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1. In general, ...

	Excellent	Very good	Good	Fair	Poor
would you say your health is...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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"/>
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"/>

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

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

3. 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.	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?		
	None	19 or younger	20 to 49	50 to 64	65 to 79	80 or older	No	Yes	Don't know
Rheumatologic									
Osteoarthritis (cartilage wear)	<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"/>
Rheumatoid arthritis (swollen joints, autoimmune 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"/>
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"/>
Gynecologic									
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"/>
Liver									
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"/>
Hematologic									
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"/>
Cancer									
Bone 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"/>
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"/>
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"/>
Kidney 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"/>
Leukemia	<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"/>

SelfAge when this condition
was first diagnosed.**Relatives**Do or did any of your first-
degree relatives (parents,
sisters, brothers, children)
have this condition?**Cancer (continued)**

	None ▼	19 or younger ▼	20 to 49 ▼	50 to 64 ▼	65 to 79 ▼	80 or older ▼	No ▼	Yes ▼	Don't know ▼
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"/>
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"/>
Lymphoma	<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"/>
Melanoma	<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"/>
Nonmelanoma skin 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"/>
Sarcoma	<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"/>
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"/>
Urinary/bladder 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"/>
Other 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"/>
Women only:									
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"/>
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"/>
Men only:									
Testicular 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"/>

Neurologic

Alzheimer's 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"/>
Parkinson's 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"/>
Dementia	<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"/>
Migraine headaches	<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"/>
Stroke (CVA)	<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"/>
TIA (mini stroke)	<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"/>
Epilepsy (seizure 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"/>

Mental Health

Anxiety	<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"/>
Depression	<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"/>
Bipolar 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"/>
Attention deficit/hyperactivity 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"/>
Alcoholism	<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 psychiatric or mental illness	<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"/>

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"/>
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"/>

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PLEASE DO NOT WRITE IN THIS AREA



[SERIAL]

		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?		
		None	19 or younger	20 to 49	50 to 64	65 to 79	80 or older	No	Yes	Don't know
<u>Cardiovascular</u>										
	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"/>
	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"/>
<u>Respiratory</u>										
	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"/>
	Emphysema or 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"/>
	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"/>
<u>Endocrine</u>										
	Diabetes	<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"/>
	Hyperthyroidism	<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"/>
	Hypothyroidism	<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>Gastrointestinal</u>										
	Acid reflux or 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"/>
	Kidney stones	<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"/>

4. In the last 3 months, how often did you have discomfort or pain anywhere in your abdomen?

- ☐ Never — Skip to question 14 on page 5.
☐ Less than 1 day a month
☐ 1 day a month
☐ 2 to 3 days a month
☐ 1 day a week
☐ More than 1 day a week
☐ Every day

5. **For women:** Did this discomfort or pain occur only during your menstrual bleeding and not at other times?

- ☐ No ☐ Yes ☐ Does not apply because I have had the change of life (menopause) or I am a male

6. Have you had this discomfort or pain 6 months or longer?

- ☐ No ☐ Yes

Never
or rarely

Sometimes

Often

Most of
the time

Always

7. How often did this discomfort or pain get better or stop after you had a bowel movement?

☐ ☐ ☐ ☐ ☐

8. When this discomfort or pain started, did you have more frequent bowel movements?

☐ ☐ ☐ ☐ ☐

9. When this discomfort or pain started, did you have less frequent bowel movements?

☐ ☐ ☐ ☐ ☐

10. When this discomfort or pain started, were your stools (bowel movements) looser?

☐ ☐ ☐ ☐ ☐

11. When this discomfort or pain started, how often did you have harder stools?

☐ ☐ ☐ ☐ ☐

12. In the last 3 months, how often did you have hard or lumpy stools?

☐ ☐ ☐ ☐ ☐

13. In the last 3 months, how often did you have loose, mushy, or watery stools?

☐ ☐ ☐ ☐ ☐

14. Do you currently have a daily cough that has lasted for 8 weeks or more?

☐ No ☐ Yes ☐ Don't know

15. 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.

None

Less than
1 year

1 to 5
years

6 to 10
years

11 years
or more

Aspirin — full or extra strength

☐ ☐ ☐ ☐ ☐

Aspirin — low dose

☐ ☐ ☐ ☐ ☐

Tylenol

☐ ☐ ☐ ☐ ☐

Advil, Aleve, Motrin, or other nonsteroidal, anti-inflammatory drugs

☐ ☐ ☐ ☐ ☐

Cox 2 inhibitors (Celebrex, Vioxx, Bextra, etc.)

☐ ☐ ☐ ☐ ☐

Other drug taken for pain relief

☐ ☐ ☐ ☐ ☐

16. Do you currently smoke cigarettes?

☐ No ☐ Yes

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

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

17. Do you currently use chewing tobacco, snuff, or snus every day, some days, or never?

(Snus, Swedish for snuff, is a moist smokeless tobacco, usually sold in small pouches that are placed under the lip against the gum.)

☐ Every day ☐ Some days ☐ Never

18. 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.) (If you were pregnant in the past 12 months, please report your usual intake when you were not pregnant.)

☐ Never — Skip to question 19 below.

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

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

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

19. 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**?

