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## UTERINE FIBROID STUDY



### MAIL QUESTIONNAIRE

**Thank you for agreeing to help us with this survey. Your participation is voluntary and all the information collected will be kept confidential.**

**If you have any questions please call toll free 1-800-948-7552 Extension 127 and ask for the Uterine Fibroid Study Manager.**

**Please complete this survey at home and return it in the enclosed envelope to:  
CODA, Inc., 1009 Slater Road, Suite 120, Durham, NC 27703**

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*Data collected by CODA, Inc.*

*Durham, NC*

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## SECTION A: MEDICAL HISTORY

A1. Has a doctor or health professional ever told you that you had any of the following conditions?  Check either NO or YES for each condition. For each YES, answer A2 and A3.		A2. If YES, how old were you when you were first diagnosed? AGE	A3. Did you take any prescription MEDICINE for this condition? NO YES (2) (1)	Office Use Only
	NO (2)	YES (1)		
1. Abnormal pap smear		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
2. Galactorrhea (breast milk when you were not pregnant or breastfeeding)		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. Asthma		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4. Anorexia		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
5. Mononucleosis or "mono"		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6. Depression		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
7. Hepatitis		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
8. Other liver disease		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
9. High blood pressure, not pregnancy-induced		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10. High cholesterol		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
11. Heart attack		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
12. Angina		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
13. Stroke		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
14. Anemia		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
15. Gonorrhea, "clap," or "drip"		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
16. Chlamydia or "drip"		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
17. Syphilis or "syph"		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
18. Genital warts		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
19. Genital herpes (lesions, sores, blisters)		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
20. Other sexually transmitted diseases SPECIFY: _____		IF YES ➤ AGE: <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

<p>A4. Has a doctor or health professional ever told you that you had any of the following conditions?</p> <p>Check either NO or YES for each condition. For each YES, answer A5-A7.</p> <p style="text-align: right;">NO (2)      YES (1)</p>	<p>A5. If YES, how old were you when you were first diagnosed?</p> <p style="text-align: center;">AGE</p>	<p>A6. Did you take any prescription MEDICINE for this condition?</p> <p style="text-align: center;">NO (2)      YES (1)</p>	<p>A7. Did you ever have SURGERY for this condition?</p> <p style="text-align: center;">NO (2)      YES (1)</p>
1. Ovarian cysts	IF YES → <input type="text"/> → AGE		
2. Endometriosis	IF YES → <input type="text"/> → AGE		
3. Uterine prolapse	IF YES → <input type="text"/> → AGE		
4. Pelvic inflammatory disease (PID), infection in your womb or tubes	IF YES → <input type="text"/> → AGE		
5. Polycystic ovaries or Stein Leventhal syndrome	IF YES → <input type="text"/> → AGE		
6. Abnormal menstrual bleeding	IF YES → <input type="text"/> → AGE		
7. Severe menstrual cramps	IF YES → <input type="text"/> → AGE		
8. Blood clot in your legs, lungs or eyes	IF YES → <input type="text"/> → AGE		
9. Gallbladder disease or gallstones	IF YES → <input type="text"/> → AGE		

<input type="checkbox"/>				
<input type="checkbox"/>				
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<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

A8. Has a doctor or health professional ever told you that you had cancer?

2 \_\_\_\_ No                      1 \_\_\_\_ Yes

<p>A9. What type of cancer(s) have you had?</p> <p style="text-align: center;">TYPE</p>	<p>A10. How old were you when you were first diagnosed?</p> <p style="text-align: center;">AGE</p>	<p>A11. Did you have chemotherapy?</p> <p style="text-align: center;">NO (2)      YES (1)</p>		<p>A12. Did you have radiation therapy?</p> <p style="text-align: center;">NO (2)      YES (1)</p>		<p>A13. Did you have surgery?</p> <p style="text-align: center;">NO (2)      YES (1)</p>	
a. _____	<input type="text"/>						
b. _____	<input type="text"/>						

<input type="checkbox"/>	<input type="checkbox"/>
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# Sub

