



# The Sister Study Health, Medical History and Lifestyle Version DFU5

### Instructions:

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

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

Like this: ●

Not like this: ⊗ ⊙

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

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
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1	2	3	4	5	6	7	8	9	0
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Version 1

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.





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

	NO	YES
a. had a routine physical exam?	<input type="radio"/>	<input type="radio"/>
b. had a bone density scan or osteoporosis screening?	<input type="radio"/>	<input type="radio"/>
c. had a screening colonoscopy or sigmoidoscopy exam?	<input type="radio"/>	<input type="radio"/>
d. had a vaccination for shingles (herpes zoster)?	<input type="radio"/>	<input type="radio"/>

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

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POUNDS

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

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FEET      INCHES

## FAMILY MEDICAL HISTORY

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

No → GO TO QUESTION 7 ON NEXT PAGE

Yes →

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

	a. Month and year of breast cancer diagnosis?	b. Sister's age at diagnosis?																
1) Sister	<table border="1"> <tr> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">MONTH</td> <td style="text-align: center;">/</td> <td style="text-align: center;">2 0</td> </tr> <tr> <td colspan="2"></td> <td></td> <td style="text-align: center;">YEAR</td> </tr> </table>					MONTH		/	2 0				YEAR	<table border="1"> <tr> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table>			AGE	
MONTH		/	2 0															
			YEAR															
AGE																		
2) Sister	<table border="1"> <tr> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">MONTH</td> <td style="text-align: center;">/</td> <td style="text-align: center;">2 0</td> </tr> <tr> <td colspan="2"></td> <td></td> <td style="text-align: center;">YEAR</td> </tr> </table>					MONTH		/	2 0				YEAR	<table border="1"> <tr> <td style="width: 30px; height: 30px;"></td> <td style="width: 30px; height: 30px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table>			AGE	
MONTH		/	2 0															
			YEAR															
AGE																		



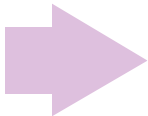
7. In all, how many of your full or half sisters, living or deceased, have **ever** been diagnosed with breast cancer?

FULL SISTERS ONLY	HALF-SISTERS ONLY
<input type="radio"/> None	<input type="radio"/> None
<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5 or more	<input type="radio"/> 5 or more

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

No → **GO TO QUESTION 10**

Yes



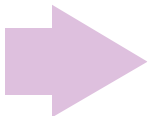
9. What is/are the relative(s)' relationship to you?  
*(Please mark all that apply.)*

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

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

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

Yes



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

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



## PERSONAL MEDICAL HISTORY

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

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



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



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



Has a doctor or other health professional <b>ever</b> told you that you had...	NO	YES	b. Have you <b>ever</b> used any prescription medications for this condition?	c. If yes, are you currently taking prescription medications?
30. high cholesterol (not borderline)?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2017 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2017 or later ↓ <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
31. congestive heart failure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2017 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2017 or later ↓ <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
32. hypertension or high blood pressure?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first diagnosed before</u> January 1, 2017 <input type="radio"/> Yes, <u>first diagnosed</u> January 1, 2017 or later ↓ <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">           a. What month and year were you diagnosed?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 2px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes





Have you <b>ever</b> taken any of the following medications, either for high blood pressure or for another reason?	NO	YES	a. Are you <b>currently</b> taking this?	b. For what reason(s) are you <b>currently</b> taking this? ( <i>Please mark all that apply.</i> )
33. ACE-inhibitors <i>These usually end in “-pril”, such as lisinopril, benazepril, enalapril, captopril, ramipril, etc.</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> High blood pressure <input type="radio"/> Reason other than high blood pressure
34. Thiazide diuretics <i>Examples include: hydrochlorothiazide (Microzide, etc.), chlorothiazide (Diuril), chlorthalidone (Hygroton)</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> High blood pressure <input type="radio"/> Reason other than high blood pressure
35. Non-thiazide diuretics <i>Examples include: triamterene (Dyrenium), furosemide (Lasix), spironolactone (Aldactone), eplerenone (Inspra)</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> High blood pressure <input type="radio"/> Reason other than high blood pressure
36. Angiotensin receptor blockers <i>These usually end in “-sartan”, such as losartan, irbesartan, olmesartan, valsartan, telmisartan, etc.</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> High blood pressure <input type="radio"/> Reason other than high blood pressure
37. Calcium channel blockers <i>Examples include: diltiazem (Cardizem, etc.), amlodipine (Norvasc, Lotrel), verapamil (Calan, Isoptin, etc.), nifedipine (Adalat, Procardia, etc.)</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> High blood pressure <input type="radio"/> Reason other than high blood pressure
38. Beta-blockers <i>These usually end in “-olol”, such as metoprolol, carvedilol, atenolol, propranolol, nebivolol, etc.</i>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> High blood pressure <input type="radio"/> Reason other than high blood pressure
39. Other types of medications that lower blood pressure <i>Examples include: clonidine (Catapres), hydralazine (Apresoline), doxazosin (Cardura), methyldopa (Aldomet), minoxidil (Loniten)</i>  Please specify other medications: <div style="border: 1px solid black; height: 40px; width: 100%; margin-top: 5px;"></div>	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> High blood pressure <input type="radio"/> Reason other than high blood pressure



