The Sister Study
Health, Medical History and Lifestyle
B-Version 2

Version 2B

Instructions:

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

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

Like this: ● Not like this: ⊘ ✓

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

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

1	2	3	4	5	6	7	8	9	0

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

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

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

- ○ Mark here if you are the participant filling this out for yourself. → **GO TO QUESTION 1, BELOW**
- ○ Mark here if someone is helping you fill out this questionnaire by either reading the questions to you and/or filling the bubbles for you.
- ○ Mark here if the participant cannot answer the questions for herself and you are completing the questionnaire on her behalf.

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

What is your relationship to the participant?

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

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

____

GENERAL HEALTH

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

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

47800

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

	NO	YES
a. had a routine physical exam?	○	○
b. been to a dentist for a routine check-up or cleaning?	○	○
c. had a bone density scan or osteoporosis screening?	○	○
d. had a screening colonoscopy or sigmoidoscopy exam?	○	○
e. had a flu vaccination (either a flu shot or nasal spray)?	○	○
f. had a vaccination for shingles (herpes zoster)?	○	○

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, Medicaid or Affordable Care Act (ACA)?

○ 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, 2014, 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? Please round to the nearest inch.

FEET INCHES

FAMILY MEDICAL HISTORY

8. Since January 1, 2014, were **any** of your sisters diagnosed with breast cancer **for the first time**?

- ○ No
- ○ Yes

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

- ○ None
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5 or more

10. Since January 1, 2014, have any **other** close blood relatives of yours been diagnosed with breast cancer **for the first time**?

- ○ No → **GO TO QUESTION 11**
- ○ Yes

10a. 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

11. Since January 1, 2014, have **any** close blood relatives of yours been diagnosed with ovarian cancer **for the first time**?

- ○ No → **GO TO THE NEXT PAGE, QUESTION 12**
- ○ Yes

11a. 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

12. Have **any** of the following blood relatives: specifically your mother, father, sister, brother, daughter, or son **ever been diagnosed with...**

(Please mark a response for each item below.)

	NO	YES
a. Parkinson's disease?	○	○
b. Alzheimer's disease?	○	○
c. diabetes?	○	○
d. heart disease?	○	○
e. a stroke?	○	○
f. ovarian, fallopian tube, or primary peritoneal cancer?	○	○
g. cervix or cervical cancer?	○	○
h. uterus or endometrial cancer?	○	○
i. prostate cancer?	○	○
j. testicle or testicular cancer?	○	○
k. colon, bowel, or rectal cancer?	○	○
l. lung cancer?	○	○
m. leukemia or blood cancer?	○	○
n. non-Hodgkin's lymphoma?	○	○
o. Hodgkin's disease?	○	○
p. melanoma?	○	○
q. bladder cancer?	○	○
r. another cancer? Do not include non-melanoma skin cancer (basal or squamous cell carcinoma).	○	○

Please specify what type(s) of other cancer:

1). | | | | | | | | | | | | | | | | | | | |

2). | | | | | | | | | | | | | | | | | | | |

3). | | | | | | | | | | | | | | | | | | | |

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, 2014.**

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
13. breast cancer? Please do not include in situ cancer.	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
14. ductal (breast) carcinoma in situ (DCIS)?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
15. lobular (breast) carcinoma in situ (LCIS)?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
16. lung cancer?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
17. ovarian cancer?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
18. cancer of the uterus or endometrium? Please do not include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
19. cancer of the colon or rectum?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
20. Hodgkin's disease or Hodgkin's lymphoma?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
21. non-Hodgkin's lymphoma?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
22. leukemia?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
23. thyroid cancer?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
24. melanoma?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
25. skin cancer (**not** melanoma)?	○ Never diagnosed ○ Diagnosed before January 1, 2014 If diagnosed before January 1, 2014, was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR Was it... *(Please mark all that apply.)* ○ basal cell? ○ squamous cell? ○ other?
26. any other type of cancer not already listed?	○ Never diagnosed ○ Diagnosed before January 1, 2014 If diagnosed before January 1, 2014, please specify what type(s) of cancer: 1). ____ 2). ____	○ Diagnosed January 1, 2014 or later If you were diagnosed with any other type(s) of cancer January 1, 2014 or later, please specify what type(s) of cancer: 1). ____ 2). ____	MONTH / 2 0 YEAR MONTH / 2 0 YEAR

27. Has a doctor or other health professional **ever** told you that you had high cholesterol or borderline high cholesterol?

○ No → **GO TO QUESTION 29**

○ Yes

Has a doctor or other health professional **ever** told you that you had...	NO	YES	a. What month and year were you diagnosed?	b. Have you **ever** used any prescription medications for this condition?	c. ***If yes***, are you currently taking prescription medications?
28. high cholesterol (not borderline)?	○ No	○ Yes	☐☐ / ☐☐☐☐ MONTH YEAR	○ No ○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	NO	YES	b. Have you **ever** used any prescription medications for this condition?	c. ***If yes***, are you currently taking prescription medications?
29. hypertension or high blood pressure?	○ No	○ Yes, first diagnosed before January 1, 2014 ○ Yes, first diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes	○ No ○ Yes
30. congestive heart failure?	○ No	○ Yes, first diagnosed before January 1, 2014 ○ Yes, first diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR	○ No ○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	NO	YES	b. Have you had this condition in the **past 12 months?**	c. Have you **ever** used any prescription medications for this condition?	d. ***If yes***, are you currently taking prescription medications?
31. cardiac arrhythmia (irregular heartbeat)?	○ No	○ Yes, first diagnosed before January 1, 2014 ○ Yes, first diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? [ ][ ] / 2 0 [ ][ ] MONTH YEAR	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes
32. angina?	○ No	○ Yes, first diagnosed before January 1, 2014 ○ Yes, first diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? [ ][ ] / 2 0 [ ][ ] MONTH YEAR	○ No ○ Yes	○ No ○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	NO	YES	a. If you had this January 1, 2014 or later, what was the month and year?
33. a heart attack or myocardial infarction?	○ No	○ Yes, my first heart attack was before January 1, 2014 ○ Yes, my first heart attack was January 1, 2014 or later →	MONTH / 2 0 YEAR
34. a stroke (this does not include TIA or "mini-stroke")?	○ No	○ Yes, my first stroke was before January 1, 2014 ○ Yes, my first stroke was January 1, 2014 or later →	MONTH / 2 0 YEAR
35. a mini-stroke or TIA (transient ischemic attack)?	○ No	○ Yes, my first mini-stroke was before January 1, 2014 ○ Yes, my first mini-stroke was January 1, 2014 or later →	MONTH / 2 0 YEAR

