

Mayo Clinic Biobank Questionnaire

Your name:

First Name/Middle Initial

Last Name

Your date of birth: _____/_____/_____

Month Day Year

Please enter today's date and your clinic number.

| TODAY'S DATE | | | |
|----------------------------|-------------------------|------------------------------------|------------------------------------|
| MONTH | DAY | YEAR | |
| <input type="radio"/> Jan | | 2 | 0 |
| <input type="radio"/> Feb | | | |
| <input type="radio"/> Mar | <input type="radio"/> 0 | <input type="radio"/> 0 | <input checked="" type="radio"/> 0 |
| <input type="radio"/> Apr | <input type="radio"/> 1 | <input type="radio"/> 1 | <input type="radio"/> 1 |
| <input type="radio"/> May | <input type="radio"/> 2 | <input checked="" type="radio"/> 2 | <input type="radio"/> 2 |
| <input type="radio"/> June | <input type="radio"/> 3 | <input type="radio"/> 3 | <input type="radio"/> 3 |
| <input type="radio"/> July | <input type="radio"/> 4 | <input type="radio"/> 4 | <input type="radio"/> 4 |
| <input type="radio"/> Aug | <input type="radio"/> 5 | <input type="radio"/> 5 | <input type="radio"/> 5 |
| <input type="radio"/> Sept | <input type="radio"/> 6 | <input type="radio"/> 6 | <input type="radio"/> 6 |
| <input type="radio"/> Oct | <input type="radio"/> 7 | <input type="radio"/> 7 | <input type="radio"/> 7 |
| <input type="radio"/> Nov | <input type="radio"/> 8 | <input type="radio"/> 8 | <input type="radio"/> 8 |
| <input type="radio"/> Dec | <input type="radio"/> 9 | <input type="radio"/> 9 | <input type="radio"/> 9 |

| CLINIC NUMBER | | | | | |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
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| <input type="radio"/> 0 | <input type="radio"/> 0 | <input type="radio"/> 0 | <input type="radio"/> 0 | <input type="radio"/> 0 | <input type="radio"/> 0 |
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INSTRUCTIONS

- Please take the time to read and answer each question carefully by marking the response that best represents your answer.
- If you are not *exactly* sure of an answer, please provide your best guess.
- When completed, **mail the survey** to the Mayo Clinic Biobank, Harwick Building, 6th Floor, in the pre-addressed, pre-paid envelope provided. Rochester (only) participants also have the option to **drop the survey off** at Desk CA in the Hilton Building subway.

MARKING INSTRUCTIONS

- Use a No. 2 pencil or a blue or black ink pen only.
- Do not use pens with ink that soaks through the paper.
- Make solid marks that fill the response completely.
- If you select the wrong response and cannot erase completely, please place an X through the incorrect response and mark the correct response.
- Make no stray marks on this form.

CORRECT: ●

INCORRECT: ✓✗○●

Place barcode label here.

PLEASE DO NOT WRITE IN THIS AREA



SERIAL

1. In general, would you say your health is...

- Excellent
- Very good
- Good
- Fair
- Poor

2. **Compared to one year ago, how would you rate your health in general now?**

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same
- Somewhat worse now than one year ago
- Much worse now than one year ago

3. **Thinking about people your age, would you say that you are in better physical shape, about the same, or worse physical shape compared to others your age?**

- Better physical shape
- About the same physical shape
- Worse physical shape

4. How would you describe...

your overall quality of life?

As bad as it can be ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your overall mental (intellectual) well-being?

As bad as it can be ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your overall physical well-being?

As bad as it can be ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your overall emotional well-being?

As bad as it can be ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your level of social activity?

As bad as it can be ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your overall spiritual well-being?

As bad as it can be ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

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9. During the *past 2 weeks*, how often have you been bothered by feeling down, depressed, or hopeless?

- Not at all
- Some
- Several days
- More than half the days
- Nearly every day
- Don't know

10. During the *past 2 weeks*, how often have you been bothered by having little interest or little pleasure in doing things?

- Not at all
- Some
- Several days
- More than half the days
- Nearly every day
- Don't know

11. Have you ever had a period lasting 4 days or longer when you became so happy or excited that you either got into trouble, people worried about you, or a doctor said you were manic?

