Young Women Study- Phase 1 Questionnaires

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Note: These survey modules will be administered online using Qualtrics. Links to preview the online surveys can be found at the beginning of each module section in this document.

Module A: Demographics

PREVIEW LINK TO QUALTRICS SURVEY:
https://bcfamilyregistry.az1.qualtrics.com/jfe/preview/SV_dbruSbGxb4SmjBP?Q_SurveyVersionID=current&Q_CHL=preview

A1. Background

The following questions ask about your background.

This module takes about 5 minutes to complete.

1. What is your date of birth? (MM/DD/YYYY)

_____ /_____ / _____
mm dd yyyy

2. In what country were you born?

- ☐ Australia
- ☐ Canada
- ☐ United States
- ☐ Other country (Specify) _____
- ☐ Don't know
- ☐ Prefer not to answer

3. In what country was your mother born?

- ☐ Australia
- ☐ Canada
- ☐ United States
- ☐ Other country (Specify) _____
- ☐ Don't know
- ☐ Prefer not to answer

4. In what country was your father born?

- ☐ Australia
- ☐ Canada
- ☐ United States
- ☐ Other country (Specify) _____
- ☐ Don't know
- ☐ Prefer not to answer

5. Are you of any Ashkenazi Jewish origin?

- ☐ Yes
- ☐ No
- ☐ Don’t know
- ☐ Prefer not to answer

6. Are you of any Hispanic, Latina, or Spanish origin?

- ☐ Yes
- ☐ No
- ☐ Other (Specify) _____
- ☐ Don’t know
- ☐ Prefer not to answer

7. Which of the following best describes your race? You can select one or more responses.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Asian
- ☐ Other (Specify) _____
- ☐ Don’t know
- ☐ Prefer not to answer

8. What is the highest level of education you completed?

- ☐ Less than 8 years
- ☐ 8 to 11 years (without high school graduation) High school graduation
- ☐ Vocational or technical school
- ☐ Some college or university
- ☐ Certificate degree
- ☐ Associates/Diploma degree
- ☐ Bachelor’s degree
- ☐ Graduate degree
- ☐ Prefer not to answer

9. What is the highest level of education your mother completed?

- ☐ Less than 8 years
- ☐ 8 to 11 years (without high school graduation) High school graduation
- ☐ Vocational or technical school
- ☐ Some college or university
- ☐ Certificate degree
- ☐ Associates/Diploma degree
- ☐ Bachelor's degree
- ☐ Graduate degree
- ☐ Don't know
- ☐ Prefer not to answer

10. What is the highest level of education your father completed?

- ☐ Less than 8 years
- ☐ 8 to 11 years (without high school graduation) High school graduation
- ☐ Vocational or technical school
- ☐ Some college or university
- ☐ Certificate degree
- ☐ Associates/Diploma degree
- ☐ Bachelor's degree
- ☐ Graduate degree
- ☐ Don't know
- ☐ Prefer not to answer

11. Counting yourself, how many members live in your household? Please include anyone who lives with you at least half of the time

- ☐ 1-12 (specify): ___
- ☐ More than 12
- ☐ Prefer not to answer

12. How many members of your household are under age 18? (Select 0 if none are in this age group)

- ☐ 0
- ☐ 1-12 (specify): ___
- ☐ More than 12
- ☐ Prefer not to answer

13. Including yourself, how many members of your household are between the ages of 18 and 64? (Select 0 if none are not in this age group?

- ☐ 0
- ☐ 1-12 (specify): ___
- ☐ More than 12
- ☐ Prefer not to answer

14. How many members of your household are 65 years or older? (Select 0 if none are in this age group)
- ☐ 0
- ☐ 1-12 (specify): ____
- ☐ More than 12
- ☐ Prefer not to answer

Module B: Reproductive History

PREVIEW LINK TO QUALTRICS SURVEY:
https://bcfamilyregistry.az1.qualtrics.com/jfe/preview/SV_8vRxVWS9JZq6HYx?Q_SurveyVersionID=current&Q_CHL=preview

The following questions ask about your reproductive history.

This module takes about 15-20 minutes to complete.

B1. Pregnancies

The following questions ask about pregnancies you may have had.

1. Have you ever been pregnant?

- ☐ Yes
- ☐ No→ *go to Section B2*
- ☐ Don't know→ *go to Section B2*

2. Are you currently pregnant?

- ☐ Yes
- ☐ No
- ☐ Don't know

3. How many pregnancies have you had in total? Please include your current pregnancy, if applicable.

_____ pregnancies

4. Do you use the English or Metric system?

- ☐ English (feet, inches, pounds, etc.)
- ☐ Metric (meters, centimeters, kilograms, etc.)

5. For each pregnancy, please fill in the column(s) below:
table displays for number of pregnancies indicated in Question 3