Have you **ever** had...	NEVER OR BEFORE 1/1/2014	HAD PROCEDURE 1/1/2014 OR LATER	a. If you had this procedure January 1, 2014 or later, what was the month and year?
36. a balloon angioplasty, stent placement, or other procedure to open or widen a heart artery? These procedures are different from the test used to diagnose a blockage.	○ Never had procedure ○ Had procedure before January 1, 2014	○ Had procedure January 1, 2014 or later	MONTH / 2 0 YEAR
37. a coronary artery bypass graft surgery?	○ Never had procedure ○ Had procedure before January 1, 2014	○ Had procedure January 1, 2014 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	NO	YES	b. Do you still have this condition?
38. diabetes? *If no*, were you ever told that you had pre-diabetes, borderline diabetes, or an elevated A1C test? ○ No ○ Yes	○ No	○ Yes, first diagnosed before January 1, 2014 ○ Yes, first diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes

39. Did you **ever** take insulin for diabetes? Only answer this question if you have ever been diagnosed with diabetes.

○ No → **GO TO QUESTION 40 ON NEXT PAGE**

○ Yes

39a. When did you first use insulin? MONTH / YEAR

39b. Do you ***currently*** take insulin?
○ No
○ Yes

40. Have you **ever** used any other prescription medications for diabetes? Only answer this question if you have ever been diagnosed with diabetes.

○ No → **GO TO QUESTION 41 ON NEXT PAGE**

○ Yes

Have you **ever** taken the following prescription medications for diabetes?	**NO**	**YES**	a. If yes, are you ***currently*** taking this medication?
a. **Metformin monotherapy:** Metformin (Glucophage), Metformin liquid (Riomet), or Metformin extended release (Glucophage XR, Fortamet, Glumetza)	○ No	○ Yes	○ No ○ Yes
b. **Metformin combination therapy:** Pioglitazone & metformin (Actoplus Met), Glyburide & metformin (Glucovance), Glipizide & metformin (Metaglip), Sitagliptin & metformin (Janumet), Saxagliptin & metformin (Kombiglyze), or Repaglinide & metformin (Prandimet)	○ No	○ Yes	○ No ○ Yes
c. **Sulfonylureas:** Glimepiride (Amaryl), Glyburide (Micronase, DiaBeta), Glipizide (Glucotrol), or Micronized glyburide (Glynase)	○ No	○ Yes	○ No ○ Yes
d. **DPP-4 inhibitors:** Sitagliptin (Januvia), Saxagliptin (Onglyza), or Linagliptin (Tradjenta)	○ No	○ Yes	○ No ○ Yes
e. **Thiazolidinediones:** Pioglitazone (Actos)	○ No	○ Yes	○ No ○ Yes
f. **GLP-1 analogs:** Exenatide (Byetta, Bydureon), Liraglutide (Victoza, Saxenda)	○ No	○ Yes	○ No ○ Yes
g. **Other, please specify:** _____	○ No	○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**
41. Parkinson's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later ↓ a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed? ☐☐ / 2 0 ☐☐ MONTH YEAR

42. Have you **ever** used any prescription medications for Parkinson's disease? Only answer this question if you have ever been diagnosed with Parkinson's disease.

○ No → **GO TO QUESTION 43 ON NEXT PAGE**

○ Yes

Have you **ever** taken the following prescription medications for Parkinson's disease? *Please only report medication as YES if taken for Parkinson's disease.*	**NO**	**YES**	a. If yes, are you ***currently*** taking this medication?
a. Carbidopa or levodopa such as Sinemet, Stalevo, or Parcopa	○ No	○ Yes	○ No ○ Yes
b. Pramipexole or Mirapex	○ No	○ Yes	○ No ○ Yes
c. Ropinirole or Requip	○ No	○ Yes	○ No ○ Yes
d. Pergolide or Permax	○ No	○ Yes	○ No ○ Yes
e. Selegiline such as Eldepryl or Zelapar	○ No	○ Yes	○ No ○ Yes
f. Rasagiline or Azilect	○ No	○ Yes	○ No ○ Yes
g. Trihexyphenidyl such as Artane, Amantadine, or Symmetrel	○ No	○ Yes	○ No ○ Yes

Have you **ever** had...	**NEVER OR BEFORE 1/1/2014**	**1/1/2014 OR LATER**	a. What was the month and year that this **first** happened since January 1, 2014?	b. How many times has this happened since January 1, 2014?
43. a hip fracture?	○ Never ○ Before January 1, 2014	○ January 1, 2014 or later	☐☐ / 20☐☐ MONTH YEAR	☐ # TIMES
44. a wrist fracture?	○ Never ○ Before January 1, 2014	○ January 1, 2014 or later	☐☐ / 20☐☐ MONTH YEAR	☐ # TIMES
45. a spine (vertebral) fracture?	○ Never ○ Before January 1, 2014	○ January 1, 2014 or later	☐☐ / 20☐☐ MONTH YEAR	☐ # TIMES
46. a rib fracture?	○ Never ○ Before January 1, 2014	○ January 1, 2014 or later	☐☐ / 20☐☐ MONTH YEAR	☐ # TIMES

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

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

○ None → **GO TO NEXT PAGE**

○ Once
○ Twice
○ Three or more

48a. Did you seek medical care as a result of any of your falls? ○ No ○ Yes

We would like to learn more about how concerned you are about the possibility of falling. For the list of activities below, how concerned are you that you might fall if you did this activity?

Please reply thinking about how you usually do the activity. If you currently don't do the activity (example: someone does your shopping for you), please answer to show whether you think you would be concerned about falling ***if*** you did the activity.

	Not at all concerned	Somewhat concerned	Fairly concerned	Very concerned
a. Cleaning the house	○	○	○	○
b. Getting dressed or undressed	○	○	○	○
c. Preparing simple meals	○	○	○	○
d. Taking a bath or shower	○	○	○	○
e. Going to the shop	○	○	○	○
f. Getting in or out of a chair	○	○	○	○
g. Going up or down stairs	○	○	○	○
h. Walking around in the neighborhood	○	○	○	○
i. Reaching for something above your head or on the ground	○	○	○	○
j. Going to answer the phone before it stops ringing	○	○	○	○
k. Walking on a slippery surface (e.g. wet or icy)	○	○	○	○
l. Visiting a friend or relative	○	○	○	○
m. Walking in a place with crowds	○	○	○	○
n. Walking on an uneven surface (e.g. rocky ground, poorly maintained pavement)	○	○	○	○
o. Walking up or down a slope	○	○	○	○
p. Going out to a social event (e.g. religious service, family gathering, or club meeting)	○	○	○	○