- No
- Yes

12. In the *past 30 days*, have you experienced heartburn, a burning pain, or discomfort behind the breast bone in the chest?

- No
- Yes

How often does this or did this heartburn occur?

- Less than once a month
- About once a month
- About once a week
- Several times a week
- Daily

Is your heartburn better (eased) by taking antacids? (Examples: Amphojel, ALternaGEL, Gaviscon, Maalox, Mylanta, Riopan, Rolaid, Tums.)

- I do not take antacids for heartburn
- No
- Yes

In the *past 30 days*, has your heartburn awakened you at night?

- No
- Yes

In the *past 30 days*, has your heartburn often travelled up toward your neck?

- No
- Yes

13. In the *past 30 days*, have you experienced acid regurgitation, a bitter or sour-tasting fluid coming up from the stomach into your mouth or throat?

- No
- Yes

Do you experience acid regurgitation at least once a week?

- No
- Yes

14. Has your weight varied during the past 12 months?

- Remained stable Gone up more than 10 pounds Gone down more than 10 pounds

Was this weight gain intentional or unintentional?

Intentional
 Unintentional

Was this weight loss intentional or unintentional?

Intentional
 Unintentional

PERSONAL AND FAMILY MEDICAL HISTORY

15. Are you adopted? No Yes

If known, complete the following information about your **blood** relatives (include children).

16. Is your father alive? Yes, he is alive No, he is dead I don't know

If dead, what was his age at death?

Under 30 41 to 50 61 to 70 Over 85
 30 to 40 51 to 60 71 to 85

17. Is your mother alive? Yes, she is alive No, she is dead I don't know

If dead, what was her age at death?

Under 30 41 to 50 61 to 70 Over 85
 30 to 40 51 to 60 71 to 85

18. For each kind of relative below, please tell us how many you have who are alive and how many have died.

| | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ | Don't know |
|-------------------|--------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Brothers: | Number alive | <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"/> |
| | Number dead | <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"/> |
| Sisters: | Number alive | <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"/> |
| | Number dead | <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"/> |
| Sons: | Number alive | <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"/> |
| | Number dead | <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"/> |
| Daughters: | Number alive | <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"/> |
| | Number dead | <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"/> |

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19. Please indicate the age you were first diagnosed with the following conditions. If you have not been diagnosed with this condition, mark "None."

In addition, please indicate whether or not your family members have had this condition by marking "Yes," "No," or "Don't know." We are only interested in relatives that are related to you by blood.

| | <u>Self</u> | | | | | | <u>Relatives</u> | | |
|--|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|--|-----------------------|-----------------------|
| | Age when this condition was first diagnosed. | | | | | | Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition? | | |
| | None | 19 or younger | 20 to 49 | 50 to 64 | 65 to 79 | 80 or older | No | Yes | Don't know |
| <u>Rheumatologic</u> | | | | | | | | | |
| Arthritis (osteoarthritis) | <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"/> |
| Arthritis (rheumatoid) | <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"/> |
| Fibromyalgia | <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"/> |
| Autoimmune disorder (lupus, scleroderma) | <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"/> |
| <u>Gynecologic</u> | | | | | | | | | |
| Endometriosis | <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"/> |
| <u>Liver</u> | | | | | | | | | |
| Hepatitis A, B, or C | <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"/> |
| Other liver disease | <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"/> |
| <u>Hematologic</u> | | | | | | | | | |
| Organ or bone marrow transplant | <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"/> |
| Bleeding disorder | <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"/> |
| Sickle cell anemia | <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"/> |
| <u>Infectious Diseases</u> | | | | | | | | | |
| HIV (AIDS) | <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"/> |
| Tuberculosis | <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"/> |
| <u>Cancer</u> | | | | | | | | | |
| Thyroid cancer | <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"/> |
| Lung cancer | <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"/> |
| Breast cancer | <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"/> |
| Esophageal cancer | <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"/> |
| Pancreatic cancer | <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"/> |
| Stomach cancer | <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"/> |
| Colon or rectal cancer | <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"/> |
| Liver cancer | <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"/> |
| Uterine/endometrial cancer | <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"/> |
| Cervical cancer | <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"/> |
| Ovarian cancer | <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"/> |
| Prostate cancer | <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"/> |

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Self

Relatives

Age when this condition was first diagnosed.

Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition?

| | Self | | | | | | Relatives | | |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | None | 19 or younger | 20 to 49 | 50 to 64 | 65 to 79 | 80 or older | No | Yes | Don't know |
| Eye | | | | | | | | | |
| Glaucoma | <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"/> |
| Cataracts | <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"/> |
| Abnormal distance vision | <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"/> |
| Lazy eye (amblyopia) | <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"/> |
| Misalignment, crossing, or wandering of the eyes (strabismus) | <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"/> |
| Macular degeneration | <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"/> |
| Cardiovascular | | | | | | | | | |
| Heart attack/myocardial infarction | <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"/> |
| Coronary artery disease | <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"/> |
| Congestive heart failure | <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"/> |
| Cardiomyopathy | <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"/> |
| Atrial fibrillation/arrhythmia | <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"/> |
| Congenital heart disease | <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"/> |
| High blood pressure (hypertension) | <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"/> |
| High cholesterol (hyperlipidemia) | <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"/> |
| Blood clots in a vein | <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"/> |
| Respiratory | | | | | | | | | |
| Asthma | <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"/> |
| Chronic obstructive pulmonary disease (COPD) | <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"/> |
| Sleep apnea | <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"/> |
| Asbestosis | <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"/> |
| Pulmonary fibrosis | <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"/> |
| Gastrointestinal | | | | | | | | | |
| Acid reflux or gastroesophageal reflux disorder (GERD) | <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"/> |
| Barrett's esophagus | <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"/> |
| Celiac disease | <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"/> |
| Irritable bowel syndrome (IBS) | <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"/> |
| Crohn's disease or ulcerative colitis | <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"/> |
| Lynch syndrome or HNPCC | <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"/> |
| Other polyposis syndrome (FAP, Peutz-Jeghers, juvenile polyposis, etc.) | <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"/> |

63 26. Have you had your uterus removed or was your last menstrual period more than
62 12 months ago?

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60 No — Skip to question 27 below.
59 Yes

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56 How old were you when you entered menopause? →

AGE

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52 What was the reason your periods stopped?
51 (Select only one answer.)

- 50
49 Natural menopause (change of life)
48 Because of hysterectomy or removal of ovaries (or both)
47 Took medication that stopped my period
46 Radiation/chemotherapy
45 Other

0 0
1 1
2 2
3 3
4 4
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40 27. Have you ever been pregnant?

- 39
38 No — Skip to question 28 on page 11.
37 Yes

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35
34 How many times have you been pregnant? (Include all stillbirths, miscarriages, ectopic or tubal
33 pregnancies, induced abortions, and current pregnancy, if applicable.)

- 32
31 1 2 3 4 5 6 7 8 9 or more

30
29 How many pregnancies resulted in a live birth? (Count multiple births as one birth.)

- 28
27 0 — Skip to question 28 on page 11.

- 26
25 1 2 3 4 5 6 7 8 9 or more

24
23 What was your age when your first child was born?

- 22
21 17 or younger 20 to 24 35 to 39
20 18 25 to 29 40 or older
19 19 30 to 34

18
17 How many of your children did you breast-feed for more than one month?

- 16
15 Did not breast-feed any 6 to 10 children
14 1 to 2 children 11 children or more
13 3 to 5 children

12
11 What was your age when your last child was born?

- 10
9 17 or younger 20 to 24 35 to 39
8 18 25 to 29 40 or older
7 19 30 to 34

6
5 Are you pregnant right now?

- 4
3 No Yes Don't know
2
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28. Have you ever used birth control pills, patches, implants, or shots?

- No Yes, currently Yes, but not currently

What is the total time you used birth control pills, patches, or shots?
(If you have stopped and started several times, please count combined years of use.)

- 6 months or less 1 to 2 years 6 to 11 years
 7 to 11 months 3 to 5 years 11 years or more

29. Have you ever taken hormone replacement therapy other than birth control pills (eg, estrogen, estrogen/progesterone combination)?

- No Yes, currently Yes, but not currently

What type are you taking now or most recently? (Mark all that apply.)