Has a doctor or other health professional ever told you that you had...	NO	YES	b. Have you had this condition in the past 12 months?	c. Have you ever used any prescription medications for this condition?	d. If yes, are you currently taking prescription medications?
40. cardiac arrhythmia (irregular heartbeat)?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed before January 1, 2017 <input type="radio"/> Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
41. angina?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed before January 1, 2017 <input type="radio"/> Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

Has a doctor or other health professional ever told you that you had...	NO	YES	a. If you had this January 1, 2017 or later, what was the month and year?
42. a heart attack or myocardial infarction?	<input type="radio"/> No	<input type="radio"/> Yes, my first heart attack was before January 1, 2017 <input type="radio"/> Yes, my first heart attack was January 1, 2017 or later →	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
43. a stroke (this does not include TIA or "mini-stroke")?	<input type="radio"/> No	<input type="radio"/> Yes, my first stroke was before January 1, 2017 <input type="radio"/> Yes, my first stroke was January 1, 2017 or later →	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>
44. a mini-stroke or TIA (transient ischemic attack)?	<input type="radio"/> No	<input type="radio"/> Yes, my first mini-stroke was before January 1, 2017 <input type="radio"/> Yes, my first mini-stroke was January 1, 2017 or later →	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/>              MONTH YEAR           </div>



Have you ever had...	NEVER OR BEFORE 1/1/2017	HAD PROCEDURE 1/1/2017 OR LATER	a. If you had this procedure January 1, 2017 or later, what was the month and year?
45. a balloon angioplasty, stent placement, or other procedure to open or widen a heart artery? <i>These procedures are different from the test used to diagnose a blockage.</i>	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2017	<input type="radio"/> Had procedure January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>
46. a coronary artery bypass graft surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2017	<input type="radio"/> Had procedure January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>

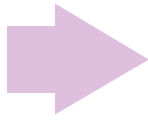
Has a doctor or other health professional ever told you that you had...	NO	YES	b. Do you still have this condition?
47. pre-diabetes, borderline diabetes, or an elevated A1C test <b>without</b> diabetes?	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2017 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2017 or later <div style="text-align: center;">↓</div> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           a. If first diagnosed 1/1/2017 or later, what month and year were you diagnosed?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes
48. diabetes? <i>Do NOT include pre-diabetes or borderline diabetes.</i>	<input type="radio"/> No	<input type="radio"/> Yes, <u>first</u> diagnosed <u>before</u> January 1, 2017 <input type="radio"/> Yes, <u>first</u> diagnosed January 1, 2017 or later <div style="text-align: center;">↓</div> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           a. If first diagnosed 1/1/2017 or later, what month and year were you diagnosed?  <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div> </div>	<input type="radio"/> No <input type="radio"/> Yes



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

No → GO TO QUESTION 50

Yes



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

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

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

Please specify:

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

No → GO TO QUESTION 51 ON NEXT PAGE

Yes



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

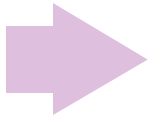


Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER
51. Parkinson's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed? <div style="display: flex; justify-content: center; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <span style="font-size: 24px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: center; gap: 40px; margin-top: 5px;"> <span>MONTH</span> <span>YEAR</span> </div>

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

No → GO TO QUESTION 53 ON NEXT PAGE

Yes



52a. Did your symptoms ever improve after taking any of these medications?	<input type="radio"/> No <input type="radio"/> Yes
52b. Are you currently taking any of these medications?	<input type="radio"/> No <input type="radio"/> Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER
53. osteoarthritis (age-related arthritis)?  <b>Do not include rheumatoid arthritis or psoriatic arthritis.</b>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?  <div style="display: flex; justify-content: center; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: center; margin-top: 5px;"> <div style="margin-right: 20px;">MONTH</div> <div>YEAR</div> </div>
54. osteoporosis (bone loss, or bone thinning)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?  <div style="display: flex; justify-content: center; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: center; margin-top: 5px;"> <div style="margin-right: 20px;">MONTH</div> <div>YEAR</div> </div>
55. osteopenia, or low bone density?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later ↓ a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?  <div style="display: flex; justify-content: center; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: center; margin-top: 5px;"> <div style="margin-right: 20px;">MONTH</div> <div>YEAR</div> </div>



56. Have you **ever** used any prescription medications to treat or prevent osteoporosis or osteopenia?  
*Do not count calcium or Vitamin D.*

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

Yes



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



Have you ever had...	NEVER OR BEFORE 1/1/2017	1/1/2017 OR LATER	a. What was the month and year that this first happened since January 1, 2017?	b. How many times has this happened since January 1, 2017?
57. a hip fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES
58. a wrist fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES
59. a spine (vertebral) fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES
60. a rib fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES
61. any other fracture?	<input type="radio"/> Never <input type="radio"/> Before January 1, 2017	<input type="radio"/> January 1, 2017 or later	<input type="text"/> / <input type="text"/> 2 0 <input type="text"/> MONTH YEAR	<input type="text"/> # TIMES
Please specify type of other fracture before January 1, 2017:		Please specify type of other fracture you had since January 1, 2017:		
<input type="text"/>		<input type="text"/>		

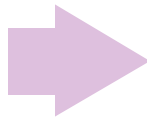
62. How many times have you fallen in the past 12 months?