	PREGNANCY 1	PREGNANCY 2
How long was this pregnancy?	☐ 3 months or less ☐ 4 to 6 months ☐ 7 months or more ☐ Don't know	☐ 3 months or less ☐ 4 to 6 months ☐ 7 months or more ☐ Don't know
What was the outcome of this pregnancy?	☐ Currently pregnant ☐ Live birth ☐ Stillbirth ☐ Miscarriage or spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion ☐ Don't know	☐ Currently pregnant ☐ Live birth ☐ Stillbirth ☐ Miscarriage or spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion ☐ Don't know
Did you experience any of the following?	☐ High blood pressure (Hypertension) ☐ Gestational diabetes ☐ Pre-eclampsia or eclampsia ☐ None of these conditions ☐ Don't know	☐ High blood pressure (Hypertension) ☐ Gestational diabetes ☐ Pre-eclampsia or eclampsia ☐ None of these conditions ☐ Don't know
What was the birth date of this baby (babies)? MM/DD/YYYY	___ / ___ / ____ mm dd yyyy	___ / ___ / ____ mm dd yyyy
What was the sex of this baby(babies)?	___ Number of Boys ___ Number of Girls	___ Number of Boys ___ Number of Girls
Please answer the following two questions using your preferred system of measurement		
What was the birth weight of this baby (these babies)? If multiple, please write all of the babies' weights on the line separated by commas.	***(English system)*** ☐ Less than 5.5 lb. ☐ 5.5-6.9 lb. ☐ 7-8.4 lb. ☐ 8.5-9.9 lb. ☐ Greater than or equal to 10 lb. ☐ Multiple babies: _____ ☐ Don't know	***(English system)*** ☐ Less than 5.5 lb. ☐ 5.5-6.9 lb. ☐ 7-8.4 lb. ☐ 8.5-9.9 lb. ☐ Greater than or equal to 10 lb. ☐ Multiple babies: _____ ☐ Don't know
	(Metric system) ☐ Less than 2.5 kg. ☐ 2.5-3.1 kg. ☐ 3.2-3.8 kg. ☐ 3.9-4.4 kg. ☐ Greater than or equal to 4.5 kg. ☐ Multiple babies: _____ ☐ Don't know	***(Metric system)*** ☐ Less than 2.5 kg. ☐ 2.5-3.1 kg. ☐ 3.2-3.8 kg. ☐ 3.9-4.4 kg. ☐ Greater than or equal to 4.5 kg. ☐ Multiple babies: _____ ☐ Don't know
How much weight did you gain during pregnancy?	***(English system)*** ☐ 0-9 lbs. ☐ 10-19 lbs.	***(English system)*** ☐ 0-9 lbs. ☐ 10-19 lbs.

	☐ 20-29 lbs. ☐ 30-39 lbs. ☐ 40-49 lbs. ☐ Greater than or equal to 50 lbs. ☐ Lost weight ☐ Don't know	☐ 20-29 lbs. ☐ 30-39 lbs. ☐ 40-49 lbs. ☐ Greater than or equal to 50 lbs. ☐ Lost weight ☐ Don't know
	(Metric system) ☐ 0-4 kg. ☐ 5-8 kg. ☐ 9-13 kg. ☐ 14-17 kg. ☐ 18-22 kg. ☐ Greater than or equal to 23 kg. ☐ Lost weight ☐ Don't know	***(Metric system)*** ☐ 0-4 kg. ☐ 5-8 kg. ☐ 9-13 kg. ☐ 14-17 kg. ☐ 18-22 kg. ☐ Greater than or equal to 23 kg. ☐ Lost weight ☐ Don't know
Did you breast feed this baby (babies)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
For how many months did you breast feed this baby(babies)?	☐ Less than 1 month ☐ 1 to 5 months ☐ 6 to 11 months ☐ 12 to 23 months ☐ 24 months or longer ☐ Don't know	☐ Less than 1 month ☐ 1 to 5 months ☐ 6 to 11 months ☐ 12 to 23 months ☐ 24 months or longer ☐ Don't know
Was this baby (babies) ever breastfed directly at the breast?	☐ Yes ☐ No ☐ Baby (Babies) refused ☐ Don't know	☐ Yes ☐ No ☐ Baby (Babies) refused ☐ Don't know
How old was this baby (babies) when [he/she] started feeding at the breast?	☐ _____days ☐ _____weeks ☐ _____months	☐ _____days ☐ _____weeks ☐ _____months
How old was this child when [he/she] completely stopped feeding at the breast?	☐ _____days ☐ _____weeks ☐ _____months	☐ _____days ☐ _____weeks ☐ _____months

B2. Fertility

The next questions are about your fertility.

1. Have you ever tried to become pregnant for one year or longer without success?

☐ Yes
☐ No

2. Are you currently trying to become pregnant?

- ☐ Yes
- ☐ No→ *go to Question 4*

3. For how many months have you been trying to become pregnant?

- ☐ <1months
- ☐ 1-25 months (specify): ____
- ☐ ≥25 months
- ☐ Don't know

4. Have you or your current partner ever been given a diagnosis of "infertility"?

- ☐ Yes
- ☐ No→ *go to Question 6*

5. Please specify the cause of infertility:

- ☐ Male infertility
- ☐ Female infertility
- ☐ Cause not investigated
- ☐ Cause investigated but not found
- ☐ Don't know

6. Have you ever taken a prescription medication for infertility?

- ☐ Yes
- ☐ No→ *go to Section B3*
- ☐ Don't know→ *go to Section B3*

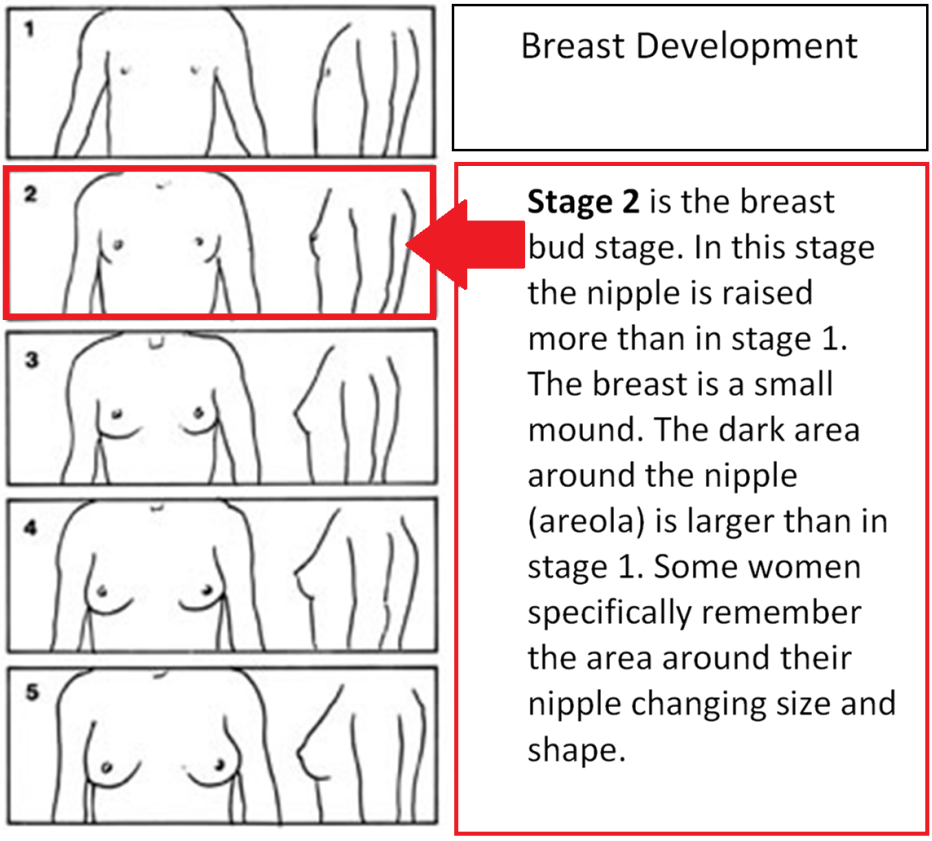
7. What medications for infertility did you take?

