The Sister Study
Quality of Life and Special Topics
Version 4

Instructions:

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

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

Like this: ● Not like this: ⊗ ✓

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

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

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

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

1	2	3	4	5	6	7	8	9	0

When writing dates, please follow this example.

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

(month) (day) (year)

Version 4

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

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

Today's Date: ☐☐ / ☐☐ / 2 0 ☐☐

MONTH DAY YEAR

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

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

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

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

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

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

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

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

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

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

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

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

Please use a ballpoint pen for this form

12. For each statement below, choose the answer that best indicates how often the statement is true for you.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. I can count on someone to provide me with emotional support (someone to confide in about myself or a problem or who will listen to me when I need to talk).	○	○	○	○	○
b. I can count on someone if I need help (for example, to take me to the doctor or help with daily chores if I am sick).	○	○	○	○	○
c. There is someone in my immediate family who believes in me and wants me to succeed.	○	○	○	○	○
d. There is someone in my immediate family who makes me feel important or special.	○	○	○	○	○

13. In general, how many relatives or friends do you feel close to (people you feel at ease with, can talk to about private matters, or call on for help)?

○ None
○ 1-2
○ 3-5
○ 6-9
○ 10 or more

14. During the **past 12 months,** about how many hours **per week** on average did you provide care for children or grandchildren?

○ None → **GO TO QUESTION 15**

○ 1-8 hours
○ 9-20 hours
○ 21-40 hours
○ 41 or more hours

14a. How stressful would you say it is to provide care for these children or grandchildren?

○ Not at all
○ A little
○ A moderate amount
○ A lot

14b. During the **past 12 months,** for whom did you provide such care? *(Please mark all that apply.)*

○ My children
○ My grandchildren
○ Other children

15. During the **past 12 months,** about how many hours **per week** on average did you provide care for an ill or disabled person? This might be a parent, child, sibling, spouse, partner, other relative, or personal friend.

○ None → **GO TO THE NEXT PAGE, QUESTION 16**

○ 1-8 hours
○ 9-20 hours
○ 21-40 hours
○ 41 or more hours

15a. How stressful would you say it is to provide care for these disabled or ill individuals?

○ Not at all
○ A little
○ A moderate amount
○ A lot

15b. During the **past 12 months,** for whom did you provide such care? *(Please mark all that apply.)*

○ Parent
○ Child
○ Sibling
○ Spouse
○ Partner
○ Other relative
○ Friend

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

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

Since **January 1, 2009,** have you experienced the death of...	**NO**	**YES**	a. Regardless of when this happened, how much distress or anxiety has this caused you in the **past 4 weeks?**
17. your spouse or partner?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
18. your sister with breast cancer?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
19. another sibling?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
20. a child?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
21. a parent?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
22. a close personal friend?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot

Please use a ballpoint pen for this form

Since **January 1, 2009,** have you experienced...	**NO**	**YES**	a. Regardless of when this happened, how much distress or anxiety has this caused you in the **past 4 weeks?**
23. a major illness that was life threatening or severely disabling to you?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
24. the recurrence or worsening of your sister's breast cancer?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
25. any other close relative's diagnosis of breast cancer?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
26. a major change in, or serious difficulty with a personal relationship (such as a divorce, or child custody issues)?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot
27. serious financial or legal troubles such as arrest or bankruptcy (either you or another family member whose troubles would directly affect you)?	○ No	○ Yes	○ None ○ A little ○ A moderate amount ○ A lot

28. In the **past 12 months,** have you had to quit, reduce your hours, or change your job because of your health or to meet the needs of your family?

- ○ No
- ○ Not applicable
- ○ Yes

28a. Why did you have to do this? *(Please mark all that apply.)*
- ○ Because of my health
- ○ To meet the needs of my family

29. In the **past 12 months,** have you been forced to leave your job, reduce your hours, or change your job for other reasons such as the economy?

- ○ No
- ○ Not applicable
- ○ Yes

30a. Are you currently unemployed and looking for work?

- ○ No
- ○ Yes

30b. Are you currently unemployed and **not** looking for work?

- ○ No
- ○ Yes

Please use a ballpoint pen for this form

As people age, some begin to worry about their ability to think clearly, make decisions and remember things.

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

Please answer the following questions about sleep.