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)

	None	1 time	2 times	3 times	4 times	5 times	6 times	7 times	8 times or more
Strenuous exercise (heart beats rapidly) (ie, running, jogging, vigorous swimming, vigorous long-distance bicycling, hockey, basketball, cross-country skiing, soccer)	<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"/>
Moderate exercise (not exhausting) (ie, fast walking, easy swimming, alpine skiing, popular and folk dancing, tennis, easy bicycling, baseball, volleyball)	<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"/>
Mild exercise (minimal effort) (ie, easy walking, archery, bowling, horseshoes, golf, snowmobiling)	<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"/>

20. In a typical day, ...

how many servings of fruit do you eat?

how many servings of vegetables do you eat?

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

how many times do you eat high-fat food such as fried food, whole milk, regular cheese, ice cream, baked goods, or regular salad dressing?

	0 to 1	2	3	4	5 or more
how many servings of fruit do you eat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
how many servings of vegetables do you eat? (One serving: 1 cup raw, leafy vegetables, ½ cup cooked vegetables, or ¾ cup vegetable juice.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
how many times do you eat high-fat food such as fried food, whole milk, regular cheese, ice cream, baked goods, or regular salad dressing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PLEASE DO NOT WRITE IN THIS AREA



[SERIAL]

21. Over the past 2 years, on average, how often did you eat a serving of red meat (not poultry or fish) in a typical day? (A serving of red meat is: 2 to 3 ounces of red meat; or a piece about the size of a deck of cards. Red meats include: beef, steak, hamburger, prime rib, ribs, veal, lamb, pork bacon, pork sausages.)

- ☐ 0 to 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐ Don't eat red meat

22. Over the past 2 years, on average, how often did you eat a serving of fish (not poultry or meat) in a typical day? (A serving of fish is a piece about the size of a deck of cards.)

- ☐ 0 to 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐ Don't eat fish

23. Over the past 2 years, on average, how often did you eat a serving of poultry (including chicken or turkey — not meat or fish) in a typical day? (A serving of poultry is a piece about the size of a deck of cards.)

- ☐ 0 to 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐ Don't eat poultry

24. How many servings of milk and other dairy products or calcium supplements do you get in a typical 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)

25. Do you drink coffee or tea?

- ☐ No — Skip to question 26 below.
☐ Yes

If you do drink coffee or tea, please fill in for all that you drink in the four categories below.
 (1 cup = 8 ounces.)

Coffee (caffeinated)

- ☐ None
☐ 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

Coffee (decaffeinated)

- ☐ None
☐ 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

Tea (caffeinated)

- ☐ None
☐ 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

Tea (decaffeinated)

- ☐ None
☐ 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

26. How many servings of diet soft drinks (pop or soda) do you have per day?
 (A serving size is one can or glass.)

- ☐ None — Skip to question 27 on page 8.

- ☐ Less than 1 serving
☐ 1 to 2 servings
☐ 3 to 4 servings
☐ 5 to 6 servings
☐ 7 to 9 servings
☐ 10 or more servings

How many of these diet soft drinks (pop or soda) contain caffeine?

- ☐ All ☐ Some ☐ None

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27. How many servings of **regular (nondiet)** soft drinks (pop or soda) do you have per day?
(A serving size is one can or glass.)

- ☐ None — **Women skip to question 28 below; Men skip to question 30 below.**
- ☐ Less than 1 serving
- ☐ 1 to 2 servings
- ☐ 3 to 4 servings
- ☐ 5 to 6 servings
- ☐ 7 to 9 servings
- ☐ 10 or more servings

How many of these regular soft drinks (pop or soda) contain caffeine?

☐ All ☐ Some ☐ None

WOMEN ONLY

28. Have you ever used birth control pills, patches, implants, or shots?

- ☐ No ☐ Yes, currently ☐ Yes, but not currently

29. Among the following, which answer best describes your current menstrual status?
(Please choose only one response.)

- ☐ I am pregnant
- ☐ I am breast-feeding (either with or without oral contraceptive use)
- ☐ I am premenopausal and taking oral contraceptives
- ☐ I am premenopausal and not taking oral contraceptives or hormone therapy
- ☐ I began taking hormone therapy before my periods stopped and am still taking hormones
- ☐ I began taking hormone therapy before my periods stopped; I have stopped taking these hormones
- ☐ My periods have stopped on their own (naturally)
- ☐ My periods stopped after radiation or chemotherapy
- ☐ My periods stopped after surgery which removed my uterus or both ovaries

30. What is your current weight? (Please round to the nearest whole number.
If you are currently pregnant, report your prepregnancy weight.)

POUNDS

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

Thank you for taking the time to complete the survey!

Questions 4 through 13: Rome III Functional Bowel Disorders. Used by permission from the Rome Foundation. Longstreth GF et al., Functional Bowel Disorders. Gastroenterology 2006; 130:1480-1491.

Questions 18: The Alcohol Use Disorders Identification Test (AUDIT). Babor, TF, Bohn, MJ, Kranzler, HR. Validation of a screening instrument for use in medical settings. J Stud Alcohol 56(4):423-432,1995.

Question 19: Godin Leisure-Time Exercise Questionnaire. G. Godin and R. J. Shephard, A simple method to assess exercise behavior in the community, taken with permission from Can. J. Appl. Sport Sci. 10(1985), pp. 141-146. Published by NRC Research Press.

Question 29: Menopausal Status. Used by permission from the California Teacher's Study. Bernstein L, Allen, Anton-Culver H., et al. High breast cancer incidence rates among California teachers: results from the California Teacher's Study (United States). Cancer Causes Control. 202 Sep;13(7):625-35.