- ☐ Bravelle (follicle stimulating hormone)
- ☐ Lutrepulse (GRH)
- ☐ Cetrotide (gonadotropin-releasing hormone antagonist)
- ☐ Menopur (HMG)
- ☐ Clomid (clomiphene citrate)
- ☐ Novarel (human chorionic gonadotropin)
- ☐ Crinone (progesterone)
- ☐ Ovidrel (HCG)
- ☐ Dostinex (prolactin reducing)
- ☐ Parlodel (prolactin reducing)
- ☐ Factrel (gonadotropin-releasing hormone)
- ☐ Pergonal (HMG)
- ☐ Femara (Letrozole)
- ☐ Pregnyl (HCG)
- ☐ Fertinex (follicle stimulating hormone)
- ☐ Profasi
- ☐ Follistim (follicle stimulating hormone)
- ☐ Prometrium (progesterone)
- ☐ Ganirelex Acetate (GRHA)
- ☐ Repronex (HMG)
- ☐ Gonal-F (FSH)
- ☐ Serophene (clomiphene citrate)
- ☐ Humegon (human menopausal gonadotropin)
- ☐ Zoladex (GRHA)
- ☐ Lupron (leuprolide acetate)
- ☐ Diphereline (triptorelin)
- ☐ Elonva (FSH)
- ☐ Endometrin (progesterone)
- ☐ Lucrin (GnRH analogue)
- ☐ Luveris (luteinising hormone)
- ☐ Orgalutron (GRHA)
- ☐ Oripro (progesterone)
- ☐ Puregon (FSH)
- ☐ Synarel (GnRH analogue)
- ☐ Utrogestan (progesterone)
- ☐ Vekovelle (FSH)
- ☐ Other (Specify): _____

B3. Puberty, Menstruation, and Menopause

These next questions ask about your pubertal development such as breast development and menstrual periods.

1. How old were you when breast development began, indicated by Stage 2 in the picture below? (Choose **one** of your preferred formats to answer: Age start or grade in school.)



- ☐ Don't know
- ☐ Age:
  - ☐ Under five years old
  - ☐ 5-20 years old (specify): _____
  - ☐ Over 20 years old
- ☐ Grade:
  - ☐ Pre-kindergarten
  - ☐ Kindergarten
  - ☐ Grade 1-12 (specify): _____
  - ☐ After high school

2. How old were you when you had your first period? (Choose **one** of your preferred formats to answer: Age start or grade in school.)

- ☐ Never had a period
- ☐ Don't know
- ☐ Age:
  - ☐ Under five years old
  - ☐ 5-20 years old (specify): _____
  - ☐ Over 20 years old
- ☐ Grade:
  - ☐ Pre-kindergarten
  - ☐ Kindergarten
  - ☐ Grade 1-12 (specify): _____
  - ☐ After high school

3. How long after your first menstrual period did your periods become regular? Regular means you could predict within a few days when your period would start. Please exclude times you were taking hormonal methods of birth control for any reason.

- ☐ Under 1 year
- ☐ 1 year
- ☐ 2 years
- ☐ 3 years
- ☐ 4 years
- ☐ Never regular
- ☐ Don't know (always on birth control or other reasons)

4. Have you ever had infrequent or irregular menstruation?

- ☐ Yes
- ☐ No → *go to Question 7*
- ☐ Don't know→ *go to Question 7*

5. How old were you when this infrequent or irregular menstruation started?

- ☐ <18
- ☐ 18-24
- ☐ 25-30
- ☐ 31-35
- ☐ 36-39
- ☐ >39
- ☐ Don't know

6. Did you ever see a medical provider about this problem?

- ☐ Yes
- ☐ No
- ☐ Don't know

7. Have you ever had painful menstruation?

- ☐ Yes
- ☐ No → *go to Question 10*
- ☐ Don't know→ *go to Question 10*

8. How old were you when this painful menstruation started?

- ☐ <18
- ☐ 18-24
- ☐ 25-30
- ☐ 31-35
- ☐ 36-40
- ☐ 41-45
- ☐ >45
- ☐ Don't know

9. Did you ever see a medical provider about this problem?

- ☐ Yes
- ☐ No
- ☐ Don't know

10. Please fill in the table below for birth control method(s). Please select **all** options that apply. If you have never used birth control, select "None".