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p>A14. Has a doctor or health professional ever told you that you had any of the following conditions?</p> <p>Check either NO or YES for each condition. For each YES, answer A15-A18.</p> <p style="text-align: center;">NO (2)      YES (1)</p>	<p>A15. What type of this condition did you have?</p> <p style="text-align: center;">TYPE</p>	<p>A16. How old were you when you were first diagnosed?</p> <p style="text-align: center;">AGE</p>	<p>A17. Did you take any prescription MEDICINE for this condition?</p> <p style="text-align: center;">NO (2)      YES (1)</p>	<p>A18. If YES, how many years have you taken prescription MEDICINE for this condition?</p> <p>If less than a year, please fill in months.</p>
<p>1. Thyroid condition</p>	<p>IF YES</p> <p>(1) ___ overactive (2) ___ underactive (3) ___ other</p> <p>SPECIFY OTHER: _____</p>	<p>AGE</p> <p style="text-align: center;"> _ _ </p>	<p>IF YES</p> <p>→  _ _ </p> <p>#years</p> <p style="text-align: center;"><b>OR</b></p> <p> _ _ </p> <p>#months</p>	<p> _   </p> <p> _ _   </p> <p> _     </p> <p> _     </p>
<p>2. Diabetes, high blood sugar or "sugar," not pregnancy-induced</p>	<p>IF YES</p> <p>(1) ___ insulin dependent (2) ___ non-insulin dependent</p>	<p>AGE</p> <p style="text-align: center;"> _ _ </p>	<p>IF YES</p> <p>→  _ _ </p> <p>#years</p> <p style="text-align: center;"><b>OR</b></p> <p> _ _ </p> <p>#months</p>	<p> _   </p> <p> _     </p> <p> _     </p>
<p>3. Arthritis</p>	<p>IF YES</p> <p>(1) ___ rheumatoid (2) ___ osteoarthritis (3) ___ other</p> <p>SPECIFY OTHER: _____</p>	<p>AGE</p> <p style="text-align: center;"> _ _ </p>	<p>IF YES</p> <p>→  _ _ </p> <p>#years</p> <p style="text-align: center;"><b>OR</b></p> <p> _ _ </p> <p>#months</p>	<p> _   </p> <p> _ _   </p> <p> _     </p> <p> _     </p>

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A19. Has a doctor or health professional ever told you that you had a urinary tract infection?

2 \_\_\_\_ No

1 \_\_\_\_ Yes



A20. How old were you when this was first diagnosed?

\_\_\_\_\_  
AGE

A21. Have you ever had chronic urinary tract infections (more than 3 in a year)?

2 \_\_\_\_ No

1 \_\_\_\_ Yes



A22. How many years have you had chronic urinary tract infections?

#OF YEARS: \_\_\_\_\_

A23. Do you still have them?

2 \_\_\_\_ No

1 \_\_\_\_ Yes

A24. Has a doctor or health professional ever told you that you had appendicitis?

2 \_\_\_\_ No

1 \_\_\_\_ Yes



A25. Did you have surgery?

2 \_\_\_\_ No

1 \_\_\_\_ Yes



A25a. At what age did you have surgery?

\_\_\_\_\_  
AGE

A25b. Did your appendix rupture?

2 \_\_\_\_ No

1 \_\_\_\_ Yes

A26. Have you ever had cold sores?

2 \_\_\_\_ No

1 \_\_\_\_ Yes



A27. At what age did you first get a cold sore?

\_\_\_\_\_  
AGE

A28. Have you ever engaged in binge-and-purge eating or throwing up on purpose after eating, also called bulimia?

2 \_\_\_\_ No

1 \_\_\_\_ Yes




A29. At what age did this start?

AGE		

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A30. Have you had any other chronic medical problems (problems that do not go away) that you have not already reported, such as multiple sclerosis, optic neuritis or such conditions as allergies, sinus or stomach problems or migraine headaches that affect your day-to-day life?

2 \_\_\_\_ No

1 \_\_\_\_ Yes




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A31. If YES, list those chronic medical conditions. Answer A32 and A33 for each.	A32. At what age did you first have this condition? AGE	A33. Do you still have this condition?	
		NO (2)	YES (1)
a. _____	_ _		
b. _____	_ _		
c. _____	_ _		
d. _____	_ _		

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A34. Have you ever had a D & C (a scraping or cleaning out of your womb)?

2 \_\_\_\_\_ No

1 \_\_\_\_\_ Yes



A35. In what year did you have a D&C?	A36. What was the reason for this D&C?	
a. 1st   _ _ _ _  YEAR	_____ _____ _____	
b. 2nd   _ _ _ _  YEAR	_____ _____ _____	
c. 3rd   _ _ _ _  YEAR	_____ _____ _____	

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A37. Have you ever had a laparoscopy (inserting a scope through a small incision near your belly button)? Please do not include any for tubal ligation.

