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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

January 1, 1998

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Data collected by CODA, Inc.

Durham, NC

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.	NO (2)	YES (1)	A2. If YES, how old were you when you were first diagnosed? AGE	A3. Did you take any prescription MEDICINE for this condition? NO (2)	A3. YES (1)	Office Use Only
1. Abnormal pap smear		IF YES →	AGE: ___			☐☐☐☐
2. Galactorrhea (breast milk when you were not pregnant or breastfeeding)		IF YES →	AGE: ___			☐☐☐☐
3. Asthma		IF YES →	AGE: ___			☐☐☐☐
4. Anorexia		IF YES →	AGE: ___			☐☐☐☐
5. Mononucleosis or “mono”		IF YES →	AGE: ___			☐☐☐☐
6. Depression		IF YES →	AGE: ___			☐☐☐☐
7. Hepatitis		IF YES →	AGE: ___			☐☐☐☐
8. Other liver disease		IF YES →	AGE: ___			☐☐☐☐
9. High blood pressure, not pregnancy-induced		IF YES →	AGE: ___			☐☐☐☐
10. High cholesterol		IF YES →	AGE: ___			☐☐☐☐
11. Heart attack		IF YES →	AGE: ___			☐☐☐☐
12. Angina		IF YES →	AGE: ___			☐☐☐☐
13. Stroke		IF YES →	AGE: ___			☐☐☐☐
14. Anemia		IF YES →	AGE: ___			☐☐☐☐
15. Gonorrhea, “clap,” or “drip”		IF YES →	AGE: ___			☐☐☐☐
16. Chlamydia or “drip”		IF YES →	AGE: ___			☐☐☐☐
17. Syphilis or “syph”		IF YES →	AGE: ___			☐☐☐☐
18. Genital warts		IF YES →	AGE: ___			☐☐☐☐
19. Genital herpes (lesions, sores, blisters)		IF YES →	AGE: ___			☐☐☐☐
20. Other sexually transmitted diseases SPECIFY: _____		IF YES →	AGE: ___			☐☐☐☐ ☐☐

A4. 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 A5-A7.	NO (2)	YES (1)	A5. If YES, how old were you when you were first diagnosed? AGE	A6. Did you take any prescription MEDICINE for this condition? NO (2)	A6. YES (1)	A7. Did you ever have SURGERY for this condition? NO (2)	A7. YES (1)
1. Ovarian cysts		IF YES →	→ AGE				
2. Endometriosis		IF YES →	→ AGE				
3. Uterine prolapse		IF YES →	→ AGE				
4. Pelvic inflammatory disease (PID), infection in your womb or tubes		IF YES →	→ AGE				
5. Polycystic ovaries or Stein Leventhal syndrome		IF YES →	→ AGE				
6. Abnormal menstrual bleeding		IF YES →	→ AGE				
7. Severe menstrual cramps		IF YES →	→ AGE				
8. Blood clot in your legs, lungs or eyes		IF YES →	→ AGE				
9. Gallbladder disease or gallstones		IF YES →	→ AGE				

Office Use Only

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

2 _____ No 1 _____ Yes

A9. What type of cancer(s) have you had? TYPE	A10. How old were you when you were first diagnosed? AGE	A11. Did you have chemo-therapy? NO (2)	A11. YES (1)	A12. Did you have radiation therapy? NO (2)	A12. YES (1)	A13. Did you have surgery? NO (2)	A13. YES (1)
a. _____							
b. _____							

Sub

A14. 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 A15-A18.	NO (2)	YES (1)	A15. What type of this condition did you have? TYPE	A16. How old were you when you were first diagnosed? AGE	A17. Did you take any prescription MEDICINE for this condition? NO (2)	A17. YES (1)	A18. If YES, how many years have you taken prescription MEDICINE for this condition? If less than a year, please fill in months.	Office Use Only
1. Thyroid condition		IF YES →	(1)____overactive (2)____underactive (3)____other SPECIFY OTHER: _____	⌊__⌋ AGE		IF YES →	⌊__⌋ #years **OR** ⌊__⌋ #months	☐☐ ☐☐☐ ☐☐☐ ☐☐☐☐
2. Diabetes, high blood sugar or "sugar," not pregnancy-induced		IF YES →	insulin (1)____dependent non-insulin (2)____dependent	⌊__⌋ AGE		IF YES →	⌊__⌋ #years **OR** ⌊__⌋ #months	☐☐ ☐☐☐ ☐☐☐☐
3. Arthritis		IF YES →	(1)____rheumatoid (2)____osteoarthritis (3)____other SPECIFY OTHER: _____	⌊__⌋ AGE		IF YES →	⌊__⌋ #years **OR** ⌊__⌋ #months	☐☐ ☐☐☐ ☐☐☐ ☐☐☐☐