Which of the following birth control method(s) have you used in the past or currently?	At what age did you start? (years)	Approximately how long did you use the birth control methods? (months or years)
☐ Pill (specify name) _____	☐ <15 years old ☐ 15-35 (specify): ____years old ☐ >35 years old ☐ Don't know	☐ Months: ☐ 0-20(specify): _____months ☐ Over 20 months ☐ Years: ☐ 0-20(specify): _____years ☐ Over 20 years ☐ Not applicable ☐ Still presently taking
☐ Patch (Ortho Evra or Xulane)	☐ <15 years old ☐ 15-35 (specify): ____years old ☐ >35 years old ☐ Don't know	☐ Months: ☐ 0-20(specify): _____months ☐ Over 20 months ☐ Years: ☐ 0-20(specify): _____years ☐ Over 20 years ☐ Not applicable ☐ Still presently taking
☐ Shot/Injection (Depo-Provera – DMPA)	☐ <15 years old ☐ 15-35 (specify): ____years old	☐ Months: ☐ 0-20(specify): _____months

	☐ >35 years old ☐ Don't know	☐ Over 20 months ☐ Years: ☐ 0-20(specify): _____years ☐ Over 20 years ☐ Not applicable ☐ Still presently taking
☐ Implant (Implanon or Nexplanon)	☐ <15 years old ☐ 15-35 (specify) :____years old ☐ >35 years old ☐ Don't know	☐ Months: ☐ 0-20(specify): _____months ☐ Over 20 months ☐ Years: ☐ 0-20(specify): _____years ☐ Over 20 years ☐ Not applicable ☐ Still presently taking
☐ Hormonal IUD (e.g., Mirena, Skyla, Kyleena)	☐ <15 years old ☐ 15-35 (specify): ____years old ☐ >35 years old ☐ Don't know	☐ Months: ☐ 0-20(specify): _____months ☐ Over 20 months ☐ Years: ☐ 0-20(specify): _____years ☐ Over 20 years ☐ Not applicable ☐ Still presently taking
☐ Non-hormonal IUD (ParaGard)	☐ <15 years old ☐ 15-35 (specify): ____years old ☐ >35 years old ☐ Don't know	☐ Months: ☐ 0-20(specify): _____months ☐ Over 20 months ☐ Years: ☐ 0-20(specify): _____years ☐ Over 20 years ☐ Not applicable ☐ Still presently taking
☐ Ring (NuvaRing)	☐ <15 years old ☐ 15-35 (specify): ____years old ☐ >35 years old ☐ Don't know	☐ Months: ☐ 0-20(specify): _____months ☐ Over 20 months ☐ Years: ☐ 0-20(specify): _____years ☐ Over 20 years ☐ Not applicable ☐ Still presently taking
☐ Other(specify): _____	☐ <15 years old ☐ 15-35 (specify): ____years old ☐ >35 years old ☐ Don't know	☐ Months: ☐ 0-20(specify): _____months ☐ Over 20 months ☐ Years: ☐ 0-20(specify): _____years ☐ Over 20 years ☐ Not applicable ☐ Still presently taking

☐ None

11. Have you had a menstrual period in the last 12 months?

- ☐ Yes
- ☐ No → *go to Question 17*
- ☐ Don't know→ *go to Question 18*

12. How many menstrual periods have you had in the last 12 months?

- ☐ 1-3
- ☐ 4-6
- ☐ 7-10
- ☐ 11-14
- ☐ Greater than 14
- ☐ Don't know

13. What was the date your last menstrual period began? MM/DD/YYYY

_____ / _____ / _____
mm dd yyyy

14. On average, during the last 12 months, how many days were there in your typical menstrual cycle (from the beginning of bleeding of one menstrual cycle to the beginning of the bleeding of the next cycle)?

- ☐ Fewer than 21 days
- ☐ 21-25 days
- ☐ 26-32 days
- ☐ 33-35 days
- ☐ 36-60 days
- ☐ 61-90 days
- ☐ More than 90 days
- ☐ Too variable to say
- ☐ Don't know

15. During the last 12 months, did your menstrual period usually start within 4 days of the day you expected it to start? By "usually" we mean for at least half of the time.

- ☐ Yes
- ☐ No
- ☐ Don't know

16. Was there a time you went for 60 days or longer without getting your period (and you were not pregnant or breastfeeding?)

- ☐ Yes
- ☐ No
- ☐ Don't know

17. Why did your period stop? *(Check all that apply)*

- ☐ Natural menopause (periods stopped by themselves)
- ☐ Hysterectomy (womb or uterus removed)
- ☐ Both ovaries removed
- ☐ Radiation or chemotherapy
- ☐ Strenuous exercise
- ☐ Illness
- ☐ Pregnancy
- ☐ Hormonal birth control (contraceptive pills, IUDs, injections, implants etc.)
  - → 17.1. How old were you when you stopped hormonal birth control?
    - ☐ _____years old
    - ☐ I am still using this method
- ☐ Breastfeeding
- ☐ Other (please specify) _____
- ☐ Don't know

18. The following questions ask about common problems which affect women from time to time. Please indicate if you have experienced any of the following:

	Yes	No	Don't know
Night sweats	☐	☐	☐
Vaginal dryness	☐	☐	☐
Hot flashes or flushes	☐	☐	☐
More irritability or grouchiness than usual	☐	☐	☐

19. In the **past two weeks**, how many days did you experience this problem?

	Not at all	1-5 days	6-8 days	9-13 days	Every day	Don't know
Night sweats	☐	☐	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐	☐	☐
Hot flashes or flushes	☐	☐	☐	☐	☐	☐
More irritability or grouchiness than usual	☐	☐	☐	☐	☐	☐

20. Have you ever taken used estrogen, progesterone, or other hormonal medications for menopausal symptoms, that is, prescription hormone replacement therapy or HRT? Please include pills, injections, or skin patches, but do not include products inserted into the vagina.

- ☐ Yes
- ☐ No
- ☐ Don't know

21. Are you currently taking hormone replacement therapy? Please do not include hormone treatment for cancer, birth control, or fertility treatments.

- ☐ Yes
- ☐ No→ *go to Section C*
- ☐ Don't know → *go to Section C*

22.How long have you taken hormone replacement therapy?