2 \_\_\_\_\_ No

1 \_\_\_\_\_ Yes



A38. In what year did you have a laparoscopy?	A39. What was the reason for this laparoscopy?	A40. What was found?
a. 1st   _ _ _ _  YEAR	_____ _____	_____ _____
b. 2nd   _ _ _ _  YEAR	_____ _____	_____ _____
c. 3rd   _ _ _ _  YEAR	_____ _____	_____ _____

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Please fill out the table for your natural mother and father.

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A41. Is parent living?			A42. If living:	A43. If deceased:
NO (2)	DON'T KNOW (8)	YES (1)	CURRENT AGE	AGE AT DEATH
Mother:			AGE: <input type="text"/>	AGE: <input type="text"/>
Father:			AGE: <input type="text"/>	AGE: <input type="text"/>

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A44. Has your <u>natural mother</u> ever had any of the following? For each YES, answer A45.			A45. <b><u>IF YES:</u></b> About how old was your mother when she first had this condition?
NO (2)	DON'T KNOW (8)	YES (1)	
a. Endometriosis			AGE: <input type="text"/>
b. Uterine fibroids			AGE: <input type="text"/>
c. Uterine or endometrial cancer			AGE: <input type="text"/>
d. Hysterectomy			AGE: <input type="text"/>
e. Stroke or TIA (transient ischemic attack)			AGE: <input type="text"/>
f. High blood pressure			AGE: <input type="text"/>
g. Diabetes			AGE: <input type="text"/>
h. Heart attack <u>before age 55</u>			AGE: <input type="text"/>
i. Other heart disease <u>before age 55</u>			AGE: <input type="text"/>

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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A46. About what age did your natural mother stop having menstrual periods, or go through menopause?

AGE

<input type="checkbox"/>	<input type="checkbox"/>
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A47. Has your <u>natural father</u> ever had any of the following? For each YES, answer A48.		A48. <b>IF YES:</b> About how old was your father when he was first diagnosed?	
	NO (2)	DON'T KNOW (8)	YES (1)
a. Stroke			AGE: <input type="text"/> <input type="text"/>
b. High blood pressure			AGE: <input type="text"/> <input type="text"/>
c. Diabetes			AGE: <input type="text"/> <input type="text"/>
d. Prostate cancer			AGE: <input type="text"/> <input type="text"/>
e. Heart attack <u>before age 55</u>			AGE: <input type="text"/> <input type="text"/>
f. Other heart disease <u>before age 55</u>			AGE: <input type="text"/> <input type="text"/>

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A49. How many full or half-sisters do you have, both living and deceased?  
(Half-sisters are those related by blood through only one parent.)

# OF FULL SISTERS   # OF HALF-SISTERS    
(00 IF NONE) (00 IF NONE)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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A49a. If any, how many in total are over 30 years of age?    
(00 IF NONE)

<input type="checkbox"/>	<input type="checkbox"/>
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If you have no full or half-sisters, check here  and go to the next page.

<input type="checkbox"/>
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A50. Have any of your <u>full or half-sisters</u> ever had any of the following? If YES, answer A51 and A52.	A51. <b>IF YES:</b> How many full or half-sisters had this condition?		A52. What is the youngest age that any full or half-sister had this condition?
	NO (2)	DON'T KNOW (8)	YES (1)
a. Endometriosis			# SISTERS: <input type="text"/> <input type="text"/> AGE: <input type="text"/> <input type="text"/>
b. Uterine fibroids			# SISTERS: <input type="text"/> <input type="text"/> AGE: <input type="text"/> <input type="text"/>
c. Uterine or endometrial cancer			# SISTERS: <input type="text"/> <input type="text"/> AGE: <input type="text"/> <input type="text"/>
d. Hysterectomy			# SISTERS: <input type="text"/> <input type="text"/> AGE: <input type="text"/> <input type="text"/>