None → GO TO QUESTION 63 ON NEXT PAGE

Once

Twice

Three or more



62a. Did you seek medical care as a result of any of your falls?

No

Yes





Has a doctor or other health professional ever told you that you had...	<b>NO</b>	<b>YES</b>	b. Have you had this condition in the past 12 months?														
63. depression?	<input type="radio"/> No	<input type="radio"/> Yes, first diagnosed before January 1, 2017  <input type="radio"/> Yes, first diagnosed January 1, 2017 or later ↓ a. What month and year were you diagnosed? <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; text-align: center;">/</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">MONTH</td> <td></td> <td colspan="2" style="text-align: center;">YEAR</td> <td colspan="2"></td> </tr> </table>			/	2	0			MONTH			YEAR				<input type="radio"/> No <input type="radio"/> Yes  c. Have you taken medication for depression in the past 12 months?  <input type="radio"/> No <input type="radio"/> Yes
		/	2	0													
MONTH			YEAR														

Has a doctor or other health professional ever told you that you had...	<b>NEVER OR BEFORE 1/1/2017</b>	<b>DIAGNOSED 1/1/2017 OR LATER</b>	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?														
64. emphysema?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; text-align: center;">/</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">MONTH</td> <td></td> <td colspan="2" style="text-align: center;">YEAR</td> <td colspan="2"></td> </tr> </table>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														
65. chronic obstructive pulmonary disease (COPD)?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; text-align: center;">/</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">MONTH</td> <td></td> <td colspan="2" style="text-align: center;">YEAR</td> <td colspan="2"></td> </tr> </table>			/	2	0			MONTH			YEAR			
		/	2	0													
MONTH			YEAR														



Has a doctor or other health professional <b>ever</b> told you that you had...	<b>NEVER OR BEFORE 1/1/2017</b>	<b>1/1/2017 OR LATER</b>	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
66. Graves' disease, or hyperthyroidism, or overactive thyroid?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> 1/1/2017	<input type="radio"/> Diagnosed 1/1/2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px;">  </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>

IF DIAGNOSED ↓

b. Were you treated with radioactive iodine?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> 1/1/2017 <input type="radio"/> Yes, 1/1/2017 or later
c. Did you have surgery to remove your thyroid?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> 1/1/2017 <input type="radio"/> Yes, 1/1/2017 or later

Has a doctor or other health professional <b>ever</b> told you that you had...	<b>NEVER OR BEFORE 1/1/2017</b>	<b>1/1/2017 OR LATER</b>	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
67. Hashimoto's thyroiditis, or hypothyroidism, or underactive thyroid?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> 1/1/2017	<input type="radio"/> Diagnosed 1/1/2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px;">  </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
68. any other type of thyroid disease or thyroid condition? Do NOT include thyroid cancer.	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> 1/1/2017  If diagnosed before January 1, 2017, please specify the condition: <input style="width: 100%;" type="text"/>	<input type="radio"/> Diagnosed 1/1/2017 or later  If you were diagnosed January 1, 2017 or later, please specify the condition: <input style="width: 100%;" type="text"/>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">  </div> <div style="border: 1px solid black; padding: 2px;">  </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>

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

- No
- Yes

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

- No
- Yes



Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
71. rheumatoid arthritis? <i>Do not include osteoarthritis or psoriatic arthritis.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
72. psoriatic arthritis? <i>Do not include osteoarthritis or rheumatoid arthritis.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
73. multiple sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
74. scleroderma or systemic sclerosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
75. systemic lupus erythematosus (SLE)? <i>Do not include discoid lupus.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>
76. Sjögren's syndrome?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">2</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;">0</div> <div style="border: 1px solid black; padding: 2px; margin-right: 5px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="margin-left: 10px;">MONTH</div> <div style="margin-left: 10px;">YEAR</div> </div>