- ☐ Less than 6 months
- ☐ 6-12 months
- ☐ 1-2 years
- ☐ 5-10 years
- ☐ 2-5 years
- ☐ 10-20 years
- ☐ 20-30 years
- ☐ Over 30 years
- ☐ Don't Know

23.What type of hormone replacement therapy did you take during that time? *Select all that apply.*

- ☐ Estrogen only (e.g., Premarin, Estraderm, Progynova)
- ☐ Combined progesterone and estrogen, such as patches or tablets (e.g., Kliovance, Estalis Trisequens, Prempro)
- ☐ Combination of separate progesterone and estrogen, such as tablets, patches, or IUDs (e.g., Mirena + Premarin, Provera + Progynova)
- ☐ Synthetic estrogen, progesterone, and androgen (testosterone) (e.g., Tibolone, Livial, Xyvion)
- ☐ I only know the brand name. (Please specify): _____
- ☐ Other. (Please specify): _____
- ☐ Don’t know

Module C: Medical History

PREVIEW LINK TO QUALTRICS SURVEY:
https://bcfamilyregistry.az1.qualtrics.com/jfe/preview/SV_9GItEYlLI5R6h2B?Q_SurveyVersionID=current&Q_CHL=preview

C1. Personal Medical History

The next questions are about health conditions you may have been diagnosed with by a doctor.

This module takes about 10-20 minutes to complete.

1. Please fill in the table below for **heart and cardiovascular diseases**.

	Have you ever been diagnosed by a doctor with any of these **heart and cardiovascular diseases**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?
Heart attack (myocardial infarction) or coronary artery disease (CAD)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Heart valve problems	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hypertension or high blood pressure	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hypertension during pregnancy, or preeclampsia	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hypertension at times other than pregnancy	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Congestive heart failure	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Bleeding or clotting	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Stroke, cerebrovascular accident, blood clot or bleeding in brain, or transient ischemic attack (TIA)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Blood clot in the legs or lungs (pulmonary embolism)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

2. Please fill in the table below for **endocrine disorders**.

	Have you ever been diagnosed by a doctor with any of these **endocrine disorders**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?
Diabetes	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Diabetes only during pregnancy (gestational diabetes)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Type 1 diabetes (insulin is prescribed for me)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Type 2 diabetes (insulin is NOT prescribed for me)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Thyroid disorder	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hyperthyroidism or Graves' disease (increased thyroid activity)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Hypothyroidism (decreased thyroid activity) requiring medications	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Thyroid nodules	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hashimoto's thyroiditis (inflammation of the thyroid gland)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hyperparathyroidism (increase in parathyroid hormone in the blood)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Polycystic ovary syndrome or PCOS	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hirsutism (excess body hair)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Osteoporosis (thin bones)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

3. Please fill in the table below for **gynecologic conditions**.

	Have you ever been diagnosed by a doctor with any of these **gynecologic conditions**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?
Endometriosis	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Endometriosis confirmed by surgery	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Uterine fibroids (benign growth in uterus)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

HPV or human papillomavirus (detected by PAP smear)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

4. Please fill in the table below for **psychological conditions**.

	Have you ever been diagnosed by a doctor with any of these **psychological conditions**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?
Clinical depression	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Anxiety disorder	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

5. Please fill in the table below for **cancers**.

	Have you ever been diagnosed by a doctor with any of these **cancers**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?
Breast cancer	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ovarian Cancer	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Uterine Cancer	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cervical cancer	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Colorectal cancer	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Lung cancer	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Sarcoma	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Leukemia	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Other cancer(specify)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

6. Please fill in the table below for **colon or gastrointestinal (GI) conditions**.

	Have you ever been diagnosed by a doctor with any of these **colon or gastrointestinal (GI) conditions**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?
Colon polyps	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Inflammatory bowel disease (Crohn's disease, ulcerative colitis)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hepatitis, cirrhosis, or serious liver damage	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

7. Please fill in the table below for **autoimmune disorders**.

	Have you ever been diagnosed by a doctor with any of these **autoimmune disorders**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?

Lupus (Inflammatory disease caused when the immune system attacks its own tissues)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Rheumatoid arthritis	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Celiac disease	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

8. Please fill in the table below for **kidney conditions**.

	Have you ever been diagnosed by a doctor with any of these **kidney conditions**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?
Kidney stones	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Kidney failure	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Kidney disease requiring dialysis	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

9. Please fill in the table below for **infectious conditions**.

	Have you ever been diagnosed by a doctor with any of these **infectious conditions**?	When were you first diagnosed? (Age **or** year)	Did you take medications for this/these conditions?
Pelvic inflammatory disease (PID)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Tonsillitis or strep throat	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Infectious mononucleosis (Mono)	☐ Yes ☐ No ☐ Don't know	☐ Age: ____ years ☐ Year: ____ ☐ Don't know	☐ Yes ☐ No ☐ Don't know

10. Please fill in the table below for medications.

	Have you ever taken this medication at least 2 times **per week** for one month or longer?	In total, how long did you take this medication at least 2 times **per week**?	During this period, **on average** how many times per week did you take this medication? (For example, twice a day is 14 times per week)	Are you **currently** taking this medication at least two times per week?
Regular Strength Aspirin (325mg) (Anacin, Bufferin, Excedrin)	☐ Yes ☐ No ☐ Don't know	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Low Dose Aspirin / Baby Aspirin (81mg)	☐ Yes ☐ No ☐ Don't know	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Acetaminophen (Tylenol, Anacin-3, Panadol, Aspirin Free Excedrin)	☐ Yes ☐ No ☐ Don't know	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Non-steroidal anti-inflammatory medications such as ibuprofen, indomethacin, naproxen, mefenamic acid, or diclofenac (Advil, Aleve, Motrin, Nuprin, Indocin, Naprosyn, Medipren etc.)	☐ Yes ☐ No ☐ Don't know	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cox-2 inhibitor (Celebrex, meloxicam, or etoricoxib Vioxx, Bextra, Valdecoxib, Elecoxib, Celecoxib, and Rofecoxib.)	☐ Yes ☐ No ☐ Don't know	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know

11. Have you ever taken any other pain or anti-inflammatory medications at least two times per week for one month or longer?