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<p style="text-align: center;">A53.</p> <p>Which of the following methods of birth control have you used for at least 1 month at some time in your life? For each YES, answer A54 and A55.</p>	<p style="text-align: center;">NO (2)</p>	<p style="text-align: center;">YES (1)</p>	<p style="text-align: center;">A54.</p> <p>At what age did you first start using this method?</p> <p style="text-align: center;">AGE STARTED</p>	<p style="text-align: center;">A55.</p> <p>In all, how many years have you used this method? If less than a year, how many months in total?</p>
a. Condom (rubber)		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS
b. Diaphragm		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS
c. Sponge		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS
d. Cervical cap		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS
e. Foam, jelly, cream or suppository alone (without diaphragm, sponge or cervical		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS
cap) f. Douche alone		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS
g. Rhythm or Safe Period or Natural Family Planning (using calendar or taking your temperature or mucous test).		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS
h. Withdrawal/pulling out		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS
i. Operation - male sterilization, vasectomy		IF YES <input type="checkbox"/>	AGE: <input type="text"/>	<input type="text"/> #YEARS <b>OR</b> <input type="text"/> #MONTHS

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SECTION B: SYMPTOMS

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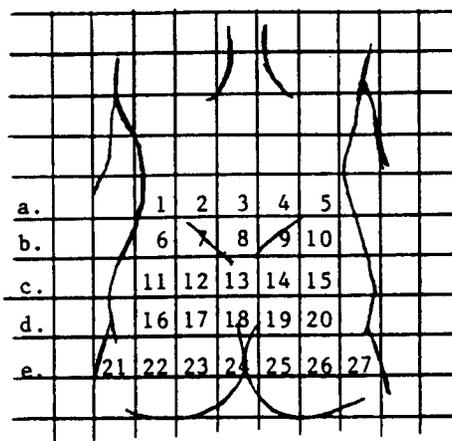
B1. Do you regularly experience lower back pain (at least once a month)?

2 \_\_\_ No

1 \_\_\_ Yes




B2. Circle or shade in the areas of the lower back where you feel the pain.



- a.
- b.
- c.
- d.
- e.

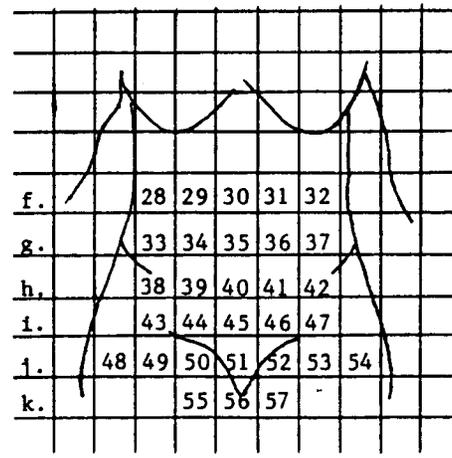
B3. Do you regularly experience abdominal pain (at least once a month)?

2 \_\_\_ No

1 \_\_\_ Yes




B4. Circle or shade in the abdominal areas where you feel the pain.



- f.
- g.
- h.
- i.
- j.
- k.

## SYMPTOM LIST

B5. Have you experienced any of the following symptoms more than once or twice in the past twelve months? Please answer each.  <b>If YES, answer B6 to B8.</b>			B6. On average, how many days do you experience this symptom?  (Please ✓)			B7. On days when you have this symptom, how much does it prevent you from carrying out your normal activities?  (Please ✓)			B8. Is it more frequent or severe around the time of your period? If you no longer have periods, check NA for Not Applicable.  (Please ✓)		
PAST 12 MONTHS	NO (2)	YES (1)	Less than 1 day a month (1)	1-4 days a month (2)	More than 4 days a month (3)	None or a little (1)	Some (2)	A lot (3)	NO (2)	YES (1)	NA (6)
a. Headache		IF YES →	→	→	→	→	→	→	→		
b. Low-grade fever (less than 101°)		IF YES →	→	→	→	→	→	→	→		
c. Muscle or joint aches and pains not due to exercise		IF YES →	→	→	→	→	→	→	→		
d. Hot flashes (feeling flushed and hot not due to exercise)		IF YES →	→	→	→	→	→	→	→		
e. Sweats (breaking into a sweat, not due to exercise)		IF YES →	→	→	→	→	→	→	→		
f. Constipation		IF YES →	→	→	→	→	→	→	→		

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\*\*\***REMINDER:** Please fill in B6-B8 for all YES answers.\*\*\*