Have you **ever**...	**NO**	**YES**	b. Have you lost any adult teeth in the **past 12 months?**
49. lost any adult teeth due to disease or decay (please do not count wisdom teeth extractions, or teeth lost due to accidents, violence, or orthodontistry)?	○ No	○ Yes, first lost any adult teeth before January 1, 2014 ○ Yes, first lost any adult teeth January 1, 2014 or later ↓ a. What month and year did you first lose any adult teeth? MONTH / 2 0 YEAR	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NO**	**YES**	b. Have you had this condition in the **past 12 months?**
50. periodontal (gum) disease?	○ No	○ Yes, first diagnosed before January 1, 2014 ○ Yes, first diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes
51. depression?	○ No	○ Yes, first diagnosed before January 1, 2014 ○ Yes, first diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? MONTH / 2 0 YEAR	○ No ○ Yes c. Have you taken medication for depression in the **past 12 months?** ○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	NO	YES	b. Have you had this condition in the **past 12 months?**
52. asthma?	○ No	○ Yes, first diagnosed before January 1, 2014 ○ Yes, first diagnosed January 1, 2014 or later ↓ a. What month and year were you diagnosed? MONTH / 20 YEAR	○ No ○ Yes c. Have you taken medication for asthma in the **past 12 months?** ○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	NEVER OR BEFORE 1/1/2014	DIAGNOSED 1/1/2014 OR LATER	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
53. allergic rhinitis, hay fever, or seasonal allergies?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
54. emphysema?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR
55. chronic obstructive pulmonary disease (COPD)?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 20 YEAR

56. Have you **ever** been diagnosed with a thyroid condition, such as Graves' disease, Hashimoto's thyroiditis, thyroid nodules, or another thyroid problem? Do not include thyroid cancer.

○ No → **GO TO QUESTION 60 ON PAGE B-13**

○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
a. Graves' disease?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
b. other hyperthyroidism (overactive thyroid)?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
c. Hashimoto's thyroiditis?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
d. other hypothyroidism (underactive thyroid)?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
e. an enlarged thyroid or goiter?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
f. thyroid nodules? *If diagnosed*, was it called "toxic"? ○ No ○ Yes	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
g. another thyroid problem? Please do **not** include thyroid cancer.	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	a. MONTH/YEAR DIAGNOSED MONTH / 2 0 YEAR b. Please specify the problem:

57. Have you **ever** used any prescription medications to treat a thyroid condition? Only answer this question if you have ever been diagnosed with a thyroid condition.

○ No → **GO TO QUESTION 58**

○ Yes

Have you **ever** taken the following prescription medications for a thyroid condition?	NO	YES	a. If yes, are you ***currently*** taking this medication?
a. Levothyroxine, such as Levothroid, Levo-T, Levoxyl, Synthroid, Tirosint, or Unithroid	○ No	○ Yes	○ No ○ Yes
b. Propylthiouracil/PTU such as Propycil	○ No	○ Yes	○ No ○ Yes
c. Methimazole/MMI such as Tapazole	○ No	○ Yes	○ No ○ Yes
d. Other, please specify:	○ No	○ Yes	○ No ○ Yes

58. Only answer this question if you have ever been diagnosed with a thyroid condition.
Have you **ever** received...

	NO	YES	**If yes,** what year?
a. radioactive iodine (I131) therapy for a thyroid condition?	○ No	○ Yes	YEAR
b. thyroid surgery (partial or resection) for a thyroid condition?	○ No	○ Yes	YEAR

59. Have you **ever** taken medication(s) that caused your thyroid problems such as Lithium/Lithobid, or Amiodarone/Cordarone? Only answer this question if you have ever been diagnosed with a thyroid condition.

○ No → **GO TO QUESTION 60 ON NEXT PAGE**

○ Yes

59a. Did your thyroid problem go away after stopping medications such as Lithium/Lithobid, or Amiodarone/Cordarone?
○ No
○ Yes
○ Have not stopped medication

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**
60. rheumatoid arthritis? Do not include osteoarthritis.	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later ↓ a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed? MONTH ___ ___ / YEAR 2 0 ___ ___

61. Have you **ever** used any prescription medications to treat rheumatoid arthritis? Only answer this question if you have ever been diagnosed with rheumatoid arthritis.

○ No → **GO TO QUESTION 62 ON NEXT PAGE**

○ Yes

Have you **ever** taken the following prescription medications for rheumatoid arthritis? *Please only report medications as YES if taken for rheumatoid arthritis.*	**NO**	**YES**	a. If yes, are you ***currently*** taking this medication?
a. Hydroxychloroquine or chloroquine, also called Plaquenil	○ No	○ Yes	○ No ○ Yes
b. Methotrexate, also called Rheumatrex or Trexall	○ No	○ Yes	○ No ○ Yes
c. Biologics, given by infusion or injection, such as Remicade, Humira, Enbrel, or other **If other, please specify:** _____	○ No	○ Yes	○ No ○ Yes
d. Corticosteroids, such as prednisone or solumedrol, either oral or intravenous (but not by injection, for example in a joint)	○ No	○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?	b. Have you **ever** used any prescription medications to treat this condition?	c. ***If yes***, are you currently taking this?
62. osteoarthritis (age-related arthritis)? Do not include rheumatoid arthritis.	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / MONTH 2 0 ☐☐ YEAR	○ No ○ Yes	○ No ○ Yes, regularly ○ Yes, as needed
63. osteoporosis (bone loss, or bone thinning)?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / MONTH 2 0 ☐☐ YEAR	○ No ○ Yes	Do not count calcium or Vitamin D. ○ No ○ Yes, regularly ○ Yes, as needed
64. osteopenia, or low bone density?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / MONTH 2 0 ☐☐ YEAR	○ No ○ Yes	Do not count calcium or Vitamin D. ○ No ○ Yes, regularly ○ Yes, as needed
65. multiple sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / MONTH 2 0 ☐☐ YEAR	○ No ○ Yes	○ No ○ Yes
66. scleroderma or systemic sclerosis?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / MONTH 2 0 ☐☐ YEAR	○ No ○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**
67. systemic lupus erythematosus (SLE)? Do not include discoid lupus.	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later ↓ a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed? __ __ / 2 0 __ __ MONTH YEAR

68. Have you **ever** used any prescription medications to treat systemic lupus erythematosus (SLE)? Only answer this question if you have ever been diagnosed with systemic lupus erythematosus (SLE).

○ No → **GO TO QUESTION 69 ON NEXT PAGE**

○ Yes

Have you **ever** taken the following prescription medications for systemic lupus erythematosus (SLE)? *Please only report medications as YES if taken for systemic lupus erythematosus (SLE).*	**NO**	**YES**	a. If yes, are you ***currently*** taking this medication?
a. Hydroxychloroquine or chloroquine, also called Plaquenil	○ No	○ Yes	○ No ○ Yes
b. Methotrexate, also called Rheumatrex or Trexall	○ No	○ Yes	○ No ○ Yes
c. Biologics, given by infusion or injection, such as Benlysta or other **If other, please specify:** _____	○ No	○ Yes	○ No ○ Yes
d. Azathioprine, also called Imuran, Cellcept, Cytoxan, or Cyclosporine	○ No	○ Yes	○ No ○ Yes
e. Corticosteroids, such as prednisone or solumedrol, either oral or intravenous (but not by injection, for example in a joint)	○ No	○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**
69. Sjögren's syndrome?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later ↓ a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed? __ __ / 2 0 __ __ MONTH YEAR

70. Have you **ever** used any prescription medications to treat Sjögren's syndrome? Only answer this question if you have ever been diagnosed with Sjögren's syndrome.