- ☐ Yes
- ☐ No → *go to Question 13*
- ☐ Don't know → *go to Question 13*

12. Please fill in the table below for other pain or anti-inflammatory medications.

Please **list** any other pain or anti-inflammatory medications that you took at least two times per week for one month or longer **in the cell**. If you do not know the name, please write "Unknown".	In total, how long did you take this medication at least 2 times **per week**?	During this period, **on average** how many times per week did you take this medication?	Are you currently taking this medication at least two times per week?

Medication 1 (specify): _____	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Medication 2 (specify): _____	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Medication 3 (specify): _____	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know

13. Have you ever taken any medications for anxiety or depression at least two times per week for one month or longer?

- ☐ Yes
- ☐ No → *go to Question 15*
- ☐ Don't know → *go to Question 15*

14. Please fill in the table below for medications for anxiety or depression.

Please **list** any medications for anxiety or depression that you took at least two times per week for one month or longer **in the cell**. If you do not know	In total, how long did you take this medication at least 2 times **per week**?	During this period, **on average** how many times per week did you take this medication?	Are you currently taking this medication at least two times per week?

the name, please write "Unknown".			
Medication 1 (specify): _____	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Medication 2 (specify): _____	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Medication 3 (specify): _____	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No ☐ Don't know

15. Have you ever taken any medications to prevent or treat osteoporosis (loss of bone strength)?

☐ Yes
☐ No → *go to Section C2*
☐ Don't know → *go to Section C2*

16. Which medication/s did you take to prevent or treat osteoporosis? *(Select all that apply)*

- ☐ Alendronate (Fosamax)
- ☐ Risedronate (Actonel)
- ☐ Ibandronate (Boniva)
- ☐ Zoledronic acid (Aclasta, Reclast)
- ☐ Denosumab (Prolia, Xgeva)
- ☐ Raloxifene (Evista)
- ☐ Other (specify)_____

17. In total, for how many months **or** years have you taken these medications?

- ☐ _____ months
- ☐ _____years
- ☐ Don't know

18. How old were you when you first started taking any of these medications to prevent or treat osteoporosis?

- ☐ Less than 20 years old
- ☐ Over 20 years old (specify): _____
- ☐ Don't know

19. Are you currently taking any of these medications to prevent or treat osteoporosis?

- ☐ Yes → *go to Section C2*
- ☐ No
- ☐ Don't know → *go to Section C2*

20. At what age did you **stop** taking these medications?

- ☐ Less than 20 years old
- ☐ 20-45 years old (specify): _____
- ☐ Over 45 years old
- ☐ Don't know

C2. Supplements and Alternative Therapies

These questions are about your regular use of vitamins. We are only interested in vitamins you took **at least two times per week for one month or longer**.

1. Have you ever taken any of the following vitamins at least two times per week for one month or longer?

Multivitamin
B vitamin complex Vitamin A
Vitamin C
Vitamin D
Vitamin E
Calcium
Folic Acid
Other

☐ Yes
☐ No→ *go to Question 3*
☐ Don't know → *go to Question 3*

2. Please fill in the table below for regular use of vitamins.

	Have you ever taken this medication at least 2 times per week for one month or longer?	In total, how long did you take this medication at least 2 times **per week**?	During this period, **on average** how many times per week did you take this medication	Are you currently taking this medication at least 2 times per week?
Multivitamin	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
B vitamin complex	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No

Vitamin A	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Vitamin C	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Vitamin D	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Vitamin E	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No

Calcium	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Folic Acid	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Other(specify): _____	☐ Yes ☐ No	☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3-4 years ☐ 5-9 years ☐ 10 years or longer ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No

The next questions are about your regular use of herbal preparations. We are only interested in herbal preparations you took **at least two times per week for one month or longer**.

3. Have you ever taken any of the herbal preparations listed below at least two times per week for one month or longer?

Soy estrogen pills
Dong quai (such as Rejuvex)
Natural progesterone cream or wild yam cream
Black cohosh (such as Remifemin)
Flaxseed or linseed oil
CoQ10
Echinacea
Gingko biloba
Ginseng
Omega-3 fish oils
Glucosamine chondroitin
Green tea
St. John's Wort
Probiotics
Other

☐ Yes
☐ No→ *go to Section D*

4. Please fill in the table below for regular use of herbal preparations.

	Have you ever taken this medication at least 2 times per week for one month or longer?	During this period, **on average** how many times per week did you take this medication?	Are you currently taking this medication at least 2 times per week?
Soy estrogen pills	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No

Dong quai (such as Rejuvex)	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Natural progesterone cream or wild yam cream	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Black cohosh (such as Remifemin)	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Flaxseed or linseed oil	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
CoQ10	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times	☐ Yes ☐ No

		per week ☐ Don't know	
Echinacea	☐ Yes ☐ No ☐ Don’t know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Gingko biloba	☐ Yes ☐ No ☐ Don’t know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Ginseng	☐ Yes ☐ No ☐ Don’t know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Omega-3 fish oils	☐ Yes ☐ No ☐ Don’t know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No

Glucosamine chondroitin	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Green tea	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
St. John's Wort	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Probiotics	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times per week ☐ Don't know	☐ Yes ☐ No
Other(specify): _____	☐ Yes ☐ No ☐ Don't know	☐ 1-5 times per week ☐ 6-10 times per week ☐ 11-15 times per week ☐ 16-20 times per week ☐ 21-25 times per week ☐ 26-30 times per week ☐ More than 30 times	☐ Yes ☐ No

		per week ☐ Don't know	

Module D: Lifestyle (Alcohol & Tobacco)

PREVIEW LINK TO QUALTRICS SURVEY:
https://bcfamilyregistry.az1.qualtrics.com/jfe/preview/SV_0q8ysYFIACkjBPf?Q_SurveyVersionID=current&Q_CHL=preview

The next questions ask about your intake of alcohol and tobacco.