Office Use Only

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

Office Use Only

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

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 ☐

↓

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. _____	☐☐		

Sub ☐☐

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Office Use Only

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	

Sub

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		

Sub

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

Office Use Only

	A41. Is parent living? NO (2)	DON'T KNOW (8)	YES (1)	A42. If living: CURRENT AGE	A43. If deceased: AGE AT DEATH
Mother:				AGE: ⌊__⌋	AGE: ⌊__⌋
Father:				AGE: ⌊__⌋	AGE: ⌊__⌋

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

A46. About what age did your natural mother stop having menstrual periods, or go through menopause?

AGE ⌊__⌋

A47. Has your natural father ever had any of the following? For each YES, answer A48.	NO (2)	DON'T KNOW (8)	YES (1) →	A48. **IF YES:** About how old was your father when he was first diagnosed?	Office Use Only
a. Stroke				AGE: ___	☐☐☐☐
b. High blood pressure				AGE: ___	☐☐☐☐
c. Diabetes				AGE: ___	☐☐☐☐
d. Prostate cancer				AGE: ___	☐☐☐☐
e. Heart attack before age 55				AGE: ___	☐☐☐☐
f. Other heart disease before age 55				AGE: ___	☐☐☐☐

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 ___ *(00 IF NONE)* # OF HALF-SISTERS ___ *(00 IF NONE)* ☐☐ ☐☐

A49a. If any, how many in total are over 30 years of age? ___ *(00 IF NONE)* ☐☐

If you have no full or half-sisters, check here ____ and go to the next page. ☐

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

A53. 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.	NO (2)	YES (1)	A54. At what age did you first start using this method? AGE STARTED	A55. In all, how many years have you used this method? If less than a year, how many months in total?	Office Use Only
a. Condom (rubber)		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐
b. Diaphragm		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐
c. Sponge		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐
d. Cervical cap		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐
e. Foam, jelly, cream or suppository alone (without diaphragm, sponge or cervical cap)		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐
f. Douche alone		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐
g. Rhythm or Safe Period or Natural Family Planning (using calendar or taking your temperature or mucous test).		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐
h. Withdrawal/pulling out		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐
i. Operation - male sterilization, vasectomy		IF YES →	AGE: ⌊_⌋⌊_⌋	#YEARS ⌊_⌋⌊_⌋ **OR** #MONTHS ⌊_⌋⌊_⌋	☐☐☐☐☐

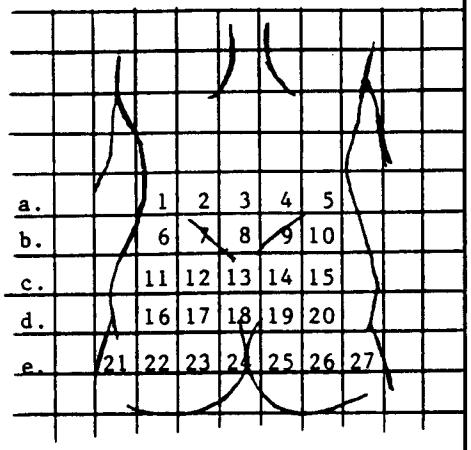
SECTION B: SYMPTOMS

Office Use Only

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.

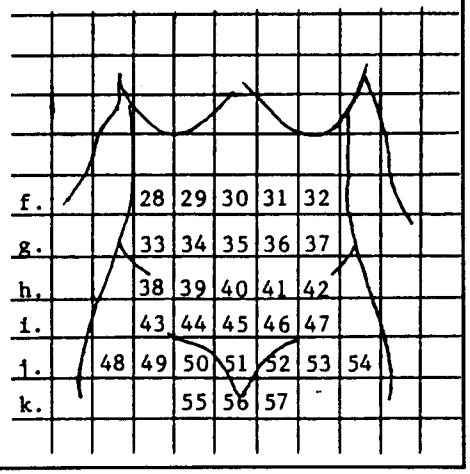


a. ☐☐☐☐☐
b. ☐☐☐☐☐
c. ☐☐☐☐☐
d. ☐☐☐☐☐
e. ☐☐☐☐☐☐☐

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

PAST 12 MONTHS	B5. Have you experienced any of the following symptoms more than once or twice in the past twelve months? Please answer each. **If YES, answer B6 to B8.** NO (2)	YES (1)	B6. On average, how many days do you experience this symptom? (Please ✓) Less than 1 day a month (1)	1-4 days a month (2)	More than 4 days a month (3)	B7. On days when you have this symptom, how much does it prevent you from carrying out your normal activities? (Please ✓) None or a little (1)	Some (2)	A lot (3)	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)	NA (6)	Office Use Only
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 →	→	→	→	→	→	→	→			☐☐☐☐