- Estrogen alone Other
 Estrogen and progesterone combination (eg, Provera or Prempro) Don't know

How old were you when you first began taking any hormone therapy? →

AGE

| | |
|---|---|
| | |
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
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| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

How many years have you taken any hormone therapy? →

NUMBER OF YEARS

| | |
|---|---|
| | |
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
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| 8 | 8 |
| 9 | 9 |

30. Have you ever taken tamoxifen (Nolvadex)?

- No Yes, currently Yes, but not currently Don't know

How long have you taken tamoxifen?

- 1 month or less 3 to 5 years
 1 to 6 months 5 years or more
 7 to 11 months Don't know how long
 1 to 2 years

31. Do you perform monthly breast self-exams? No Yes

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32. Do you examine your own testicles monthly?

- No
- Yes

33. Have you ever had a prostate-specific antigen (PSA) blood test?

- No
- Yes
- Don't know

Did you ever have an abnormal test?

- No
- Yes
- Don't know

When was the last time you had an abnormal test?

- A year ago or less
- More than 1 but not more than 2 years ago
- More than 2 but not more than 5 years ago
- More than 5 years ago
- Don't know

HEALTH BEHAVIORS

34. Have you seen a dentist for a general check-up and teeth cleaning within the *last 12 months*?

- No
- Yes

35. How often do you protect your skin from the sun by using sunblock (SPF 15 or greater) or by wearing protective clothing such as a hat and a long-sleeved shirt when you go outside?

- Always
- Sometimes
- Never

36. How often do you wear a seatbelt when driving or riding in a motor vehicle?

- Always
- Sometimes
- Never

37. How often do you drive or ride in a car or other motor vehicle when the driver has been using drugs, has had 3 or more drinks, or is driving under the influence?

- Daily
- Rarely to weekly
- Never

38. How often do you wear a helmet when riding a motorcycle, bicycle, snowmobile, rollerblades, or all-terrain vehicle?

- Always
- Sometimes
- Never
- I do not participate in these activities

39. Do you have a working fire extinguisher in your home?

- No
- Yes
- Don't know

PLEASE DO NOT WRITE IN THIS AREA



SERIAL

3/8" SPINE PERF

40. Do you have working smoke detectors in your home?

- No
- Yes
- Don't know

41. On average, how many times a day do you eat high-fat food such as red meat, fried food, whole milk, regular cheese, ice cream, baked goods, or regular salad dressing?

- 0 to 1
- 2
- 3 or more

42. How many servings of fruit do you eat during a typical day?

(One serving: 1 medium piece of fruit or ¾ cup fruit juice.)

- 0 to 1
- 2
- 3
- 4
- 5 or more

43. How many servings of vegetables do you eat during a typical day?

(One serving: 1 cup raw, leafy vegetables, ½ cup cooked vegetables, or ¾ cup vegetable juice.)

- 0 to 1
- 2
- 3
- 4
- 5 or more

44. How many servings of milk and other dairy products or calcium supplements do you get in an average day?

- 1 or no servings (or less than 600 mg dose supplements)
- 2 to 3 servings (or between 600 and 1,200 mg dose supplements)
- 4 or more servings (or more than 1,200 mg dose supplements)

45. How many servings of diet soft drinks do you have per day? (A serving size is 1 can or glass.)

- None
- 1 to 2 servings
- 3 to 4 servings
- 5 to 6 servings
- 7 to 9 servings
- 10 or more servings

46. How many servings of regular (nondiet) soft drinks do you have per day?

(A serving size is 1 can or glass.)

- None
- 1 to 2 servings
- 3 to 4 servings
- 5 to 6 servings
- 7 to 9 servings
- 10 or more servings

47. How many cups of coffee, caffeinated or decaffeinated, do you drink?

None — Skip to question 48 on page 14.

- Less than 1 cup per month
- 1 cup per week
- 2 to 4 cups per week
- 5 to 6 cups per week
- 1 cup per day
- 2 to 3 cups per day
- 4 to 5 cups per day
- 6 or more cups per day

How often is the coffee you drink decaffeinated?