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

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

Yes



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



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

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

No → **GO TO QUESTION 79**

Yes →

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

		/					OR		
MONTH			YEAR					AGE	

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

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

Yes



<p>a. Thinking back to your <b>first</b> episode of diverticulitis, when did your first episode occur?</p> <table style="border: none; margin-left: 20px;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 24px; vertical-align: middle;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-weight: bold; padding: 0 10px;">OR</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="3" style="text-align: center; font-size: 8px;">YEAR</td> <td></td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">AGE</td> </tr> </table> <p>b. How many <b>total</b> episodes or attacks of diverticulitis have you had?</p> <table style="border: none; margin-left: 20px;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;"># EPISODES</td> </tr> </table> <p>c. Have you <b>ever</b> been admitted to the hospital for an episode of diverticulitis?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p>d. Have you <b>ever</b> had a CT scan that was positive or confirmed the diagnosis of diverticulitis?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>			/					OR			MONTH			YEAR					AGE				# EPISODES		<p>e. When was your most recent episode or attack of diverticulitis?</p> <table style="border: none; margin-left: 20px;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 24px; vertical-align: middle;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-weight: bold; padding: 0 10px;">OR</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="3" style="text-align: center; font-size: 8px;">YEAR</td> <td></td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">AGE</td> </tr> </table> <p><b>For your most recent episode of diverticulitis...</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">NO</th> <th style="width: 10%; text-align: center;">YES</th> </tr> </thead> <tbody> <tr style="background-color: #f2f2f2;"> <td>f. were you seen by a doctor?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>g. did you go to the emergency department?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr style="background-color: #f2f2f2;"> <td>h. were you hospitalized?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>i. were you prescribed antibiotics?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr style="background-color: #f2f2f2;"> <td>j. did you have a CT scan?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>k. did you have surgery?</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>-----</p> <p>k1. IF YES, when did you have the surgery?</p> <table style="border: none; margin-left: 20px;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 24px; vertical-align: middle;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-weight: bold; padding: 0 10px;">OR</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 8px;">MONTH</td> <td></td> <td colspan="3" style="text-align: center; font-size: 8px;">YEAR</td> <td></td> <td></td> <td colspan="2" style="text-align: center; font-size: 8px;">AGE</td> </tr> </table>			/					OR			MONTH			YEAR					AGE			NO	YES	f. were you seen by a doctor?	<input type="radio"/>	<input type="radio"/>	g. did you go to the emergency department?	<input type="radio"/>	<input type="radio"/>	h. were you hospitalized?	<input type="radio"/>	<input type="radio"/>	i. were you prescribed antibiotics?	<input type="radio"/>	<input type="radio"/>	j. did you have a CT scan?	<input type="radio"/>	<input type="radio"/>	k. did you have surgery?	<input type="radio"/>	<input type="radio"/>			/					OR			MONTH			YEAR					AGE	
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Has a doctor or other health professional ever told you that you had...	NEVER OR BEFORE 1/1/2017	DIAGNOSED 1/1/2017 OR LATER	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
80. Crohn's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
81. ulcerative colitis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
82. polyps in the colon or rectum?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
83. Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
84. dementia excluding Alzheimer's disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017  <b>Please specify type of dementia you had before January 1, 2017:</b> <input type="text"/>	<input type="radio"/> Diagnosed January 1, 2017 or later  <b>Please specify type of dementia you had since January 1, 2017:</b> <input type="text"/>	<input type="text"/> / <input type="text"/> MONTH      YEAR
85. cognitive impairment?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
86. pernicious anemia (vitamin B12 anemia)? <i>Do not include iron-deficiency anemia.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
87. hemochromatosis?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
88. shingles?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR
89. cataracts?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed before January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<input type="text"/> / <input type="text"/> MONTH      YEAR



Has a doctor or other health professional <b>ever</b> told you that you had...	<b>NEVER OR BEFORE 1/1/2017</b>	<b>DIAGNOSED 1/1/2017 OR LATER</b>	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
90. glaucoma?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
91. macular degeneration?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
92. pulmonary embolism?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
93. deep vein thrombosis, DVT, or deep vein blood clots in your legs or somewhere else?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
94. kidney failure requiring dialysis or transplant?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
95. kidney stones?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
96. gout?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>
97. gallstones or gallbladder disease?	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017	<input type="radio"/> Diagnosed January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>

Have you <b>ever</b> had...	<b>NEVER OR BEFORE 1/1/2017</b>	<b>HAD PROCEDURE 1/1/2017 OR LATER</b>	a. If you had this procedure January 1, 2017 or later, what was the month and year?
98. gallbladder surgery?	<input type="radio"/> Never had procedure <input type="radio"/> Had procedure <u>before</u> January 1, 2017	<input type="radio"/> Had procedure January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px; text-align: center;">0</div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>

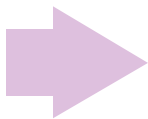


Since January 1, 2017, has a doctor or other health professional told you that you had...	<b>NEVER OR BEFORE 1/1/2017</b>	<b>DIAGNOSED 1/1/2017 OR LATER</b>	a. If diagnosed January 1, 2017 or later, what month and year were you diagnosed?
99. any other major health condition?  <i>Do not report any cancer or health condition reported elsewhere in this questionnaire.</i>	<input type="radio"/> Never diagnosed <input type="radio"/> Diagnosed <u>before</u> January 1, 2017  If diagnosed before January 1, 2017, please specify what type of major health condition(s):  1) <input type="text"/>  2) <input type="text"/>	<input type="radio"/> Diagnosed January 1, 2017 or later  If you were diagnosed with any other major health condition(s) January 1, 2017 or later, please specify what type of major health condition(s):  1) <input type="text"/>  2) <input type="text"/>	<div style="display: flex; justify-content: space-between;"> <div style="text-align: center;"> <input type="text"/> / <input type="text"/>  <small>MONTH</small> </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/>  <small>YEAR</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;"> <input type="text"/> / <input type="text"/>  <small>MONTH</small> </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/>  <small>YEAR</small> </div> </div>

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

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

Yes



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

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

No

Yes, specify:





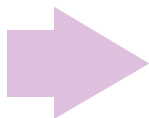
101. Since January 1, 2017, have you experienced any of the following **medical symptoms...**  
*(Please mark a response for each item below.)*

	NO	YES
a. swelling in your wrist, finger, elbow, or knee joints lasting six or more weeks?	<input type="radio"/>	<input type="radio"/>
b. joint stiffness in the mornings, lasting at least one hour, and for more than six weeks (do not include stiffness related or due to an injury or surgery)?	<input type="radio"/>	<input type="radio"/>
c. a tremor or trembling in either of your hands?	<input type="radio"/>	<input type="radio"/>
d. walking or other movements getting noticeably slower?	<input type="radio"/>	<input type="radio"/>
e. handwriting getting noticeably smaller?	<input type="radio"/>	<input type="radio"/>
f. difficulty getting started when walking or making other movements?	<input type="radio"/>	<input type="radio"/>
g. wheezing or whistling in your chest?	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>
i. shortness of breath when at rest?	<input type="radio"/>	<input type="radio"/>
j. shortness of breath when lying down?	<input type="radio"/>	<input type="radio"/>
k. shortness of breath when walking?	<input type="radio"/>	<input type="radio"/>
l. swelling (or edema) in your legs?	<input type="radio"/>	<input type="radio"/>