**SYMPTOM LIST - CONTINUED**

B5. Have you experienced any of the following symptoms more than once or twice in the past twelve months? Please answer each.  <b>If YES, answer B6 to B8.</b>	B6. On average, how many days do you experience this symptom?  (Please ✓)			B7. On days when you have this symptom, how much does it prevent you from carrying out your normal activities?  (Please ✓)			B8. Is it more frequent or severe around the time of your period? If you no longer have periods, check NA for Not Applicable.  (Please ✓)				
	NO (2)	YES (1)	Less than 1 day a month (1)	1-4 days a month (2)	More than 4 days a month (3)	None or a little (1)	Some (2)	A lot (3)	NO (2)	YES (1)	NA (6)
PAST 12 MONTHS											
g. Diarrhea		IF YES →	→	→	→	→	→	→	→		
h. Three or more bowel movements a day		IF YES →	→	→	→	→	→	→	→		
i. Nausea		IF YES →	→	→	→	→	→	→	→		
j. Irritability		IF YES →	→	→	→	→	→	→	→		
k. Breast tenderness		IF YES →	→	→	→	→	→	→	→		
l. Back pain		IF YES →	→	→	→	→	→	→	→		

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**\*\*\*REMINDER:** Please fill in B6-B8 for all YES answers.\*\*\*

### SYMPTOM LIST - CONTINUED

B5. Have you experienced any of the following symptoms more than once or twice in the past twelve months? Please answer each.  <b>If YES, answer B6 to B8.</b>			B6. On average, how many days do you experience this symptom?  (Please ✓)			B7. On days when you have this symptom, how much does it prevent you from carrying out your normal activities?  (Please ✓)			B8. Is it more frequent or severe around the time of your period? If you no longer have periods, check NA for Not Applicable.  (Please ✓)		
PAST 12 MONTHS	NO (2)	YES (1)	Less than 1 day a month (1)	1-4 days a month (2)	More than 4 days a month (3)	None or a little (4)	Some (2)	A lot (3)	NO (2)	YES (1)	NA (6)
m. Abdominal cramps, including menstrual cramps		IF YES →	→	→	→	→	→	→	→		
n. Abdominal fullness, bloating or swelling		IF YES →	→	→	→	→	→	→	→		
o. Overeating		IF YES →	→	→	→	→	→	→	→		
p. Painful urination		IF YES →	→	→	→	→	→	→	→		
q. Pain around the vaginal opening during sexual intercourse. Check here if not having sex <input type="checkbox"/> (6)		IF YES →	→	→	→	→	→	→	→		
r. Pain deep inside during sexual intercourse. Check here if not having sex <input type="checkbox"/> (6)		IF YES →	→	→	→	→	→	→	→		

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\*\*\***REMINDER:** Please fill in B6-B8 for all YES answers.\*\*\*



## SECTION C: EMPLOYMENT

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C1. Have you ever worked or been trained in any of the following workplaces or jobs, including part-time or temporary summer employment for at least a month? For each YES, answer C2.			<b><u>IF YES</u></b> C2. <b>In all, how many years did you work in this workplace or job? If less than a year, please estimate the number of months.</b>
ON THE JOB:	NO (2)	YES (1)	
a. Gas station or auto repair shop			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
b. Dry cleaning shop			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
c. Farmer, farmworker or forestry worker			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
d. Laboratory worker			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
e. Housekeeper, maid, janitor or cleaning worker			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
f. Hair stylist or manicurist			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
g. Exterminator or pest control worker			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
h. Taxi or bus driver or other motor vehicle operator			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
i. Parking lot attendant or toll booth operator			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
j. Veterinarian, animal care worker or poultry or livestock farmer			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
k. Nurse			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
l. Dental assistant			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS
m. Flight attendant			<input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> #YEARS <b>OR</b> #MONTHS

C3. Have you ever had any jobs or training where you used or had contact with any of the following <u>at least once a week</u> for at least one month? Check NO or YES for each substance. For each YES, answer C4.		<b><u>IF YES:</u></b> C4. In all, how many years did you work in a job where you used or had contact with this substance at least once a week? If less than a year, please estimate the number of months.	
ON THE JOB:	NO (2)	YES (1)	
a. Metal or metal compounds, such as lead, mercury, arsenic, boron, chromium, cadmium, and selenium (as filings, dust or fumes)			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS
b. Drugs or pharmaceuticals			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS
c. Chemicals used to develop or process photographic film			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS
d. Dyes, <u>other than hair dyes</u>			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS
e. Grease or oils, such as cutting oil or creosote			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS
f. Welding fumes			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS
g. Solvents, (chemicals that lubricate, soften or dissolve grease, oil, paints or other materials)			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS
h. Chemicals to make rubber or plastic			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS
i. Pesticides to control insect pests			<input type="text"/> <input type="text"/> #YEARS OR <input type="text"/> <input type="text"/> #MONTHS