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

HOURS

40. In the **past year,** how many hours of sleep per night on average did you typically get?

HOURS

41. In the **past month,** how many hours of sleep per night on average did you typically get?

☐☐ # HOURS

42. Do you have difficulty falling asleep or staying asleep on a regular basis?

○ No → **GO TO QUESTION 43**

○ Yes

42a. How many nights in a typical month do you have trouble sleeping? ☐☐ # NIGHTS

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

○ No → **GO TO QUESTION 44**

○ Yes

43a. In the **past month,** about how often did you feel excessively sleepy during the day?

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

44. Have you **ever** been told, or suspected yourself, that you seem to "act out your dreams" while asleep, for example, punching or flailing arms in the air, making running movements, shouting, or screaming?

○ No → **GO TO NEXT PAGE, QUESTION 45**

○ Yes

44a. How often do you do this?

- ○ Less than 3 times in total
- ○ Less than once a month
- ○ 1 - 3 times a month
- ○ Once a week
- ○ More than once a week

44b. How old were you when you first knew you did this? ☐☐ AGE

Please use a ballpoint pen for this form

45. Has a doctor or other health professional **ever** told you that you have restless leg syndrome?

- ○ No
- ○ Yes

		No	Yes
46.	Do you have, or have you had, recurrent uncomfortable feelings or sensations in your legs while you are sitting or lying down?	○	○
47.	Do you have, or have you had, a recurrent need or urge to move your legs while you were sitting or lying down?	○	○

IF YOU ANSWERED NO TO *BOTH*, GO TO QUESTION 58, PAGE 15

IF YOU ANSWERED YES TO *EITHER* OF THE ABOVE, GO TO QUESTION 48

If you answered ***Yes*** to either 46 or 47:

48. Are you more likely to have these feelings when you are resting (either sitting or lying down) or when you are physically active?

- ○ Resting
- ○ Active

49. If you get up or move around when you have these feelings do these feelings get any better while you actually keep moving?

- ○ No
- ○ Yes
- ○ Don't know

50. Which times of day are these feelings in your legs **most** likely to occur?
(Please mark all that apply.)

- ○ Morning
- ○ Mid-day
- ○ Afternoon
- ○ Evening
- ○ Night
- ○ About equal at all times

51. Will simply changing leg position by itself **once** without continuing to move usually relieve these feelings?

- ○ Usually relieves
- ○ Does not usually relieve
- ○ Don't know

52. Are these feelings **ever** due to muscle cramps?

- ○ No
- ○ Don't know

GO TO QUESTION 53

- ○ Yes

52a. Are they **always** due to muscle cramps?

- ○ No
- ○ Yes
- ○ Don't know

53. Do these feelings occur when sitting or when lying down?

- ○ Only when sitting
- ○ Only when lying down
- ○ Both when sitting and when lying down
- ○ Neither

Please use a ballpoint pen for this form

54. When you experience the feelings in your legs, how **distressing** are they?

- ○ Not at all distressing
- ○ A little bit
- ○ Moderately
- ○ Extremely distressing

55. In the **past 12 months,** how often did you experience these feelings in your legs?
(Please mark the best single answer.)

- ○ 6 times per week or daily
- ○ 4 - 5 days per week
- ○ 2 - 3 days per week
- ○ 1 day per week
- ○ 2 - 3 days per month
- ○ 1 day per month or less
- ○ Never

56. Approximately how old were you when you **first** noticed these feelings in your legs?
(Please write age.)

AGE

57. Did you **first** notice these feelings during a pregnancy?

- ○ No
- ○ Never been pregnant

GO TO NEXT PAGE, QUESTION 58

- ○ Yes

57a. Other than pregnancy, about how old were you when you **first** noticed these feelings in your legs?

AGE

- ○ Never felt this outside of pregnancy

58. During the **past 12 months,** have you taken any vitamins or minerals regularly, at least once a month?

○ No, not regularly → **GO TO PAGE 21, QUESTION 79**

○ Yes, fairly regularly

During the **past 12 months,** have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. Did you usually take types that...
Multiple Vitamins 59. One A Day, Centrum, or Thera type multiple vitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ contain minerals, iron, zinc, etc.? ○ do not contain minerals? ○ Don't know
60. Stress-tabs or B-Complex type multiple vitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	
61. Antioxidant combination-type multiple vitamins?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	