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

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

Yes



102a. How many times did you have a mammogram, breast ultrasound, or breast MRI since January 1, 2017?	<input type="text"/> <input type="text"/>	# TIMES
102b. What was the month and year of your most recent mammogram, breast ultrasound, or breast MRI?	<input type="text"/> <input type="text"/>	/ <input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
	MONTH	YEAR



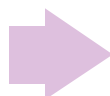
103. Since January 1, 2017, have you had a breast cyst or cysts drained (aspirated) or removed?

- No
- Yes

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

- No → **GO TO QUESTION 105**

Yes

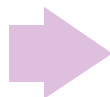


104a. On how many occasions have you had this since January 1, 2017?	<input type="text"/> <input type="text"/> # OCCASIONS
104b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> MONTH YEAR
104c. On which breast was the most recent biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts

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

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

Yes



105a. On how many occasions have you had this since January 1, 2017?	<input type="text"/> <input type="text"/> # OCCASIONS
105b. What was the month and year of your most recent procedure?	<input type="text"/> <input type="text"/> / 2 0 <input type="text"/> <input type="text"/> MONTH YEAR
105c. On which breast was the most recent lumpectomy or excisional biopsy performed?	<input type="radio"/> Left breast <input type="radio"/> Right breast <input type="radio"/> Both breasts



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

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

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

- No
- Yes → **PLEASE INCLUDE A COPY WITH YOUR COMPLETED QUESTIONNAIRE.**
- Not applicable



Have you ever had...	NEVER OR BEFORE 1/1/2017	1/1/2017 OR LATER	a. If you had this procedure January 1, 2017 or later, what was the month and year?	b. Why was this done?
112. a mastectomy of your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both
113. a mastectomy of your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> To treat breast cancer <input type="radio"/> To prevent breast cancer <input type="radio"/> Both

Have you ever had...	NEVER OR BEFORE 1/1/2017	1/1/2017 OR LATER	a. If you had this procedure January 1, 2017 or later, what was the month and year?	b. Did you have a silicone gel implant?
114. breast reconstruction or enlargement surgery on your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
115. breast reconstruction or enlargement surgery on your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
116. a breast implant surgically removed from your <b>left</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes
117. a breast implant surgically removed from your <b>right</b> breast?	<input type="radio"/> Never <input type="radio"/> Yes, <u>before</u> January 1, 2017	<input type="radio"/> Yes, January 1, 2017 or later	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">/</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px; text-align: center;">0</div> <div style="margin: 0 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> </div> <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <span>MONTH</span> <span>YEAR</span> </div>	<input type="radio"/> No <input type="radio"/> Yes

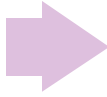


## MENSTRUAL HISTORY

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

No → GO TO QUESTION 119 ON PAGE 32

Yes



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

No → ANSWER BOX A BELOW

Yes → ANSWER BOX B ON PAGE 30

### BOX A

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

118b. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

--	--

MONTH

/

--	--	--	--

YEAR

OR

--	--

AGE

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

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

--

GO TO QUESTION 118g ON PAGE 31



## BOX B

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

118d. When was your last menstrual period?

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

118e. What statement best describes you?

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

GO TO QUESTION 118g  
ON NEXT PAGE

OR

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

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

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



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

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

Yes



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



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

Since January 1, 2017, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2017?	b. Do you <b>currently</b> use this female hormone product(s)?
119. <b>estrogen and progesterone at the same time</b> , whether as a combination product (such as Prempro or Combipatch) or as separate medications (for example Premarin plus Provera or a progesterone shot)?  <i>Do not include vaginal creams, rings, or suppositories.</i>	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
120. <b>estrogen alone</b> , whether as a pill (such as Premarin), patch, or other form (such as a spray, gel, or implant), with no additional progesterone in any form?  <i>Do not include vaginal creams, rings, or suppositories.</i>	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes
121. <b>progesterone alone</b> (not for birth control)?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto;"></div> # MONTHS	<input type="radio"/> No <input type="radio"/> Yes





Since January 1, 2017, have you used...	NO	YES	a. If yes, how many months in all have you used this since January 1, 2017?
122. vaginal estrogen creams, rings, or suppositories?	<input type="radio"/> No	<input type="radio"/> Yes	<div style="border: 1px solid black; width: 40px; height: 20px; margin: 0 auto; display: flex; justify-content: space-between;"> <span style="width: 15px; height: 15px;"></span> <span style="width: 15px; height: 15px;"></span> </div> <p style="text-align: center; margin-top: 5px;"># MONTHS</p> <p>b. Do you currently use this female hormone product(s)?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p>c. Does this product also contain progesterone?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> Don't know</p> <p>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?</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Yes</p>



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



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



## VITAMINS, SUPPLEMENTS, AND MEDICATIONS

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

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

Yes, fairly regularly



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



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



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



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



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







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



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

**Do not include:**

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

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

Yes

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TOTAL #

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



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



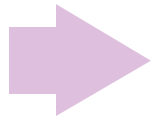


c. How often do you take it?	d. On days when you take it, how many times do you take it?	e. In what form did you take this? <i>(Please mark all that apply.)</i>	
<input type="radio"/> Once a month or less <input type="radio"/> Less than once a week <input type="radio"/> Once a week <input type="radio"/>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



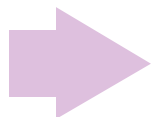
164. Which of the following best describes your **current** marital status? Please choose the **one** response that best describes your current situation.