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. **If YES, answer B6 to B8.** PAST 12 MONTHS	NO (2)	YES (1)	B6. On average, how many days do you experience this symptom? (Please ✓) Less than 1 day a month (1)	1-4 days a month (2)	More than 4 days a month (3)	B7. On days when you have this symptom, how much does it prevent you from carrying out your normal activities? (Please ✓) None or a little (1)	Some (2)	A lot (3)	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)	NA (6)	Office Use Only
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 →										☐☐☐☐

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

SYMPTOM LIST - CONTINUED

PAST 12 MONTHS	B5. Have you experienced any of the following symptoms more than once or twice in the past twelve months? Please answer each. **If YES, answer B6 to B8.** NO (2)	YES (1)	B6. On average, how many days do you experience this symptom? (Please ✓) Less than 1 day a month (1)	1-4 days a month (2)	More than 4 days a month (3)	B7. On days when you have this symptom, how much does it prevent you from carrying out your normal activities? (Please ✓) None or a little (1)	Some (2)	A lot (3)	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)	NA (6)	Office Use Only
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 ☐ (6)		IF YES →	→	→	→	→	→	→	→			☐☐☐☐
r. Pain deep inside during sexual intercourse Check here if not having sex ☐ (6)		IF YES →	→	→	→	→	→	→	→			☐☐☐☐

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

B9. Now think back to when you were around 30 years old. How often on average did you have these symptoms at <u>that</u> time in your life? AROUND 30 YEARS OLD:	Never, or less than once a month (1)	Once a month or more (2)	Office Use Only
a. Headache			☐
b. Low-grade fever (less than 101°)			☐
c. Muscle or joint aches and pains not due to exercise			☐
d. Sleep that is restless or disturbed, or trouble going back to sleep after waking			☐
e. Difficulty falling asleep at the beginning of sleep time			☐
f. Hot flashes (feeling flushed and hot not due to exercise)			☐
g. Sweats (breaking into a sweat, not due to exercise)			☐
h. Constipation			☐
i. Diarrhea			☐
j. Three or more bowel movements a day			☐
k. Nausea			☐
l. Irritability			☐
m. Breast tenderness			☐
n. Back pain			☐
o. Abdominal cramps, including menstrual cramps			☐
p. Abdominal fullness, bloating, or swelling			☐
q. Overeating			☐
r. Painful urination			☐
s. Pain around the vaginal opening during sexual intercourse Check here if you were not having sex ☐ (6)			☐
t. Pain deep inside during sexual intercourse Check here if you were not having sex ☐ (6)			☐