Please use a ballpoint pen for this form

During the **past 12 months,** have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
62. Vitamin A (not beta-carotene)?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 8000 IU ○ 8000 IU ○ More than 8000 IU
63. Beta-carotene?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	
64. Thiamin (B1)?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 100 mg ○ 100-250 mg ○ More than 250 mg
65. Niacin (B3)?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 500 mg ○ 500 mg ○ More than 500 mg

During the **past 12 months**, have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
66. Vitamin B6?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 100 mg ○ 100 mg ○ More than 100 mg
67. Vitamin B12?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 500 mcg ○ 500 mcg ○ 1000 mcg ○ 2000 mcg ○ More than 2000 mcg
68. Vitamin C?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 500 mg ○ 500 mg ○ 1000 mg ○ More than 1000 mg
69. Vitamin D alone?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 2000 IU ○ 2000 IU ○ More than 2000 IU

Please use a ballpoint pen for this form

During the **past 12 months,** have you taken...	**NO**	**YES**	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
70. Vitamin E?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 400 IU ○ 400 IU ○ More than 400 IU
71. Folic acid, folate?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 400 mcg ○ 400 mcg ○ More than 400 mcg
72. Calcium plus vitamin D?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	
73. Calcium without vitamin D?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 600 mg ○ 600 mg ○ More than 600 mg

During the **past 12 months,** have you taken...	NO	YES	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
74. Chromium?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 200 mcg ○ 200 - 1000 mcg ○ More than 1000 mcg
75. Iron?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 65 mg ○ 65 mg ○ More than 65 mg
76. Magnesium?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 250 mg ○ 250 mg ○ More than 250 mg
77. Selenium?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 200 mcg ○ 200 mcg ○ More than 200 mcg

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During the **past 12 months,** have you taken...	**NO**	**YES**	a. How often?	b. For how many years in all have you taken this?	c. How much did you usually take on the days you took it?
Single Vitamins and Minerals (not part of multiple vitamins)					
78. Zinc, alone or combined with something else?	○ No	○ Yes	○ A few days per month ○ 1 - 3 days per week ○ 4 - 6 days per week ○ Every day	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years	○ Less than 50 mg ○ 50 mg ○ More than 50 mg

In the **past 12 months,** did you take any of these supplements at least once a month?	**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
79. Black cohosh	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
80. Chamomile	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
81. Co-enzyme Q10 (CoQ10)	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
82. Cod liver oil	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
83. Cranberry pills	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
84. DHEA	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Please use a ballpoint pen for this form

In the **past 12 months,** did you take any of these supplements at least once a month?	**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
85. Echinacea	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
86. Evening primrose oil	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
87. Fiber supplement	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
88. Fish oil (EPA)	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
89. Flax seed/flax seed oil	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
90. Garlic pills	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

In the **past 12 months,** did you take any of these supplements at least once a month?	**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
91. Ginger	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
92. Ginkgo	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
93. Ginseng	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
94. Glucosamine/Chondroitin	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
95. Kava Kava	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
96. Lecithin	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Please use a ballpoint pen for this form

In the **past 12 months,** did you take any of these supplements at least once a month?		**NO**	**YES**	a. How frequently did you take this?	b. For how many years in all have you taken this?
97.	Lutein	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
98.	Melatonin	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
99.	Milk thistle	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
100.	Mixed carotenoids	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
101.	Omega-3 or omega-3 fatty acids	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
102.	Probiotics/acidophilus	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

In the **past 12 months,** did you take any of these supplements at least once a month?		NO	YES	a. How frequently did you take this?	b. For how many years in all have you taken this?
103.	Soy isoflavones	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
104.	St. John's Wort	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
105.	Turmeric capsules	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
106.	Valerian	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
107.	Something else	○ No	○ Yes	○ Less than 3 days per week ○ 3 - 5 days per week ○ 6 - 7 days per week	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Please use a ballpoint pen for this form

Have you used any of the following complementary or alternative practices within the **past 12 months?**		**NO**	**YES**	a. How frequently?	b. For how many years in all?
108.	Juicing	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
109.	Acupuncture	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
110.	Yoga	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
111.	Spirituality, meditation, prayer	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
112.	Therapeutic touch/massage	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
113.	Tai chi	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Have you used any of the following complementary or alternative practices within the **past 12 months?**		**NO**	**YES**	a. How frequently?	b. For how many years in all?
114.	Qi gong	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
115.	Chiropractic	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
116.	Reiki	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
117.	Biofeedback	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
118.	Homeopathy	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years
119.	Visualization/guided imagery	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