○ No → **GO TO QUESTION 71 ON NEXT PAGE**

○ Yes

Have you **ever** taken the following prescription medications for Sjögren's syndrome? *Please only report medications as YES if taken for Sjögren's syndrome.*	**NO**	**YES**	a. If yes, are you ***currently*** taking this medication?
a. Hydroxychloroquine or chloroquine, also called Plaquenil	○ No	○ Yes	○ No ○ Yes
b. Methotrexate, also called Rheumatrex or Trexall	○ No	○ Yes	○ No ○ Yes
c. Biologics, given by infusion or injection, such as Rituximab, also called Rituxan, or other **If other, please specify:** _____	○ No	○ Yes	○ No ○ Yes
d. Pilocarpine, also called Salagen; or Cevimeline, also called Evoxac; or Cyclosporine Ophthalmic, also called Restasis	○ No	○ Yes	○ No ○ Yes
e. Corticosteroids, such as prednisone or solumedrol, either oral or intravenous (but not by injection, for example in a joint)	○ No	○ Yes	○ No ○ Yes

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
71. Crohn's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
72. ulcerative colitis?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
73. shingles?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
74. polyps in the colon or rectum?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
75. polycystic ovarian syndrome or PCOS?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
76. one or more ovarian cysts?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
77. uterine fibroids or fibroid tumors?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
78. endometriosis? *If diagnosed*, was your endometriosis confirmed by laparoscopy (insertion of a thin, lighted tube through a small incision in the abdomen to examine organs)? ○ No ○ Yes	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
79. Alzheimer's disease?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
80. dementia excluding Alzheimer's disease? **Please specify type:**	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
81. cognitive impairment?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
82. kidney failure requiring dialysis or transplant?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
83. kidney stones?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
84. gallstones or gallbladder disease?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
85. gout?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
86. cataracts?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR
87. glaucoma?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	MONTH / 2 0 YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
88. macular degeneration?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
89. pulmonary embolism?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR
90. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	○ Never diagnosed ○ Diagnosed before January 1, 2014	○ Diagnosed January 1, 2014 or later	☐☐ / 2 0 ☐☐ MONTH YEAR

Has a doctor or other health professional **ever** told you that you had...	**NEVER OR BEFORE 1/1/2014**	**DIAGNOSED 1/1/2014 OR LATER**	a. If diagnosed January 1, 2014 or later, what month and year were you diagnosed?
91. any other major health condition? Please ***do not*** report any cancer or health condition you already reported in this questionnaire.	○ Never diagnosed ○ Diagnosed before January 1, 2014 If diagnosed before January 1, 2014, please specify what type of major health condition(s): 1). ☐ 2). ☐	○ Diagnosed January 1, 2014 or later If you were diagnosed with any other major health condition(s) January 1, 2014 or later, please specify what type of major health condition(s): 1). ☐ 2). ☐	1). ☐☐ / 2 0 ☐☐ MONTH YEAR 2). ☐☐ / 2 0 ☐☐ MONTH YEAR

Have you **ever** had...		**NEVER OR BEFORE 1/1/2014**	**HAD PROCEDURE 1/1/2014 OR LATER**	a. If you had this procedure January 1, 2014 or later, what was the month and year?
92.	gallbladder surgery?	○ Never had procedure ○ Had procedure before January 1, 2014	○ Had procedure January 1, 2014 or later	MONTH / 2 0 YEAR

Have you **ever** had any of the following weight loss procedures...		**NEVER OR BEFORE 1/1/2014**	**HAD PROCEDURE 1/1/2014 OR LATER**	a. If you had this procedure January 1, 2014 or later, what was the month and year?
93.	lap band?	○ Never had procedure ○ Had procedure before January 1, 2014	○ Had procedure January 1, 2014 or later	MONTH / 2 0 YEAR
94.	bariatric surgery?	○ Never had procedure ○ Had procedure before January 1, 2014	○ Had procedure January 1, 2014 or later	MONTH / 2 0 YEAR

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

○ No → **GO TO QUESTION 96 ON NEXT PAGE**

○ Yes

95a. How old were you the **first** time you noticed this problem? AGE

95b. Are there any reasons (such as head injury) that explain the decrease in your sense of smell?

○ No
○ Yes, specify:

96. Since January 1, 2014, have you experienced any of the following medical symptoms...
(Please mark a response for each item below.)

	NO	YES
a. swelling in your wrist, finger, elbow, or knee joints lasting six or more weeks?	○	○
b. joint stiffness in the mornings, lasting at least one hour, and for more than six weeks (do not include stiffness related or due to an injury or surgery)?	○	○
c. a tremor or trembling in either of your hands?	○	○
d. walking or other movements getting noticeably slower?	○	○
e. handwriting getting noticeably smaller?	○	○
f. difficulty getting started when walking or making other movements?	○	○
g. wheezing or whistling in your chest?	○	○
h. shortness of breath when hurrying on level ground, or when walking up a slight hill, or when climbing a flight of stairs at your usual pace?	○	○
i. shortness of breath when at rest?	○	○
j. shortness of breath when lying down?	○	○
k. shortness of breath when walking?	○	○
l. swelling (or edema) in your legs?	○	○
m. excessive sweating other than due to menopause?	○	○
n. unexplained and unintentional weight loss of 10 or more pounds?	○	○
o. a problem with sneezing or a runny nose or blocked nose when you did not have a cold or the flu?	○	○

97. Since January 1, 2014, have you had a mammogram, breast ultrasound, or breast MRI?

○ No → **GO TO QUESTION 98 ON NEXT PAGE**

○ Yes

97a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2014?

☐☐ # 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, 2014, have you been told you had abnormal findings on a mammogram, breast ultrasound, or breast MRI?