This module takes about 10-15 minutes to complete.

D1. Alcohol

The next questions ask about your consumption of alcohol.

1. Have you ever consumed any alcoholic beverages, such as beer, wine, or spirits at least one per week for 6 months or longer?

- ☐ Yes
- ☐ No → *go to Question 7*

2. At what age did you first start drinking alcoholic beverages at least once per week for 6 months or longer?

- ☐ Less than 15 years old
- ☐ 15-40 years old (specify): _____
- ☐ More than 40 years old
- ☐ Don’t know

3. For how many years, did you consume alcohol at least once per week?

- ☐ Less than 1 year
- ☐ 1-20 years old (specify): _____
- ☐ More than 20 years
- ☐ Don’t know

4. Are you currently drinking alcohol at least once per week?

- ☐ Yes → *go to Question 6*
- ☐ No

5. At what age did you stop consuming alcohol at least once per week?

- ☐ Less than 18 years old
- ☐ 18-50 years old (specify): _____
- ☐ More than 50 years old
- ☐ Don't know

6. When you consume(d) alcohol at least once per week, how much of each beverage do/did you usually drink?

	None or never	Less than 1 per week	1-2 per week	3-4 per week	5-7 per week	8-14 per week	15 or more per week	Don't know
Beer (1 drink= 1 bottle, can, or glass)	☐	☐	☐	☐	☐	☐	☐	☐
Wine, Champagne (1 drink= 1 glass)	☐	☐	☐	☐	☐	☐	☐	☐
Cocktails, Liquor (1 drink = 1 cocktail, shot, or mixed drink)	☐	☐	☐	☐	☐	☐	☐	☐
Other type (1 drink) Please specify: _____	☐	☐	☐	☐	☐	☐	☐	☐

The next questions concern drinking alcoholic beverages in a single sitting during certain time periods over your lifetime.

7. Have you ever consumed 4 or more alcoholic beverages within a two-hour period, such as beer, wine, or liquor?

- ☐ Yes
- ☐ No → *go to Question 10*

8. During the age ranges below, did you ever drink 4 or more alcoholic beverages within a two-hour period?

	Yes	No	Don't know
Teens (age 10-19)	☐	☐	☐
20's (age 20-29)	☐	☐	☐
30's (age 30-39)	☐	☐	☐

9. About how many times did you drink 4 or more alcoholic beverages within a two-hour period during those years?

	Times per week	Times per month	Times per year	Total number of times
Teens (age 10-19)	☐ 1-7 times(specify): _____ ☐ More than 7 times ☐ Don't know	☐ 1-20 times(specify): _____ ☐ More than 20 times ☐ Don't know	☐ 1-20 times(specify): _____ ☐ More than 20 times ☐ Don't know	☐ Less than 5 ☐ 5-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-30 ☐ 31-35 ☐ 36-40 ☐ 41-45 ☐ 46-50 ☐ More than 50 times ☐ Don't know
20's (age 20-29)	☐ 1-7 times(specify): _____ ☐ More than 7 times ☐ Don't know	☐ 1-20 times(specify): _____ ☐ More than 20 times ☐ Don't know	☐ 1-20 times(specify): _____ ☐ More than 20 times ☐ Don't know	☐ Less than 5 ☐ 5-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-30 ☐ 31-35 ☐ 36-40 ☐ 41-45 ☐ 46-50 ☐ More than 50 times ☐ Don't know
30's (age 30-39)	☐ 1-7 times(specify): _____ ☐ More than 7 times ☐ Don't know	☐ 1-20 times(specify): _____ ☐ More than 20 times ☐ Don't know	☐ 1-20 times(specify): _____ ☐ More than 20 times ☐ Don't know	☐ Less than 5 ☐ 5-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-30 ☐ 31-35 ☐ 36-40 ☐ 41-45 ☐ 46-50 ☐ More than 50 times ☐ Don't know

10. Did you ever wake up in the morning after you had been drinking and found that you couldn't remember where you had been or what had happened?

- ☐ Yes
- ☐ No → *go to Section D2*

11. About how many times did this happen in your lifetime?

- ☐ Less than 5 times
- ☐ 5-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ 61-70
- ☐ 71-80
- ☐ 81-90
- ☐ 91-100
- ☐ More than 100 times
- ☐ Don't know

D2. Smoking

The next questions ask about your consumption of tobacco.

1. In the past 10 years, did you ever smoke at least 1 cigarette per day?

- ☐ Yes
- ☐ No → *go to Question 7*

2. At what age did you **first** start smoking at least 1 cigarette per day?

- ☐ Less than 15 years old
- ☐ 15-40 (specify): _____ years old
- ☐ More than 40 years old
- ☐ Don't know

3. For how many years in total have you smoked at least 1 cigarette per day?

- ☐ Less than 1 year
- ☐ 1-20 (specify): _____ years
- ☐ More than 20 years
- ☐ Don't know

4. when you smoke(d) at least 1 cigarette per day, how many cigarettes do (did) you usually smoke in a day? (Note: 1 pack = 20 cigarettes)

- ☐ Less than half pack
- ☐ Half pack to 1 pack
- ☐ More than 1 pack
- ☐ Don't know

5. Are you currently smoking at least 1 cigarette per day?

- ☐ Yes → *go to Question 7*
- ☐ No

6. At what age did you stop smoking at least 1 cigarette per day?

- ☐ Less than 15 years old
- ☐ 15-40 years old (specify): _____
- ☐ More than 40 years old
- ☐ Don't know

The following questions are about your use of hookah and electronic cigarettes.

The next question asks about smoking tobacco in a hookah. A hookah is a type of water pipe.

7. Have you ever smoked tobacco in a hookah in your entire life?

- ☐ Yes
- ☐ No → *go to Question 10*

8. How old were you when you first smoked a hookah even if only one or two puffs? Please do not include cigarettes in your answer.