- Never married
- Widowed
- Divorced
- Separated



**GO TO QUESTION 165**

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



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

# YEARS

OR  Less than 1 year

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

- Man
- Woman

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

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

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

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

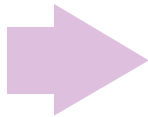


Since January 1, 2017...	NO	YES	During the years you smoked,		
			a. IF YES, in which years did you smoke? (Please mark all that apply.)	b. How many days per week do/did you smoke?	c. How many cigarettes do/did you usually smoke per day on the days you smoked?
167. did you smoke 10 cigarettes or more?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> 2020 <input type="radio"/> 2021	<input type="radio"/> Less than one day per week <input type="radio"/> 1-3 days per week <input type="radio"/> 4-6 days per week <input type="radio"/> Every day	<div style="border: 1px solid black; width: 60px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> # CIGARETTES

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

No → GO TO QUESTION 169 ON NEXT PAGE

Yes



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

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

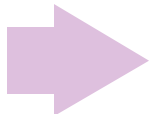
168c. About how many disposable e-cigarettes or e-cigarette cartridges have you used in the past year? 
 None  
 1 or more puffs but never a whole one  
 1-10  
 11-20  
 21-50  
 51-99  
 100 or more



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

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

Yes



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

AGE

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

AGE

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

No → **GO TO 169e ON NEXT PAGE**

Yes

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

Pleasure

Relaxation

Pain relief

Other symptom relief  
(For example, relief of treatment-related nausea)

Other reason





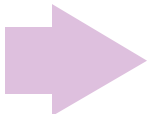
Did you use marijuana...	NO	YES	a. On average, how frequently did you use marijuana?	b. How did you use it? (Please mark all that apply.)
169e. in your teens?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Once a year or less <input type="radio"/> Less than once a month <input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



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

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

Yes



170a. When did you **first** use cannabidiol, also called CBD?

		/				
MONTH			YEAR			

170b. When did you **last** use cannabidiol, also called CBD?

		/				
MONTH			YEAR			

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

No → **GO TO 171 ON NEXT PAGE**  
 Yes

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

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

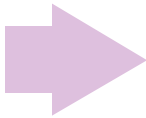


Since January 1, 2017...	NO	YES	a. If yes, in which years since January 1, 2017 did you drink alcohol? (Please mark all that apply.)	b. About how often did you drink alcohol?	c. On average, how many drinks did you have on the days that you drank alcohol?
171. have you drunk alcoholic beverages?	<input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

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

No → **GO TO QUESTION 173**

Yes



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

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

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

No

Yes



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

During the <b>past 7 days</b> , on how many days did you...		a. How much time did you usually spend doing these physical activities on one of those days?
174. do <b>vigorous</b> 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.	<input type="text"/> → # DAYS OR <input type="radio"/> No vigorous physical activity	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure
175. do <b>moderate</b> 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.	<input type="text"/> → # DAYS OR <input type="radio"/> No moderate physical activity	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure
176. <b>walk</b> 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.	<input type="text"/> → # DAYS OR <input type="radio"/> No walking for at least 10 mins	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure

During the <b>past 7 days</b> , how much time did you...	
177. usually spend <b>sitting</b> on a <b>weekday</b> ? 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.	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure
178. usually spend <b>standing</b> on a <b>weekday</b> ? This includes standing while at work, at home, and during leisure time.	<input type="text"/> AND <input type="text"/> HOURS PER DAY MINUTES PER DAY <input type="radio"/> Not sure

179. How similar was your level of activity this past week to your usual level of activity?
- Less than usual
  - About the same
  - More than usual



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

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

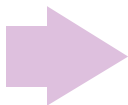
Since January 1, 2017, which (if any) of these special diets have you followed for longer than a month, other than during pregnancy?	NO	YES	a. How long did you follow this diet?	b. Have you followed this diet for <b>at least a month in the past year?</b>
182. Vegetarian	<input type="radio"/> No	<input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



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

No → GO TO QUESTION 188 ON NEXT PAGE

Yes



<p>187a. In the last 12 months, have you had a chemical relaxer or straightener applied to your hair?</p>	<p><input type="radio"/> No  <input type="radio"/> Yes → Q187c</p>				
<p>187b. If No, how old were you when you last had a chemical relaxer or straightener applied to your hair?</p>	<table border="1" style="margin: auto;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table>			AGE	
AGE					

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



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

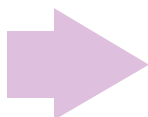
	Not at all	Less than 30 minutes per day	30 minutes or more per day
a. Winter season	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Spring season	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Summer season	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Fall season	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