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C3. Have you ever had any jobs or training where you used or had contact with any of the following <u>at least once a week</u> for at least one month? Check NO or YES for each substance. For each YES, answer C4.		<b>IF YES:</b> C4. In all, how many years did you work in a job where you used or had contact with this substance at least once a week? If less than a year, please estimate the number of months.	
ON THE JOB:	NO (2)	YES (1)	
j. Herbicides to control weeds			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
k. Fumigants			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
l. Chemical fertilizers			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
m. Stains, varnish or other wood finishes			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
n. Paints or paint products, or paint thinner or remover			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
o. Natural gas, gasoline or fuel products			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
p. Chemicals to sterilize medical or dental instruments			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
q. Laboratory animals			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
r. Farm animals			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS
s. Other animals			<input type="text"/> #YEARS OR <input type="text"/> #MONTHS

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**SECTION D: ACTIVITIES**

D1. Outside of work, for a craft or hobby, have you regularly done any of the following activities? For each YES, answer D2.		<b>IF YES:</b> D2. Since age 18, have you done this activity for more than 100 days or less than 100 days in all? The 100 days can be combined any way. For example; every day for one summer, about once a week for two years or about once a month for 8 years.	
OUTSIDE OF WORK:	NO (2)	YES (1)	(circle)
a. Print making or silk screening			Less than 100 days in all..... 1 100 days or more..... 2
b. Developing or printing photographs			Less than 100 days in all..... 1 100 days or more..... 2
c. Stained or leaded glass art			Less than 100 days in all..... 1 100 days or more..... 2
d. Oil or acrylic painting			Less than 100 days in all..... 1 100 days or more..... 2
e. Ceramics or pottery			Less than 100 days in all..... 1 100 days or more..... 2
f. Furniture refinishing			Less than 100 days in all..... 1 100 days or more..... 2

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D3. As a child (less than 18), did you ever work at picking vegetables, fruits, tobacco, cotton or other crops?

2 \_\_\_\_\_ No

1 \_\_\_\_\_ Yes



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D4. What did you pick?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

D5. How long, in total, did you work at picking as a child? If less than a year, please estimate the number of months.

# OF YEARS   OR # OF MONTHS

Gardening and lawn products D6. Have you or another household member or a lawn service used any of the following products on your lawn? If YES, answer D7 and D8.			IF YES:	
			D7. How many years have you or someone else used this product?	D8. During the years that you or someone else used this product, about how many times per year was it used?
	NO (2)	YES (1)		
a. Products that kill insects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> #YEARS	<input type="text"/> <input type="text"/> <input type="text"/> # TIMES PER YEAR
b. Products that kill weeds or pest plants like poison ivy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> #YEARS	<input type="text"/> <input type="text"/> <input type="text"/> # TIMES PER YEAR
c. Products that kill mildew, blight or other fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> #YEARS	<input type="text"/> <input type="text"/> <input type="text"/> # TIMES PER YEAR

**SECTION E: PETS**

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Only

E1. Have you ever had a pet cat or dog for a year or more?

2 \_\_\_ No

1 \_\_\_ Yes



**GO TO SECTION F**



E2. When did you have a pet cat or dog?

1 \_\_\_ Only as a child (less than age 18)

2 \_\_\_ Only as an adult

3 \_\_\_ Both as a child and an adult

E3. How many total years, as a child and an adult, have you had a pet cat or dog?

a. # YEARS AS A CHILD    
(Less than 18)

b. # YEARS AS AN ADULT    
(18 or older)

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

E4. Have you or someone else ever used any products to kill fleas or ticks on your pets?

2 \_\_\_ No

1 \_\_\_ Yes



E5. What products have you or someone else used to kill fleas or ticks on your pets?  
Check NO or YES for each.

a. dip      \_\_\_ NO      \_\_\_ YES

b. spray    \_\_\_ NO      \_\_\_ YES

c. powder   \_\_\_ NO      \_\_\_ YES

d. collar    \_\_\_ NO      \_\_\_ YES

E6. During how many years have you or someone else used these products on your pets?