○ No → **GO TO QUESTION 98 ON NEXT PAGE**

○ 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. 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
○ Potentially malignant tumor
○ Other
○ Don't know

98. Since January 1, 2014, have you had a breast cyst or cysts drained (aspirated) or removed?

○ No
○ Yes

99. Since January 1, 2014, have you had a surgical, needle, or other biopsy to diagnose or rule out a breast condition?

○ No → **GO TO QUESTION 100**

○ Yes

99a. On how many occasions have you had this since January 1, 2014?
OCCASIONS

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

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

100. Since January 1, 2014, have you had a breast lump or lumps removed (lumpectomy or excisional biopsy)?

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

○ Yes

100a. On how many occasions have you had this since January 1, 2014?
OCCASIONS

100b. What was the month and year of your most recent procedure?
MONTH / 2 0 YEAR

100c. On which breast was the most recent lumpectomy or excisional biopsy performed?
○ Left breast
○ Right breast
○ Both breasts

Have you **ever** had...		**NEVER OR BEFORE 1/1/2014**	**1/1/2014 OR LATER**	a. If you had this procedure January 1, 2014 or later, what was the month and year?	b. Why was this done?
101.	a mastectomy of your **left** breast?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR	○ To treat breast cancer ○ To prevent breast cancer ○ Both
102.	a mastectomy of your **right** breast?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR	○ To treat breast cancer ○ To prevent breast cancer ○ Both

Have you **ever** had...		**NEVER OR BEFORE 1/1/2014**	**1/1/2014 OR LATER**	a. If you had this procedure January 1, 2014 or later, what was the month and year of the most recent surgery?	b. Did you have a silicone gel implant?
103.	breast reconstruction surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR	○ No ○ Yes
104.	breast reconstruction surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR	○ No ○ Yes

Since January 1, 2014, were you told you had any of the following benign breast conditions after a cyst aspiration, cyst removal, needle biopsy, surgical biopsy, lumpectomy, or mastectomy?

Have you **ever** had...	**NEVER OR BEFORE 1/1/2014**	**1/1/2014 OR LATER**	a. If you had this January 1, 2014 or later, what was the month and year?
105. fibrocystic or **benign nonproliferative** changes within normal range? For example, cysts, mild hyperplasia, benign calcifications, fibrosis, etc.	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR
106. fibroadenoma?	○ Never ○ Yes, before January 1, 2014 b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR b. What type? ○ Simple fibroadenoma ○ Complex fibroadenoma ○ Both ○ Don't know
107. benign breast disease?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR
108. proliferation **without atypia**? For example, sclerosing adenosis, intraductal papilloma, moderate hyperplasia, suspicious calcifications, etc.	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR
109. atypical hyperplasia?	○ Never ○ Yes, before January 1, 2014 b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR b. What type? ○ Atypical ductal hyperplasia ○ Atypical lobular hyperplasia ○ Both ○ Don't know

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

○ No

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

○ Not applicable

Have you **ever** had...	NEVER OR BEFORE 1/1/2014	1/1/2014 OR LATER	a. If you had this procedure January 1, 2014 or later, what was the month and year?	b. Did you have a silicone gel implant?
111. breast enlargement surgery on your **left** breast?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR	○ No ○ Yes
112. breast enlargement surgery on your **right** breast?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR	○ No ○ Yes
113. a breast implant surgically removed from your **left** breast?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR	○ No ○ Yes
114. a breast implant surgically removed from your **right** breast?	○ Never ○ Yes, before January 1, 2014	○ Yes, January 1, 2014 or later	MONTH / 2 0 YEAR	○ No ○ Yes

MENSTRUAL HISTORY

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

○ No → **GO TO QUESTION 116 ON NEXT PAGE**

○ Yes

115a. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

MONTH / YEAR

OR

AGE

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

Since January 1, 2014, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2014?	b. Do you currently use this female hormone product(s)?
116. a combined pill containing both estrogen and progesterone (such as Prempro)?	○ No	○ Yes	# MONTHS	○ No ○ Yes
117. an estrogen-only pill (such as Premarin) with no additional progesterone in any form?	○ No	○ Yes	# MONTHS	○ No ○ Yes
118. an estrogen pill (such as Premarin) **and** a separate progesterone pill (such as Provera) or progesterone shot?	○ No	○ Yes	# MONTHS	○ No ○ Yes
119. an estrogen-only patch with no additional progesterone in any form?	○ No	○ Yes	# MONTHS	○ No ○ Yes
120. a patch containing both estrogen and progesterone (such as Combipatch)?	○ No	○ Yes	# MONTHS	○ No ○ Yes
121. an estrogen-only patch **and** a separate progesterone pill or progesterone shot?	○ No	○ Yes	# MONTHS	○ No ○ Yes
122. progesterone alone (not for birth control)?	○ No	○ Yes	# MONTHS	○ No ○ Yes

Since January 1, 2014, have you used...	NO	YES	If yes, how many months in all have you used this since January 1, 2014?
123. vaginal estrogen creams, rings, or suppositories?	○ No	○ Yes	a. ☐☐ # MONTHS b. Do you currently use this female hormone product(s)? ○ No ○ Yes c. Does this product also contain progesterone? ○ No ○ Yes ○ Don't know d. Did you also take progesterone in another form (e.g., patch, pill) during the time you were using vaginal estrogen creams, rings, or suppositories? ○ No ○ Yes
124. any other estrogen products, including "natural" estrogens?	○ No	○ Yes	a. ☐☐ # MONTHS b. Do you currently use this female hormone product(s)? ○ No ○ Yes c. Which of the following products have you used since January 1, 2014? *(Please mark all that apply.)* ○ Capsules ○ Gel or cream applied to the skin ○ Injection ○ Liquid ○ Troche or lozenge (dissolved under the tongue) ○ Other

Since January 1, 2014, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2014?	b. Do you currently use this?	c. Why did you use this? *(Please mark all that apply.)*
125. tamoxifen or Nolvadex?	○ No	○ Yes	# MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
126. ospemifene or Osphena?	○ No	○ Yes	# MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
127. raloxifene or Evista?	○ No	○ Yes	# MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
Aromatase inhibitors: 128. anastrozole or Arimidex?	○ No	○ Yes	# MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
129. exemestane or Aromasin?	○ No	○ Yes	# MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
130. letrozole or Femara?	○ No	○ Yes	# MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
131. other aromatase inhibitor? Please specify:	○ No	○ Yes	# MONTHS	○ No ○ Yes	○ Treat breast cancer ○ Prevent breast cancer ○ Another reason
132. Herceptin?	○ No	○ Yes	# MONTHS	○ No ○ Yes	
133. testosterone?	○ No	○ Yes	# MONTHS	○ No ○ Yes	
134. Estratest?	○ No	○ Yes	# MONTHS	○ No ○ Yes	

Have you **ever** had...	NEVER OR BEFORE 1/1/2014	HAD PROCEDURE 1/1/2014 OR LATER	If you had this procedure January 1, 2014 or later, what was the month and year?
135. a hysterectomy (surgical removal of the uterus)?	○ Never had procedure ○ Had procedure before January 1, 2014	○ Had procedure January 1, 2014 or later	a. MONTH/YEAR HAD PROCEDURE [ ][ ] / [2][0][ ][ ] MONTH YEAR b. Did you have all or part of either of your ovaries removed at the same time you had the hysterectomy? ○ No → **GO TO QUESTION 136** ○ Yes c. Did you have... ○ both ovaries completely removed? ○ one ovary and part of the other ovary removed? ○ one ovary removed? ○ part of one or part of both ovaries removed? d. Did you have all or part of either ovary left after this surgery? ○ No ○ Yes
136. a separate surgery to remove part or all of one or both ovaries (but not your uterus)?	○ Never had procedure ○ Had procedure before January 1, 2014	○ Had procedure January 1, 2014 or later	a. MONTH/YEAR HAD PROCEDURE [ ][ ] / [2][0][ ][ ] MONTH YEAR b. Did you have... ○ both ovaries completely removed? ○ one ovary and part of the other ovary removed? ○ one ovary removed? ○ part of one or part of both ovaries removed? c. Did you have all or part of either ovary left after this surgery? ○ No ○ Yes

137. Have you **ever** douched?

○ No → **GO TO QUESTION 138 ON PAGE C-7**

○ Yes

137a. How old were you when you first douched?