AND   PER WEEK  
 HOURS MINUTES

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

No



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

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

**GO TO QUESTION 202 ON PAGE 59**

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



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

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

	JOB 1	JOB 2
192. When did you first start this job?	<input type="radio"/> Before 2017 <input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> 2020 <input type="radio"/> 2021	<input type="radio"/> Before 2017 <input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> 2020 <input type="radio"/> 2021
193. When did you last have this job?	<input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> 2020 <input type="radio"/> 2021 <input type="radio"/> I still work there	<input type="radio"/> 2017 <input type="radio"/> 2018 <input type="radio"/> 2019 <input type="radio"/> 2020 <input type="radio"/> 2021 <input type="radio"/> I still work there
194. Where did/do you work? Please write down the name of the company you worked for and the <b>full street address</b> 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.	<input type="text"/> NAME OF COMPANY/PLACE OF WORK  <input type="text"/> STREET #  <input type="text"/> STREET NAME  <input type="text"/> SUITE #  <input type="text"/> CITY OR TOWN  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> STATE                      ZIP CODE  <input type="text"/> COUNTY	<input type="text"/> NAME OF COMPANY/PLACE OF WORK  <input type="text"/> STREET #  <input type="text"/> STREET NAME  <input type="text"/> SUITE #  <input type="text"/> CITY OR TOWN  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> STATE                      ZIP CODE  <input type="text"/> COUNTY





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





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

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



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

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

	Excellent	Very good	Good	Fair	Poor
a. In general, would you say your health is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. In general, would you say your quality of life is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. In general, how would you rate your physical health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. In general, how would you rate your mental health, including your mood and your ability to think?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. In general, how would you rate your satisfaction with your social activities and relationships?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

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

- No
- Yes



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

- Never
- Rarely
- Sometimes
- Often
- Always

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

- None
- Mild
- Moderate
- Severe
- Extremely severe

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

No pain											Worst imaginable pain
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
0	1	2	3	4	5	6	7	8	9	10	

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

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



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

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



<p>Have you ever been <i>-treated unfairly...</i></p> <p style="text-align: right;">NO</p>	<p>YES</p>	<p>a. Has this happened in the <b>past five years?</b></p>	<p>b. If yes, about how often has this happened in the <b>past five years?</b></p>	<p>c. What do you think is the <b>main reason</b> for these experiences? (<i>Please mark all that apply.</i>)</p>
<p>210. in home renting, buying, or mortgage?</p> <p style="text-align: right;"><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p>	<p><input type="radio"/> No <input type="radio"/> Yes</p>	<p><input type="radio"/> Less than once a year <input type="radio"/> A few times a year <input type="radio"/> A few times a month <input type="radio"/> At least once a week <input type="radio"/> Almost daily</p>	<p><input type="radio"/> Race or ethnicity <input type="radio"/> Sexual orientation <input type="radio"/> Age <input type="radio"/> Gender <input type="radio"/> Religion <input type="radio"/> Weight <input type="radio"/> Education/income level <input type="radio"/> Disability or illness <input type="radio"/> Other, specify: <input style="width: 100%; height: 20px;" type="text"/></p>
<p>211. in being stopped, searched, or threatened by police?</p> <p style="text-align: right;"><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p>	<p><input type="radio"/> No <input type="radio"/> Yes</p>	<p><input type="radio"/> Less than once a year <input type="radio"/> A few times a year <input type="radio"/> A few times a month <input type="radio"/> At least once a week <input type="radio"/> Almost daily</p>	<p><input type="radio"/> Race or ethnicity <input type="radio"/> Sexual orientation <input type="radio"/> Age <input type="radio"/> Gender <input type="radio"/> Religion <input type="radio"/> Weight <input type="radio"/> Education/income level <input type="radio"/> Disability or illness <input type="radio"/> Other, specify: <input style="width: 100%; height: 20px;" type="text"/></p>
<p>212. in receiving service at a store, restaurant, or other business?</p> <p style="text-align: right;"><input type="radio"/> No</p>	<p><input type="radio"/> Yes</p>	<p><input type="radio"/> No <input type="radio"/> Yes</p>	<p><input type="radio"/> Less than once a year <input type="radio"/> A few times a year <input type="radio"/> A few times a month <input type="radio"/> At least once a week <input type="radio"/> Almost daily</p>	<p><input type="radio"/> Race or ethnicity <input type="radio"/> Sexual orientation <input type="radio"/> Age <input type="radio"/> Gender <input type="radio"/> Religion <input type="radio"/> Weight <input type="radio"/> Education/income level <input type="radio"/> Disability or illness <input type="radio"/> Other, specify: <input style="width: 100%; height: 20px;" type="text"/></p>
<p>213. in job hiring, promotion, or firing?</p> <p style="text-align: right;"><input type="radio"/> No <input type="radio"/> Not applicable (See below)</p> <p><i>If you have never held a job other than homemaking that took at least 10 hours a week, where you worked for one year or longer, please answer <b>Not Applicable</b>.</i></p>	<p><input type="radio"/> Yes</p>	<p><input type="radio"/> No <input type="radio"/> Yes</p>	<p><input type="radio"/> Less than once a year <input type="radio"/> A few times a year <input type="radio"/> A few times a month <input type="radio"/> At least once a week <input type="radio"/> Almost daily</p>	<p><input type="radio"/> Race or ethnicity <input type="radio"/> Sexual orientation <input type="radio"/> Age <input type="radio"/> Gender <input type="radio"/> Religion <input type="radio"/> Weight <input type="radio"/> Education/income level <input type="radio"/> Disability or illness <input type="radio"/> Other, specify: <input style="width: 100%; height: 20px;" type="text"/></p>