Please use a ballpoint pen for this form

Have you used any of the following complementary or alternative practices within the **past 12 months?**	**NO**	**YES**	a. How frequently?	b. For how many years in all?
120. Deep breathing exercises	○ No	○ Yes	○ Less than once a month ○ 1-4 times a month ○ More than 4 times a month	○ Less than 1 year ○ 1 year ○ 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10+ years

121. Typically, how often do you have bowel movements?

○ Less than once every other day
○ Once every other day
○ Once per day
○ 2 or more times per day

122. How often do you use laxatives, not including fiber or fiber tabs?

○ Never
○ Less than once a month
○ 1 - 3 times per month
○ 1 - 3 times per week
○ 4 - 6 times per week
○ Daily or more

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

Since **January 1, 2009,** which (if any) of these special diets have you followed for longer than a month, other than during pregnancy?	**NO**	**YES**	a. How long did you follow this diet?	b. Have you followed this diet for **at least a month in the past year?**
123. High fiber	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
124. Low fat	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
125. Restricted calories	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
126. Liquid/juice	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
127. Vegetarian	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
128. Low salt	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
129. Macrobiotic	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
130. Diabetic diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
131. Atkins	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
132. Zone (Barry Sears)	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No

Please use a ballpoint pen for this form

Since **January 1, 2009,** which (if any) of these special diets have you followed for longer than a month, other than during pregnancy?		**NO**	**YES**	a. How long did you follow this diet?	b. Have you followed this diet for **at least a month in the past year?**
133.	Weight Watchers	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
134.	Tried to gain weight	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
135.	Diet with pre-prepared meals	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
136.	Physician-based diet with special supplements such as puddings, beverages or vitamins	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
137.	South Beach diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
138.	Raw food diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
139.	HCG diet	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No
140.	Other diet, please specify: ☐	○ No	○ Yes	○ Less than 8 weeks ○ 8 weeks - 1 year ○ More than 1 year	○ Yes ○ No

Have you **ever** had any of the following weight loss procedures?		**NO**	**YES**	a. What age did you have this?
141.	Lap band	○ No	○ Yes	☐☐ AGE
142.	Bariatric surgery	○ No	○ Yes	☐☐ AGE

143. Do you have, or have you **ever** had, a food allergy?

○ No
○ Don't know } **GO TO PAGE 33, QUESTION 156**

○ Yes

Do you have, or have you **ever** had, an allergy to the following foods?	**NO**	**YES**	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
144. Milk	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
145. Egg	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
146. Peanuts	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
147. Other nuts	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know

Please use a ballpoint pen for this form

Do you have, or have you **ever** had, an allergy to the following foods?	NO	YES	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
148. Shellfish	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
149. Fish	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
150. Any kind of fruit	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
151. Wheat	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
152. Soy	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know

Do you have, or have you **ever** had, an allergy to the following foods?	NO	YES	b. Have you eaten this item in the past year?	c. Are you still allergic to this food?
153. Rye	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
154. Vegetable(s)	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know
155. Other food, specify: ☐	○ No	○ Yes, it started before age 18 ○ Yes, it started age 18 or later → a. Age it started ☐☐ AGE	○ No ○ Yes	○ No ○ Yes ○ Don't know

Please use a ballpoint pen for this form

156. Do you have lactose intolerance?

○ No
○ Don't know

GO TO NEXT PAGE, QUESTION 157

○ Yes

156a. Do you consume any type of dairy products on most days?
○ No
○ Yes

157. During the past month, did you eat any **hot or cold cereals?**

○ No → **GO TO NEXT PAGE, QUESTION 158**

○ Yes

157a. During the past month, how often did you eat **hot or cold cereals?** You can report per day, per week, or per month.

TIMES

○ Per day
○ Per week
○ Per month

157b. During the past month, what kind of cereal did you usually eat? *Please record the name using the enclosed card. If your cereal is not listed, please enter the cereal name.*

FIRST CEREAL

157c. Was there another cereal that you usually ate?

○ No → **GO TO NEXT PAGE, QUESTION 158**

○ Yes

157d. During the past month, what second kind of cereal did you usually eat? *Please record the name using the enclosed card. If your cereal is not listed, please enter the cereal name.*

SECOND CEREAL

158. During the past month, did you have any **milk** (either to drink or on cereal)? Include regular milks, chocolate or other flavored milks, lactose-free milk, buttermilk. Do **not** include soy milk or small amounts of milk in coffee or tea.