☐☐ AGE

137b. Have you douched in the **past 12 months**?

○ No

○ Yes

137c. How old were you when you last douched? ☐☐ AGE

Did you douche...	NO	YES	IF YES, on average, how frequently did you douche?	How did you use it? *(Please mark all that apply.)*	What solutions did you use most often when you were douching? *(Please mark all that apply.)*
137d. in your **teens**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To treat vaginal symptoms ○ Other	○ Water ○ Homemade water and vinegar mixture ○ Commercial water and vinegar product ○ Commercial scented product ○ Commercial medicated product such as those containing iodine or betadine ○ Other
137e. in your **20s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To treat vaginal symptoms ○ Other	○ Water ○ Homemade water and vinegar mixture ○ Commercial water and vinegar product ○ Commercial scented product ○ Commercial medicated product such as those containing iodine or betadine ○ Other
137f. in your **30s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To treat vaginal symptoms ○ Other	○ Water ○ Homemade water and vinegar mixture ○ Commercial water and vinegar product ○ Commercial scented product ○ Commercial medicated product such as those containing iodine or betadine ○ Other

Did you douche...	NO	YES	IF YES, on average, how frequently did you douche?	How did you use it? *(Please mark all that apply.)*	What solutions did you use most often when you were douching? *(Please mark all that apply.)*
137g. in your **40s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To treat vaginal symptoms ○ Other	○ Water ○ Homemade water and vinegar mixture ○ Commercial water and vinegar product ○ Commercial scented product ○ Commercial medicated product such as those containing iodine or betadine ○ Other
137h. in your **50s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To treat vaginal symptoms ○ Other	○ Water ○ Homemade water and vinegar mixture ○ Commercial water and vinegar product ○ Commercial scented product ○ Commercial medicated product such as those containing iodine or betadine ○ Other
137i. in your **60s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To treat vaginal symptoms ○ Other	○ Water ○ Homemade water and vinegar mixture ○ Commercial water and vinegar product ○ Commercial scented product ○ Commercial medicated product such as those containing iodine or betadine ○ Other
137j. in your **70s or older**? ↓ **IF YOU HAVE NOT REACHED THIS AGE, GO TO THE NEXT PAGE**	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To treat vaginal symptoms ○ Other	○ Water ○ Homemade water and vinegar mixture ○ Commercial water and vinegar product ○ Commercial scented product ○ Commercial medicated product such as those containing iodine or betadine ○ Other

138. Have you **ever** applied talcum powder to a sanitary napkin, tampon, underwear, diaphragm, cervical cap, or directly to your vaginal area?

○ No → **GO TO QUESTION 139 ON PAGE C-9**

○ Yes

138a. How old were you when you first used talcum powder on or near your vaginal area?

☐☐ AGE

138b. Have you used talcum powder on or near your vaginal area in the **past 12 months**?

○ No

138c. How old were you when you last used talcum powder on or near your vaginal area? ☐☐ AGE

○ Yes

Did you use talcum powder on or near your vaginal area...	NO	YES	IF YES, on average, how frequently did you use talcum powder on or near your vaginal area?	How did you use it? *(Please mark all that apply.)*
138d. in your **teens**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To prevent dampness and chafing ○ Other
138e. in your **20s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To prevent dampness and chafing ○ Other
138f. in your **30s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To prevent dampness and chafing ○ Other

Did you use talcum powder on or near your vaginal area...	NO	YES	IF YES, on average, how frequently did you use talcum powder on or near your vaginal area?	How did you use it? *(Please mark all that apply.)*
138g. in your **40s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To prevent dampness and chafing ○ Other
138h. in your **50s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To prevent dampness and chafing ○ Other
138i. in your **60s**?	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To prevent dampness and chafing ○ Other
138j. in your **70s or older**? ↓ **IF YOU HAVE NOT REACHED THIS AGE, GO TO THE NEXT PAGE**	○ No	○ Yes	○ Once a year or less ○ 2-11 times per year ○ 1-3 times per month ○ Once a week or more	○ After your menstrual period ○ To feel clean ○ To reduce vaginal odor ○ Before sex ○ After sex ○ To prevent dampness and chafing ○ Other

MEDICATIONS

Since January 1, 2014, 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, 2014?
139.	acetaminophen (Tylenol)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
140.	"baby aspirin" or low-dose aspirin (100mg/tablet or less)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
141.	aspirin or other aspirin containing products (325 mg/tablet or more)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
142.	ibuprofen (such as Advil, Motrin, Nuprin, etc.)?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
143.	Celebrex or other COX-2 inhibitors?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
144.	Aleve or Naprosyn?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
145.	Relafen, Ketoprofen, Anaprox, or other non-steroidal anti-inflammatories?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years
146.	antibiotics?	○ No	○ Yes	○ Less than 12 months ○ 1 year ○ 2 years ○ 3 years ○ 4 years ○ More than 4 years

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

These questions are about prescription and non-prescription medications that you **currently take regularly, seasonally, or as needed.** This includes all pills, patches, shots, inhaled medications, vitamins, and herbal supplements. Please include inhalers, nasal sprays, and other medications even if you use them occasionally and include all medications prescribed in once a month or once a year doses, such as some medications to prevent osteoporosis, or treat asthma symptoms or migraines.
Do not include:

· Aspirin or other pain medications already reported in previous questions

147. Do you **currently** take any prescription or other medications **regularly, seasonally, or as needed?** Please include all medications, including inhalers, nasal sprays, and other medications, even if you use them only as needed, for example to treat asthma symptoms or migraines.

○ No → **GO TO QUESTION 148 ON PAGE D-1**

○ Yes

TOTAL #

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

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

47800

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

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

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

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

→ **GO TO QUESTION 149**

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

→

148a. How many years have you been married or living as though married with this spouse/partner?

☐☐ # YEARS OR ○ Less than 1 year

148b. Is your spouse/partner a man or a woman?