- Never or almost never
- About ¼ of the time
- About ½ of the time
- About ¾ of the time
- Always or almost always

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48. For the job (includes homemaking) you have held the longest, approximately how much of the time were you engaged in each of the following physical activities?

| None of the time | A little of the time | Some of the time | Most of the time | All of the time |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <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"/> | <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"/> | <input type="radio"/> |

- Sitting
- Standing
- Walking
- Light manual labor
- Heavy manual labor

49. Considering a 7-day period (a week), how many times on average do you do the following kinds of exercise for more than 15 minutes during your free time?

| None | 1 time | 2 times | 3 times | 4 times | 5 times | 6 times | 7 times | 8 times or more |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <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"/> | <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"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

- Strenuous exercise (heart beats rapidly)**
(ie, running, jogging, vigorous swimming, vigorous long-distance bicycling, hockey, basketball, cross-country skiing, soccer)
- Moderate exercise (not exhausting)**
(ie, fast walking, easy swimming, alpine skiing, popular and folk dancing, tennis, easy bicycling, baseball, volleyball)
- Mild exercise (minimal effort)**
(ie, easy walking, archery, bowling, horseshoes, golf, snowmobiling)

50. How often did you have a drink containing alcohol in the *past 12 months*?
(Consider a "drink" to be a can or bottle of beer, a glass of wine, a wine cooler, or 1 cocktail or a shot of hard liquor, eg, scotch, gin, or vodka.)

- Never — Skip to question 51 on page 15.
- Once a month or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 to 5 times a week
- 6 or more times a week

How many drinks did you have on a typical day when you were drinking in the *past 12 months*?

- 0 to 2 drinks
- 3 to 4 drinks
- 5 to 6 drinks
- 7 to 9 drinks
- 10 or more drinks

How often did you have 6 or more drinks on one occasion in the *past 12 months*?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

38" SPINE PERF

51. Have you used any of these tobacco products for 12 months or longer?
 (Please mark a response for each tobacco product.)

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3
2
1

Cigar

Pipe

Snuff

Chewing tobacco

- No
 Yes

For how many years?

NUMBER OF YEARS

| | |
|---|---|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

- No
 Yes

For how many years?

NUMBER OF YEARS

| | |
|---|---|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

- No
 Yes

For how many years?

NUMBER OF YEARS

| | |
|---|---|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

- No
 Yes

For how many years?

NUMBER OF YEARS

| | |
|---|---|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

52. Have you smoked at least 100 cigarettes in your entire life?

- No Yes Don't know/not sure

How old were you when you first started smoking cigarettes on a regular basis? →

AGE

| | |
|---|---|
| | |
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

On average, how many cigarettes do/did you smoke per day?

- 1 to 10 per day 31 to 40 per day
 11 to 20 per day 41 or more per day
 21 to 30 per day

Do you currently smoke cigarettes?

- No
 Yes

What year did you quit? →

YEAR

| | | | |
|---|---|---|---|
| | | | |
| 0 | 0 | 0 | 0 |
| 1 | 1 | 1 | 1 |
| 2 | 2 | 2 | 2 |
| 3 | 3 | 3 | 3 |
| 4 | 4 | 4 | 4 |
| 5 | 5 | 5 | 5 |
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| 7 | 7 | 7 | 7 |
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56. During the *past 12 months*, have you used the following medicines on a regular basis, that is, at least once per week? If so, please indicate how long you have taken each medication.

| | Less than 1 year | 1 to 5 years | 6 to 10 years | 11 years or more |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Advil, Aleve, Motrin, or other nonsteroidal, anti-inflammatory drugs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Celebrex, Vioxx, or Bextra | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Aspirin — full dose or extra strength | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Tylenol | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other drug taken for pain relief | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Aspirin — low dose or baby strength taken for prevention of heart disease or stroke | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Insulin | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Glucophage | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| DiaBeta, Diabinese, Glucotrol, or Micronase | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Actos, Avandia, or Rezulin | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other drug taken for diabetes mellitus (sugar diabetes) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

None of these

ENVIRONMENT

57. What is the nature of the business or industry where you have worked during the majority of your life? (Please select one.)