# YEARS

<input type="text"/>	<input type="text"/>
----------------------	----------------------

E7. Did you or someone else ever spray your yard to help keep your pet from getting fleas?

2 \_\_\_ No

1 \_\_\_ Yes



~~E8. During how many years was your yard sprayed?~~

~~# YEARS~~

<input type="text"/>	<input type="text"/>
----------------------	----------------------

## SECTION F: HOUSEHOLD PESTS

F1. Have you or another household member ever used any of the following products to kill insects or pests in your home? For each YES, answer F2.	NO (2)	YES (1)	<b>IF YES:</b> F2. During how many years have you or another household member used this product?
a. Household sprays to kill insects, such as ants and roaches	<input type="checkbox"/>	<input type="checkbox"/>	#YEARS: <input style="width: 40px;" type="text"/>
b. Poisons to kill rodents, such as mice	<input type="checkbox"/>	<input type="checkbox"/>	#YEARS: <input style="width: 40px;" type="text"/>
c. Fly paper	<input type="checkbox"/>	<input type="checkbox"/>	#YEARS: <input style="width: 40px;" type="text"/>
d. Candles made to keep insects away	<input type="checkbox"/>	<input type="checkbox"/>	#YEARS: <input style="width: 40px;" type="text"/>
e. Mothballs	<input type="checkbox"/>	<input type="checkbox"/>	#YEARS: <input style="width: 40px;" type="text"/>

Office Use Only

F3. Have you ever lived in a residence that was treated with insecticides to kill roaches or fleas by someone other than a household member?

2  No

1  Yes




F4. How many years in total have you lived in places treated by others?

# YEARS

F5. Have you ever lived in a residence that was treated with special chemicals to kill termites or carpenter ants?

2  No

1  Yes




F6. Think of all the times that this has happened in all the places that you have lived. In total, how many times has this happened?

# TIMES

F7. As a child or adult, have you ever lived where there was regular spraying by air or by truck for mosquitoes or other insects?

2 \_\_\_\_ No                      1 \_\_\_\_ Yes

F8. As a child or adult, have you ever used insect repellents on your body at least once a day, **for five days** in a row (for example, OFF or DEET)?

2 \_\_\_\_ No                      1 \_\_\_\_ Yes



F9. How many years as a child and adult have you used insect repellent once a day for **at least five days**?

a. #YEARS AS CHILD [ ][ ]  
(Under 18)

b. #YEARS AS ADULT [ ][ ]  
(18 or older)

F10. During the year of most heavy use, how many days did you use insect repellent?

#DAYS [ ][ ][ ]

**SECTION G: ALCOHOL USE**

Office Use  
Only

G1. In the last 12 months, how often did you drink beer, wine, or liquor (including mixed drinks)?

Please check only one answer.

- 01 \_\_\_\_\_ About every day
- 02 \_\_\_\_\_ 3-5 times a week
- 03 \_\_\_\_\_ About once a week
- 04 \_\_\_\_\_ Less than once a week
- 05 \_\_\_\_\_ Less than once a month
- 06 \_\_\_\_\_ Never

--	--

G2. In the last 12 months, when you drank beer, wine, or liquor, how many total drinks did you usually have?

Please check only one answer.

- 01 \_\_\_\_\_ 12 or more
- 02 \_\_\_\_\_ 9 - 11
- 03 \_\_\_\_\_ 6 - 8
- 04 \_\_\_\_\_ 3 - 5
- 05 \_\_\_\_\_ 1 - 2
- 06 \_\_\_\_\_ Not applicable, never drink

--	--

G3. How often in the last 12 months have you had at least 5 drinks on 1 day? For example, on a holiday, weekend or special occasion.

Please check only one answer.

- 1 \_\_\_\_\_ About once a week or more
- 2 \_\_\_\_\_ Less than once a week
- 3 \_\_\_\_\_ Less than once a month
- 4 \_\_\_\_\_ Never or not applicable

--

G4. When you were around 30 years old, how often did you drink beer, wine or liquor (including mixed drinks)?

Office Use  
Only

Please check only one answer.

- 01 \_\_\_\_\_ About every day
- 02 \_\_\_\_\_ 3-5 times a week
- 03 \_\_\_\_\_ About once a week
- 04 \_\_\_\_\_ Less than once a week
- 05 \_\_\_\_\_ Less than once a month
- 06 \_\_\_\_\_ Never

G5. When you were around 30 years old, how many drinks did you have on a typical day when you did have beer, wine or liquor?

