p>





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



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.

Grid for medication name

- Less than 12 months
- 1 year
- 2 years
- 3 years
- 4 years
- More than 4 years

7.

Grid for medication name

- Less than 12 months
- 1 year
- 2 years
- 3 years
- 4 years
- More than 4 years

8.

Grid for medication name

- Less than 12 months
- 1 year
- 2 years
- 3 years
- 4 years
- More than 4 years

9.

Grid for medication name

- Less than 12 months
- 1 year
- 2 years
- 3 years
- 4 years
- More than 4 years

10.

Grid for medication name

- Less than 12 months
- 1 year
- 2 years
- 3 years
- 4 years
- More than 4 years

11.

Grid for medication name

- Less than 12 months
- 1 year
- 2 years
- 3 years
- 4 years
- More than 4 years

12.

Grid for medication name

- 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? <i>(Please mark all that apply.)</i>	
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/> 2-3 days a week <input type="radio"/> 4-5 days a week <input type="radio"/> 6-7 days a week	<input type="radio"/> 1 time per day <input type="radio"/> 2 times per day <input type="radio"/> 3 times per day <input type="radio"/> 4 times per day <input type="radio"/> 5 or more times per day	<input type="radio"/> Pill <input type="radio"/> Inhaler <input type="radio"/> Cream <input type="radio"/> Liquid	<input type="radio"/> Patch <input type="radio"/> Spray <input type="radio"/> Shot <input type="radio"/> Other

Please use a ballpoint pen for this form



Please check to see that all questions are answered.

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

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

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

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

***Thank you!***