- | | |
|---|--|
| <input type="radio"/> Active Duty Military | <input type="radio"/> Services: Educational, Health, and Social |
| <input type="radio"/> Construction | <input type="radio"/> Services: Professional, Scientific, Management, and Administrative |
| <input type="radio"/> Farming, Forestry, Fishing, and Hunting | <input type="radio"/> Services: Waste Management |
| <input type="radio"/> Finance, Insurance, Real Estate, and Rental and Leasing | <input type="radio"/> Services: Other (except Public Administration) |
| <input type="radio"/> Information and Communications | <input type="radio"/> Telecommunications |
| <input type="radio"/> Manufacturing/Production | <input type="radio"/> Transportation and Warehousing |
| <input type="radio"/> Mining | <input type="radio"/> Utilities |
| <input type="radio"/> Public Administration | <input type="radio"/> Wholesale Trade |
| <input type="radio"/> Retail Trade | <input type="radio"/> Other, please specify: _____ |
| <input type="radio"/> Services: Arts, Entertainment, Recreation, Accommodations, and Food | <input type="radio"/> None of the above |

58. Are, or were you ever, regularly exposed to any of the following substances? (Please mark a response for each substance.)

| | No | Yes | Don't know |
|--|-----------------------|-----------------------|-----------------------|
| Asbestos | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Benzene or derivatives | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Chlorinated hydrocarbons (CHC), solvents, or related compounds | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Chromium/chromium compounds | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Coal dust | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Nickel/nickel compounds | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Radioactive substance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Taconite | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

63 59. Where do you currently live most of the year?

- On a working farm or ranch
- In a rural home or hobby farm, not a working farm or ranch
- In a suburb, city, or village
- Other

57 60. Have you ever lived on a working farm?

- No
- Yes

What type of farm was it? (Mark all that apply.)

- Commercial
- Dairy
- Cattle
- Agricultural

48 61. Have you ever personally mixed or applied fertilizer to add nutrients to the soil?

(Include fertilizer used for farm use, commercial application, and/or personal use in your home or garden.)

- No
- Yes

How many years did you personally mix or apply fertilizers?

(One growing season = 1 year.)

- 1 year or less
- 2 to 5 years
- 6 to 10 years
- 11 to 20 years
- 21 to 30 years
- 31 years or more

34 62. Have you ever personally mixed or applied any insecticides to kill insects?

(Include crop, livestock, and structural insecticides and fumigants. Include insecticides used for farm use, commercial application, and/or personal use in your home or garden.)

- No
- Yes

How many years did you personally mix or apply insecticides?

(One growing season = 1 year.)

- 1 year or less
- 2 to 5 years
- 6 to 10 years
- 11 to 20 years
- 21 to 30 years
- 31 years or more

19 63. Have you ever personally mixed or applied herbicides to kill weeds or fungicides to kill mold or fungus?

(Include crop and livestock herbicides or fungicides for farm use, commercial application, and/or personal use in your home or garden.)

- No
- Yes

How many years did you personally mix or apply herbicides or fungicides?

(One growing season = 1 year.)

- 1 year or less
- 2 to 5 years
- 6 to 10 years
- 11 to 20 years
- 21 to 30 years
- 31 years or more

PLEASE DO NOT WRITE IN THIS AREA



SERIAL

64. Do you consider yourself to be Hispanic or Latino?

- No, not Hispanic/Latino
- Yes, Hispanic/Latino

Are you...

- Mexican-American
- Mexican
- Ecuadorian

- Puerto Rican
- Other, please specify:

65. Which of the following do you consider yourself? (Mark all that apply.)

Asian

Black or African American

White

American Indian or Alaskan Native

Native Hawaiian or other Pacific Islander

Other, please specify:

Are you...

- Cambodian
- Laotian
- Hmong
- Vietnamese
- Other, please specify:

Are you...

- Somali
- Amharic
- Nigerian
- Oromo
- Liberian
- U.S.-born
- Other, please specify:

66. If you checked more than one in the previous question, with which do you identify the most? (Mark only one.)

- Asian
- Black or African American
- White
- American Indian or Alaskan Native
- Native Hawaiian or other Pacific Islander
- Multi-racial
- Other

67. Are you currently...

- Married
- Living with someone in a marriage-like relationship
- Separated
- Divorced
- Widowed
- Never been married

68. Were you born in the United States?

- No
- Yes

How many years have you lived in the United States?

NUMBER OF YEARS

What country were you born in?

| | | |
|---|---|---|
| 0 | 0 | 0 |
| 1 | 1 | 1 |
| 2 | 2 | 2 |
| 3 | 3 | 3 |
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