- ○ Man
- ○ Woman

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

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

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

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

151. Have you **ever** smoked at least 10 cigarettes or more?

○ No → **GO TO QUESTION 152**

○ Yes

151a.	What is your current smoking status?	○ Former smoker ○ Current smoker
151b.	When did you **first** start smoking?	○ Before 2014 ○ 2014 ○ 2015 ○ 2016 ○ 2017 ○ 2018 ○ 2019
151c.	Did you smoke at least 10 cigarettes since January 1, 2014?	○ No ○ Yes
151d.	When did you **last** smoke?	○ I am a current smoker ○ I last smoked in 2019 ○ I last smoked in 2018 ○ I last smoked in 2017 ○ I last smoked in 2016 ○ I last smoked in 2015 ○ I last smoked in 2014 ○ I last smoked before 2014
151e.	During the years you smoked, how many days per week do/did you smoke?	○ Less than one day per week ○ 1-3 days per week ○ 4-6 days per week ○ Every day
151f.	During the years you smoked, how many cigarettes do/did you usually smoke per day on the days you smoked?	☐☐☐ # CIGARETTES

152. Since January 1, 2014, how many regular smokers have you lived with (not counting yourself, if you smoke)?

○ None
○ 1
○ 2
○ 3-4
○ 5 or more

153. About how many minutes or hours per day are you exposed to other people's tobacco smoke (include all locations—home, work, and all other places you spend time where others might smoke)?

- ○ None
- ○ Less than 30 minutes
- ○ 30-59 minutes
- ○ 1-2 hours
- ○ 3-4 hours
- ○ 5-6 hours
- ○ 7-8 hours
- ○ More than 8 hours

154. Have you **ever** used an electronic cigarette or e-cigarette, such as NJOY, Blu, or Smoking Everywhere, even one or two times?

- ○ No → **GO TO QUESTION 155 ON NEXT PAGE**
- ○ Yes

154a. Do you now use e-cigarettes…
- ○ Every day
- ○ Some days
- ○ Not at all

154b. What brand of e-cigarette do/did you use?

BRAND

154c. About how many disposable e-cigarettes or e-cigarette cartridges have you used in the past year?
- ○ None
- ○ 1 or more puffs but never a whole one
- ○ 1-10
- ○ 11-20
- ○ 21-50
- ○ 51-99
- ○ 100 or more

155. Have you **ever** used marijuana, even once? Please include smoking or ingesting marijuana, using cannabis oil, etc.

○ No → **GO TO QUESTION 156 ON NEXT PAGE**

○ Yes

155a.	How old were you the ***first*** or ***only*** time you used marijuana?	☐☐ AGE
155b.	Have you ever used marijuana ***regularly***, over a period of months or years? Please include smoking or ingesting marijuana, using cannabis oil, etc.	○ No → **GO TO QUESTION 156** ○ Yes
155c.	At what ages did you use marijuana regularly? *(Please mark all that apply.)*	○ Teens ○ 50s ○ 20s ○ 60s ○ 30s ○ 70s ○ 40s ○ 80s
155d.	Did you use marijuana for... *(Please mark all that apply.)*	○ Medical purposes ○ Recreation
155e.	Have you used marijuana regularly in the ***past 12 months***?	○ No ○ Yes

Since January 1, 2014...	NO	YES	a. IF YES, in which years since January 1, 2014 did you drink alcohol? *(Please mark all that apply.)*	b. About how often did you drink alcohol?	c. On average, how many drinks did you have on the days that you drank alcohol?
156. have you drunk **alcoholic beverages?**	○ No	○ Yes	○ 2014 ○ 2015 ○ 2016 ○ 2017 ○ 2018 ○ 2019	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

157. Since January 1, 2014, did you **ever** drink four or more alcoholic beverages in a row, in one sitting?

○ No → **GO TO QUESTION 158**

○ Yes

157a. How often has this happened since January 1, 2014?

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

158. Since January 1, 2014, has a doctor or other health professional told you that your drinking was hurting your health?

○ No
○ Yes

In the past year...		NO	YES	a. About how often did you drink this?	b. On average, how many drinks did you have on the days that you drank this?
159.	have you drunk **regular coffee?**	○ No	○ Yes	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1
160.	have you drunk **decaffeinated coffee?**	○ No	○ Yes	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1
161.	have you drunk **tea or iced tea (not herbal teas)?**	○ No	○ Yes	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1
162.	have you drunk **decaffeinated tea or decaffeinated iced tea?**	○ No	○ Yes	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

In the past year...		NO	YES	a. About how often did you drink this?	b. On average, how many drinks did you have on the days that you drank this?
163.	have you drunk **regular or decaffeinated green tea?**	○ No	○ Yes	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1
164.	have you drunk **regular, non-diet soft drinks?**	○ No	○ Yes	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1
165.	have you drunk **artificially sweetened soft drinks?**	○ No	○ Yes	○ Every day ○ 5-6 times per week ○ 3-4 times per week ○ 2 times per week ○ Once per week ○ 2-3 times per month ○ Once per month ○ A few times per year	○ 7 or more ○ 6 ○ 5 ○ 4 ○ 3 ○ 2 ○ 1

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

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

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

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

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

172. Since January 1, 2014, have you used **hair dye** to color your hair?

○ No → **GO TO QUESTION 173 ON NEXT PAGE**

○ Yes

172a. In what years did you do this? *(Please mark all that apply.)*

- ○ 2014
- ○ 2015
- ○ 2016
- ○ 2017
- ○ 2018
- ○ 2019

172b. What color did you **usually** use?

- ○ Black
- ○ Light brown
- ○ Dark brown
- ○ Light blonde
- ○ Dark blonde
- ○ Light red
- ○ Dark red
- ○ Other

172c. What type of hair dye do you use most often?

- ○ Temporary dyes (wash out with a few shampoos)
- ○ Semi-permanent dyes (colors are pre-mixed or require mixing but no other chemicals are added; color fades out in about 4-8 weeks)
- ○ Demi-permanent dyes (other chemicals are mixed with the color; has strong smell; color fades out)
- ○ Permanent dyes (other chemicals are mixed with the color; has strong smell; color grows out over time, sometimes leaving your "roots" showing)

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

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

174. Have you moved since January 1, 2014?

○ No → **GO TO QUESTION 175 ON NEXT PAGE**

○ Yes

174a. What month and year did you move into your current residence?

MONTH / 2 0 YEAR

174b. Please write down your current address.

STREET #

STREET NAME

APT #

CITY OR TOWN STATE ZIP CODE

COUNTY

174c. Please write down the name of the nearest cross street (the street that intersects with the street where you live):

NAME OF NEAREST CROSS STREET

175. Since January 1, 2014, about how often has your residence been treated with insecticides or pesticides to control insects, rodents, or other pests, either inside or around the foundation?

○ Never → **GO TO QUESTION 176**

○ Less than once a year
○ Once a year
○ Every 4-6 months
○ Every 2-3 months
○ Monthly
○ Weekly
○ Daily

175a. For what kinds of pests were pest control chemicals used at your residence? *(Please mark all that apply.)*

○ Ants
○ Cockroaches
○ Bees or wasps
○ Bed bugs
○ Flies
○ Spiders
○ Mosquitoes
○ Fleas or ticks, not on pets
○ Termites
○ Any other pest such as moths, silverfish, caterpillars, mice, rats, gophers, or moles

175b. When pest control chemicals were applied since January 1, 2014, about how often did you **personally** apply them?