Please check only one answer.

- 01 \_\_\_\_\_ 12 or more
- 02 \_\_\_\_\_ 9 - 11
- 03 \_\_\_\_\_ 6 - 8
- 04 \_\_\_\_\_ 3 - 5
- 05 \_\_\_\_\_ 1 - 2
- 06 \_\_\_\_\_ Not applicable, never drank

G6. When you were around 30 years old, how often did you have at least 5 drinks on 1 day? For example, on a holiday, weekend or special occasion.

Please check only one answer.

- 1 \_\_\_\_\_ About once a week or more
- 2 \_\_\_\_\_ Less than once a week
- 3 \_\_\_\_\_ Less than once a month
- 4 \_\_\_\_\_ Never or not applicable

**SECTION H: DEMOGRAPHICS**

Office Use  
Only

H1. Which category best describes you?

Please check only one answer.

- 01 \_\_\_\_\_ White, not Hispanic
- 02 \_\_\_\_\_ White, Hispanic
- 03 \_\_\_\_\_ Black, not Hispanic
- 04 \_\_\_\_\_ Black, Hispanic
- 05 \_\_\_\_\_ Asian/Pacific Islander
- 06 \_\_\_\_\_ American Indian/Eskimo/Aleut
- 07 \_\_\_\_\_ Other : What other category best describes you? \_\_\_\_\_

H2. Check the number that represents your highest level of education.

Please check only one answer.

- 01 \_\_\_\_\_ Less than high school
- 02 \_\_\_\_\_ High school
- 03 \_\_\_\_\_ Some college or some tech school, no degree
- 04 \_\_\_\_\_ Jr. college or tech school degree
- 05 \_\_\_\_\_ College degree
- 06 \_\_\_\_\_ College plus additional training
- 07 \_\_\_\_\_ Master's degree
- 08 \_\_\_\_\_ Doctorate/Law/Medicine
- 09 \_\_\_\_\_ Other, specify: \_\_\_\_\_

H3. Including income provided by you, your husband or any other person living in your household, which range of incomes comes closest to your total household income before taxes for the past year?

Please check only one answer.

- 01 \_\_\_\_\_ Less than \$20,000
- 02 \_\_\_\_\_ Between \$20,000 and \$40,000
- 03 \_\_\_\_\_ Between \$40,000 and \$60,000
- 04 \_\_\_\_\_ Between \$60,000 and \$80,000
- 05 \_\_\_\_\_ Between \$80,000 and \$100,000
- 06 \_\_\_\_\_ Between \$100,000 and \$120,000
- 07 \_\_\_\_\_ More than \$120,000

H4. How many persons were supported by this income? Include yourself.

#PERSONS

H5. Are you currently:

Please check only one answer.

- 1 \_\_\_\_\_ Single, never married
- 2 \_\_\_\_\_ Married, or living with someone as married
- 3 \_\_\_\_\_ Widowed
- 4 \_\_\_\_\_ Separated or divorced

## SECTION I: STRESS

I-1. How hard is it for your family to pay for basic expenses like food, clothing, shelter, medical care, and transportation?

Office Use  
Only

Please check only one answer.

- 1 \_\_\_\_\_ No problem
- 2 \_\_\_\_\_ Slight or occasionally difficult
- 3 \_\_\_\_\_ Moderately difficult
- 4 \_\_\_\_\_ Very difficult to pay expenses

I-2. Many people feel stressed in their day-to-day lives. How stressful is your day-to-day life?

Please check only one answer.

- 1 \_\_\_\_\_ Not at all stressful
- 2 \_\_\_\_\_ Mildly stressful
- 3 \_\_\_\_\_ Moderately stressful
- 4 \_\_\_\_\_ Very stressful

I-3. How do you deal with stress in your day-to-day life?

Please check only one answer.

- 1 \_\_\_\_\_ I view stress as a challenge and deal well with it
- 2 \_\_\_\_\_ I do not like the stress, but I manage
- 3 \_\_\_\_\_ I feel anxious, overwhelmed, or exhausted

I-4. How often do you feel the need to squelch or swallow strong feelings of anger?

Please check only one answer.

- 1 \_\_\_\_\_ Daily
- 2 \_\_\_\_\_ Weekly
- 3 \_\_\_\_\_ Less often or never