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

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

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

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

- No
- Yes
- Don't know





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

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

(mark one)

		:		
(hr)			(min)	

AM  
 PM

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

(mark one)

		:		
(hr)			(min)	

AM  
 PM

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

(mark one)

		:		
(hr)			(min)	

AM  
 PM

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

(mark one)

		:		
(hr)			(min)	

AM  
 PM

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

--	--

# HOURS



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

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

# HOURS

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

HOUR

MINUTES

AM

PM

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

# HOURS

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

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

# HOURS

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

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

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

- Not at all dependent
- Slightly dependent
- Fairly dependent
- Very dependent



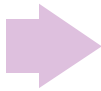
228. In the **past 7 days**...

	Not At All	A Little Bit	Some-what	Quite A Bit	Very Much
a. my sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I was satisfied with my sleep.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. my sleep was refreshing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I had difficulty falling asleep.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I had trouble staying asleep.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

No → **GO TO QUESTION 230**

Yes



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

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

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

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



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

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

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

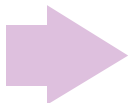
- Very good
- Fairly good
- Fairly bad
- Very bad

Have you ever been told...	NEVER OR BEFORE 1/1/2017	1/1/2017 OR LATER	a. If yes, has this happened more than 3 times since 1/1/2017?	b. If you first knew this after 1/1/2017, what was the year, or how old were you?												
233. or suspected yourself, that you seem to "act out your dreams" while asleep?  <i>For example, punching or flailing arms in the air, making running movements, shouting, or screaming.</i>	<input type="radio"/> Never  <input type="radio"/> Yes, first knew this before 1/1/2017	<input type="radio"/> Yes, first knew this after 1/1/2017	<input type="radio"/> No  <input type="radio"/> Yes (more than 3 times)	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">2</td> <td style="border: 1px solid black; width: 20px; text-align: center;">0</td> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td colspan="4" style="text-align: center;">YEAR</td> </tr> </table> </div> <p style="text-align: center;">OR</p> <div style="border: 1px solid black; padding: 5px; display: inline-block;"> <table style="border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px;"></td> <td style="border: 1px solid black; width: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">AGE</td> </tr> </table> </div>	2	0			YEAR						AGE	
2	0															
YEAR																
AGE																

234. Have you ever been told that you sleepwalk?

No → GO TO QUESTION 235 ON NEXT PAGE

Yes



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

YEAR			

OR

AGE	

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

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



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

No → **GO TO QUESTION 236**

Yes 

235a. When were you <b>first</b> told you had sleep apnea?	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	MONTH YEAR
235b. Do you <b>currently</b> have this condition?	<input type="radio"/> No <input type="radio"/> Yes
235c. Do you <b>currently</b> use a continuous positive airway pressure machine (CPAP)? <i>Please include BiPAP (bi-level PAP), VPAP (variable PAP), and APAP (auto-titrating PAP) machines.</i>	<input type="radio"/> No <input type="radio"/> Yes

	NO	YES
236. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	<input type="radio"/>	<input type="radio"/>
237. Has anyone observed you stop breathing during your sleep?	<input type="radio"/>	<input type="radio"/>

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

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



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

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

Yes



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



240. Have you moved since January 1, 2017?

No → GO TO QUESTION 241 ON NEXT PAGE

Yes

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

		/	2	0		
MONTH			YEAR			

240b. Please write down your current address.

--	--	--	--	--	--	--	--	--	--	--	--

STREET #

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

STREET NAME

--	--	--	--	--	--	--	--	--	--

APT #

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

CITY OR TOWN

--	--	--	--

STATE

--	--	--	--	--	--	--	--

ZIP CODE

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

COUNTY

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

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NAME OF NEAREST CROSS STREET



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

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

GO TO QUESTION 242 ON NEXT PAGE

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



241a. What was the approximate date you started feeling sick? *If you had this more than once, report for the time when you were the most sick.*

		/	2	0		
MONTH			YEAR			

241b. How many days until you recovered? That is, how many days until you felt well enough to resume your normal activities?

# DAYS	

Not yet recovered →

b1. Approximately how many days have you been sick so far?

# DAYS	

241c. Were you admitted to the hospital? *Do NOT include visit(s) to the Emergency Department only.*

No → GO TO QUESTION 242 ON NEXT PAGE

Yes →

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

# DAYS	

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

- No
- Yes





242. Have you ever been tested for an ACTIVE COVID-19 infection? This tests for virus causing infection at that time. (Do NOT include antibody tests, blood tests used to measure past infection with COVID-19.)

No → GO TO QUESTION 243

Yes (nasal or throat swab, or saliva sample)



242a. Have you ever had a positive test result for COVID-19 infection?

- No
- Still waiting for results

} GO TO QUESTION 243

Yes → b. What was the sample collection date of the first positive test?

		/	2	0		
MONTH			YEAR			

c. Was it confirmed with a second test?

- No
- Yes



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

No

Yes



Please specify:

---

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](mailto:update@sisterstudy.org)

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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!***