SECTION C: EMPLOYMENT

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. ON THE JOB:	NO (2)	YES (1)	**IF YES** C2. **In all**, how many years did you work in this workplace or job? If less than a year, please estimate the number of months.	Office Use Only
a. Gas station or auto repair shop			#YEARS **OR** #MONTHS	☐☐☐☐☐
b. Dry cleaning shop			#YEARS **OR** #MONTHS	☐☐☐☐☐
c. Farmer, farmworker or forestry worker			#YEARS **OR** #MONTHS	☐☐☐☐☐
d. Laboratory worker			#YEARS **OR** #MONTHS	☐☐☐☐☐
e. Housekeeper, maid, janitor or cleaning worker			#YEARS **OR** #MONTHS	☐☐☐☐☐
f. Hair stylist or manicurist			#YEARS **OR** #MONTHS	☐☐☐☐☐
g. Exterminator or pest control worker			#YEARS **OR** #MONTHS	☐☐☐☐☐
h. Taxi or bus driver or other motor vehicle operator			#YEARS **OR** #MONTHS	☐☐☐☐☐
i. Parking lot attendant or toll booth operator			#YEARS **OR** #MONTHS	☐☐☐☐☐
j. Veterinarian, animal care worker or poultry or livestock farmer			#YEARS **OR** #MONTHS	☐☐☐☐☐
k. Nurse			#YEARS **OR** #MONTHS	☐☐☐☐☐
l. Dental assistant			#YEARS **OR** #MONTHS	☐☐☐☐☐
m. Flight attendant			#YEARS **OR** #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. ON THE JOB:	NO (2)	YES (1)	**IF YES:** 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.	Office Use Only
a. Metal or metal compounds, such as lead, mercury, arsenic, boron, chromium, cadmium, and selenium (as filings, dust or fumes)			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
b. Drugs or pharmaceuticals			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
c. Chemicals used to develop or process photographic film			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
d. Dyes, <u>other than hair dyes</u>			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
e. Grease or oils, such as cutting oil or creosote			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
f. Welding fumes			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
g. Solvents, (chemicals that lubricate, soften or dissolve grease, oil, paints or other materials)			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
h. Chemicals to make rubber or plastic			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
i. Pesticides to control insect pests			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #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.			**IF YES:** 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.	Office Use Only
ON THE JOB:	NO (2)	YES (1) →		
j. Herbicides to control weeds			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
k. Fumigants			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
l. Chemical fertilizers			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
m. Stains, varnish or other wood finishes			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
n. Paints or paint products, or paint thinner or remover			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
o. Natural gas, gasoline or fuel products			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
p. Chemicals to sterilize medical or dental instruments			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
q. Laboratory animals			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
r. Farm animals			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐
s. Other animals			⌊_⌋⌊_⌋ #YEARS **OR** ⌊_⌋⌊_⌋ #MONTHS	☐☐☐☐☐

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.	NO (2)	YES (1)	**IF YES:** 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. (circle)	Office Use Only
OUTSIDE OF WORK:				
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	☐☐

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

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2 _____ No 1 _____ Yes

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.	NO (2)	YES (1)	**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?
a. Products that kill insects			⌊__⌋ #YEARS	⌊__⌋ # TIMES PER YEAR
b. Products that kill weeds or pest plants like poison ivy			⌊__⌋ #YEARS	⌊__⌋ # TIMES PER YEAR
c. Products that kill mildew, blight or other fungus			⌊__⌋ #YEARS	⌊__⌋ # TIMES PER YEAR

SECTION E: PETS

Office Use 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) ☐☐

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 ⌊__⌋⌊__⌋

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 ⌊__⌋⌊__⌋

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)	**IF YES:** F2. During how many years have you or another household member used this product?	Office Use Only
a. Household sprays to kill insects, such as ants and roaches			#YEARS: ⌊__⌋	☐☐
b. Poisons to kill rodents, such as mice			#YEARS: ⌊__⌋	☐☐
c. Fly paper			#YEARS: ⌊__⌋	☐☐
d. Candles made to keep insects away			#YEARS: ⌊__⌋	☐☐
e. Mothballs			#YEARS: ⌊__⌋	☐☐

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

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☐

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

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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

H1. Which category best describes you?

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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?

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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

☐

I-5. Have you experienced any of the following events during the past 12 months? If YES, answer I-6 for each.			**IF YES:** I-6. What level of stress did you feel because of this event? (Check ✓ the column that best describes)				Office Use Only
IN THE PAST 12 MONTHS:	NO (2)	YES (1)	None (1)	Mild (2)	Moderate (3)	Severe (4)	
a. Change of residence		IF YES →					☐☐
b. Job loss for you		IF YES →					☐☐
c. Job loss for family member		IF YES →					☐☐
d. You or family member looking for a new job		IF YES →					☐☐
e. New job for you		IF YES →					☐☐
f. New job for family member		IF YES →					☐☐
g. Significant loss of spendable income		IF YES →					☐☐
h. Major accident, operation or illness for you		IF YES →					☐☐
i. Major accident, operation or illness for a child		IF YES →					☐☐
j. Major accident, operation, illness or death of your husband, close friend or close relative		IF YES →					☐☐
k. New romantic relationship		IF YES →					☐☐
l. Serious problems in marriage or other close relationship		IF YES →					☐☐
m. Divorce or breakup of primary relationship		IF YES →					☐☐
n. Robbery or assault		IF YES →					☐☐
o. Other major change or event in your life What was it? _____		IF YES →					☐☐
							☐☐

I-7. We asked you several questions about stress, but here is room to just tell us in your own words. What are the things that are really hard on you?

Office Use Only

_____

_____

_____

_____

_____

_____

_____

_____

_____ ☐

Date you completed this questionnaire: ____ ____ / ____ ____ / ____ ____ ____ ____ ☐☐ ☐☐ ☐☐☐☐

MONTH DAY YEAR

Thank you very much for completing this questionnaire.