○ All of the time
○ Most of the time
○ About half the time
○ Some of the time
○ Never
○ Not applicable

176. Since January 1, 2014, about how often was the garden or yard around this residence treated with weed killers or insecticides, including those labeled organic such as pyrethrum or rotenone?

○ Never
○ Not applicable → **GO TO QUESTION 177 ON NEXT PAGE**

○ Less than once a year
○ Once a year
○ Every 4-6 months
○ Every 2-3 months
○ Monthly
○ Weekly
○ Daily

176a. When weed killers or insecticides were used in the garden or yard since January 1, 2014, about how often did you **personally** apply them?

○ All of the time
○ Most of the time
○ About half the time
○ Some of the time
○ Never
○ Not applicable

177. Since January 1, 2014 have you had a full-time or part-time job other than homemaking that you held for at least 12 months (at least 9 months if it was a teaching job)?

○ No

177a. Which of the following **best** describes your current situation?

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

GO TO QUESTION 188 ON PAGE E-1

○ Yes → **GO TO QUESTION 177b ON NEXT PAGE**

IF YOU DID NOT HAVE A JOB SINCE JANUARY 1, 2014, GO TO QUESTION 188 ON PAGE E-1

177b. How many different jobs have you had since January 1, 2014? ☐☐ # OF JOBS

Please tell us about the jobs you have had since January 1, 2014, starting with the most recent and working backwards. **PLEASE DO NOT REPORT JOBS YOU STOPPED WORKING BEFORE 2014.**

	JOB 1	JOB 2
178. When did you first start this job?	○ Before 2014 ○ 2014 ○ 2015 ○ 2016 ○ 2017 ○ 2018 ○ 2019	○ Before 2014 ○ 2014 ○ 2015 ○ 2016 ○ 2017 ○ 2018 ○ 2019
179. When did you last have this job?	○ 2014 ○ 2015 ○ 2016 ○ 2017 ○ 2018 ○ 2019 ○ I still work there	○ 2014 ○ 2015 ○ 2016 ○ 2017 ○ 2018 ○ 2019 ○ I still work there
180. Where did/do you work? Please write down the name of the company you worked for and the **full street address** of this workplace. Knowing the name and addresses of the places you work will allow us to evaluate the impact of air pollution and other factors in the general environment on your health. We will never use this information for any other purpose and will never contact your employer.	NAME OF COMPANY/PLACE OF WORK STREET # STREET NAME SUITE # CITY OR TOWN STATE ZIP CODE COUNTY	NAME OF COMPANY/PLACE OF WORK STREET # STREET NAME SUITE # CITY OR TOWN STATE ZIP CODE COUNTY

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

	JOB 1	JOB 2
186. How many times per month did/do you work at night? "Work at night" means any shift that includes at least one hour between midnight and 2:00 AM.	○ Never ○ 1-2 times/month ○ 3-5 times/month ○ 6-10 times/month ○ 11-15 times/month ○ More than 15 times per month	○ Never ○ 1-2 times/month ○ 3-5 times/month ○ 6-10 times/month ○ 11-15 times/month ○ More than 15 times per month

187. While working at this job did/do you regularly...	JOB 1	NO	YES	JOB 2	NO	YES
	a. work in dusty conditions?	○	○	a. work in dusty conditions?	○	○
	b. breathe in chemical vapors or fumes?	○	○	b. breathe in chemical vapors or fumes?	○	○
	c. get chemicals or oils on your skin or clothing?	○	○	c. get chemicals or oils on your skin or clothing?	○	○
	d. come in contact with solvents or degreasers?	○	○	d. come in contact with solvents or degreasers?	○	○
	e. come in contact with metal chips, dust, or fumes?	○	○	e. come in contact with metal chips, dust, or fumes?	○	○
	f. come in contact with pesticides?	○	○	f. come in contact with pesticides?	○	○
	g. use cleaning solutions (not counting dish or laundry detergents)?	○	○	g. use cleaning solutions (not counting dish or laundry detergents)?	○	○
	h. travel in a vehicle?	○	○	h. travel in a vehicle?	○	○

SPACE IS PROVIDED FOR TWO JOBS. IF YOU HAVE HAD MORE THAN TWO JOBS LASTING 12 MONTHS OR MORE SINCE JANUARY 1, 2014, PLEASE ANSWER THE SAME QUESTIONS FOR EACH JOB AND RECORD YOUR ANSWERS ON A SEPARATE SHEET OF PAPER.

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

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

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

189. 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

190. 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

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

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

192. 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

193. 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?	○	○	○	○	○

194. 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."	○	○	○	○

195. Since **January 1, 2014,** have you experienced...

	NO	YES
a. the death of your spouse or partner?	○	○
b. the death of a sibling?	○	○
c. the death of a child?	○	○
d. the death of a parent?	○	○
e. the death of a close personal friend?	○	○
f. a major illness that was life threatening or severely disabling to you?	○	○
g. the recurrence or worsening of a sister's breast cancer?	○	○
h. a major change in or serious difficulty with a personal relationship?	○	○
i. serious financial or legal troubles that directly affect you?	○	○

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

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

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

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

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

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

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

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

(hr) : (min)

(mark one)
○ AM
○ PM

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

(hr) : (min)

(mark one)
○ AM
○ PM

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

HOURS

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

HOURS

203. In the **past 7 days**...

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

204. In the **past 7 days**...

	Never	Rarely	Some-times	Often	Always
a. I had trouble staying asleep.	○	○	○	○	○
b. I had trouble sleeping.	○	○	○	○	○
c. I got enough sleep.	○	○	○	○	○

205. In the **past 7 days** my sleep quality was...

- ○ Very poor
- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good

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

- ○ No → **GO TO QUESTION 207**
- ○ Yes

206a. 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

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

	Not during the past month	Less than once a week	Once or twice a week	Three or more times a week
a. cannot get to sleep within 30 minutes.	○	○	○	○
b. wake up in the middle of the night or early morning.	○	○	○	○
c. have to get up to use the bathroom.	○	○	○	○
d. cannot breathe comfortably.	○	○	○	○
e. cough or snore loudly.	○	○	○	○

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

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

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

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

210. During the **past month**, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

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

211. 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 THE QUESTION 212**

○ Yes

211a.	Has this happened more than 3 times?	○ Yes ○ No
211b.	How old were you when you first knew you did this?	☐☐ AGE

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

○ No

○ Yes

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

○ No → **GO TO QUESTION 214**

○ Yes

213a.	Do you currently have this condition?	○ No ○ Yes
213b.	Do you use a continuous positive airway pressure (CPAP) machine?	○ No ○ Yes

		NO	YES
214a.	Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	○	○
214b.	Has anyone observed you stop breathing during your sleep?	○	○
214c.	Do you often feel tired or fatigued during daytime?	○	○

Please check to see that all questions are answered.

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

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

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

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!