○ No
○ Don't know

GO TO NEXT PAGE, QUESTION 159

○ Yes

158a. During the past month, how often did you have any **milk** (either to drink or on cereal)? You can report per day, per week, or per month.

☐☐ # TIMES

○ Per day
○ Per week
○ Per month

158b. During the past month, what kind of milk did you usually drink? Pick one.

○ Whole or regular milk
○ Fat-free, skim, or non-fat milk
○ 2% fat or reduced-fat milk
○ Soy milk
○ 1%, ½%, or low-fat milk
○ Other, specify:

Please use a ballpoint pen for this form

During the past month, did you...		NO	YES	a. How often?
159.	drink any **regular soda or pop** that contains sugar? Do **not** include diet soda.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
160.	drink any **100% pure fruit juices** such as orange, mango, apple, grape and pineapple juices? Do **not** include fruit-flavored drinks with added sugar or fruit juice you made at home and added sugar to.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
161.	drink any **coffee or tea** that had **sugar or honey** added to it? Include coffee and tea you sweetened yourself and presweetened tea and coffee drinks such as Arizona Iced Tea and Frappuccino. Do **not** include artificially sweetened coffee or diet tea.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
162.	drink any **sweetened** fruit drinks, sports or energy drinks, such as Kool-aid, lemonade, Hi-C, cranberry drink, Gatorade, Red Bull, or Vitamin Water? Include fruit juices you made at home and added sugar to. Do **not** include diet drinks or artificially sweetened drinks.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
163.	eat any **fruit?** Include fresh, frozen, or canned fruit. Do **not** include juices.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
164.	eat a green leafy or lettuce **salad**, with or without other vegetables?	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
165.	eat any kind of **fried potatoes** including french fries, home fries, or hash brown potatoes?	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
166.	eat **any other kind of potatoes,** such as baked, boiled, mashed potatoes, sweet potatoes, or potato salad?	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
167.	eat any **refried beans, baked beans, beans in soup, pork and beans or other cooked dried beans?** Do **not** include green beans.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
168.	eat any **brown rice** or other cooked whole grains, such as bulgur, cracked wheat, or millet? Do **not** include white rice.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month

During the past month, did you...		NO	YES	a. How often?
169.	eat **any other vegetables?** Do **not** include green salads, potatoes, and cooked dried beans.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
170.	eat any Mexican-type **salsa** made with tomato?	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
171.	eat any **pizza?** Include frozen pizza, fast food pizza, and homemade pizza.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
172.	have any **tomato sauces** such as with spaghetti or noodles or mixed into foods such as lasagna? Do **not** count tomato sauce on pizza.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
173.	eat any kind of **cheese?** Include cheese as a snack, cheese on burgers, sandwiches, and cheese in foods such as lasagna, quesadillas, or casseroles. Do **not** include cheese on pizza.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
174.	eat any **red meat,** such as beef, pork, ham, or sausage? Do **not** include chicken, turkey or seafood. Include red meat you had in sandwiches, lasagna, stew, and other mixtures. Red meats may also include veal, lamb, and any lunch meats made with these meats.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
175.	eat any **processed meat,** such as bacon, lunch meats, or hot dogs? Include processed meats you had in sandwiches, soups, pizza, casseroles, and other mixtures. Processed meats are those preserved by smoking, curing, or salting, or by the addition of preservatives. Examples are: ham, bacon, pastrami, salami, sausages, bratwursts, frankfurters, hot dogs, and spam.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
176.	eat any **whole grain bread** including toast, rolls and in sandwiches? Whole grain breads include whole wheat, rye, oatmeal and pumpernickel. Do **not** include white bread.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
177.	eat any **chocolate** or any other types of **candy?** Do **not** include sugar-free candy.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month

Please use a ballpoint pen for this form

During the past month, did you...		NO	YES	a. How often?
178.	eat any **doughnuts,** sweet rolls, Danish, muffins, *pan dulce* or pop-tarts? Do **not** include sugar-free items.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
179.	eat any **cookies, cake, pie, or brownies?** Do **not** include sugar-free kinds.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
180.	eat any ice cream or other **frozen desserts?** Do **not** include sugar-free kinds.	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month
181.	eat any **popcorn?**	○ No	○ Yes	# TIMES ○ Per day ○ Per week ○ Per month

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