- ☐ Less than 15 years old
- ☐ 15-40 years old (specify): _____
- ☐ More than 40 years old
- ☐ Don't know

9. How often do you now smoke tobacco in a hookah?

- ☐ Every day
- ☐ Some days
- ☐ Rarely
- ☐ Not at all

The next set of questions are about electronic cigarettes. Electronic cigarettes, or e-cigarettes as they are often called, are battery- operated devices that simulate smoking a cigarette, but do not involve the burning of tobacco. The heated vapor produced by an electronic cigarette often contains nicotine.

10. Have you ever used an electronic cigarette, even just one time in your lifetime?

- ☐ Yes
- ☐ No → *go to Section E*

11. Were any of the electronic cigarettes that you used in the past 30 days flavored to taste like menthol, mint, clove, spice, candy, fruit, chocolate, or other sweets?

- ☐ Yes
- ☐ No

12. How old were you when you first smoked on electronic cigarette even if only one or two puffs? Please do not include regular cigarettes in your answer.

- ☐ Less than 15 years old
- ☐ 15-40 years old (specify): _____
- ☐ More than 40 years old
- ☐ Don't know

13. How many times in total do you think you have used an electronic cigarette in your lifetime?

- ☐ 1-10
- ☐ 11-20
- ☐ 21-50
- ☐ Over 50 times
- ☐ Don't know

14. How often do you now use electronic cigarettes?

- ☐ Every day
- ☐ Some days
- ☐ Rarely
- ☐ Not at all

Module E: Physical Activity & Neighborhood

PREVIEW LINK TO QUALTRICS SURVEY:
https://bcfamilyregistry.az1.qualtrics.com/jfe/preview/SV_4OrFWoch3rxtanz?Q_SurveyVersionID=current&Q_CHL=preview

This module takes about 10- 15 minutes to complete.

The following are questions about your physical activity at different times in your life. Please estimate the average amount of time per week and the average number of months per year that you spent in strenuous and moderate exercise.

E1. Strenuous Exercise

1. How often did you participate in strenuous exercise activities or sports (e.g., swimming laps, aerobics, calisthenics, running, jogging, basketball, strenuous cycling, volleyball, soccer)? Please select **average hours per week**. *Select "N/A" for 'Not applicable'.*

	Average hours per week									
	N/A	None	0.5 hour	1 hour	1.5 hour	2 hours	3 hours	4-6 hours	7-10 hours	≥11 hours
During High school	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Between ages 18 and 24	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Between ages 25 and 34	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Between ages 35 and 40	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
In the past year	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. How often did you participate in **strenuous** exercise activities or sports (e.g., swimming laps, aerobics, calisthenics, running, jogging, basketball, strenuous cycling, volleyball, soccer)? Please select **average months per year**. *Select "N/A" for 'Not applicable'.*

	Average months per year				
	N/A	1-3 months	4-6 months	7-9 months	10-12 months
During High school	☐	☐	☐	☐	☐
Between ages 18 and 24	☐	☐	☐	☐	☐
Between ages 25 and 34	☐	☐	☐	☐	☐
Between ages 35 and 40	☐	☐	☐	☐	☐
In the past year	☐	☐	☐	☐	☐

E2. Moderate Exercise

1. How often did you participate in **moderate** exercise activities or sports (e.g., brisk walking, golf, recreational cycling, recreational tennis, or baseball)? Please select **average hours per week**. *Select "N/A" for 'Not applicable'.*

	Average hours per week									
	N/A	None	0.5 hour	1 hour	1.5 hour	2 hours	3 hours	4-6 hours	7-10 hours	≥11 hours
During High school	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Between ages 18 and 24	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Between ages 25 and 34	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Between ages 35 and 40	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
In the past year	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. How often did you participate in **moderate** exercise activities or sports (e.g., brisk walking, golf, recreational cycling, recreational tennis, or baseball)? Please select **average months per year.** *Select "N/A" for 'Not applicable'.*

	Average months per year				
	N/A	1-3 months	4-6 months	7-9 months	10-12 months
During High school	☐	☐	☐	☐	☐
Between ages 18 and 24	☐	☐	☐	☐	☐
Between ages 25 and 34	☐	☐	☐	☐	☐
Between ages 35 and 40	☐	☐	☐	☐	☐
In the past year	☐	☐	☐	☐	☐

3. In the past year, on average, how often did you spend time in the following activities? Please select **average hours per day in the past year**.

	Average hours per day							
	None	<1	1	2	3-4	5-6	7-9	≥10
Housework	☐	☐	☐	☐	☐	☐	☐	☐
Gardening	☐	☐	☐	☐	☐	☐	☐	☐
Standing or walking at home or at work	☐	☐	☐	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐	☐	☐
Resting or napping	☐	☐	☐	☐	☐	☐	☐	☐

4. In the past year, on average, how often did you spend time in the following activities? Please select **average days per week in the past year**. Select "N/A" for 'Not applicable'.

	Days per week in past year				
	N/A	1	2-3	4-5	6-7
Housework	☐	☐	☐	☐	☐
Gardening	☐	☐	☐	☐	☐
Standing or walking at home or at work	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐
Resting or napping	☐	☐	☐	☐	☐

E3. Your Height and Weight

The following questions are about your height and weight. Please answer these questions in your preferred system of measurement: English (feet, inches, pounds, etc.) or Metric (meters, centimeters, kilograms, etc.)

1. What is your current height?

☐ ____feet ____ inches ☐ ____meters ____ centimeters

2. What is your current weight?

☐ _____lb. ☐ _____kg.

3. What was your weight at age 18?

☐ _____lb. ☐ _____kg.

4. What is the most you have ever weighed since age 18? (Do not include times when you are pregnant)

☐ _____lb. ☐ _____kg.

5. Excluding times when you were pregnant or breast feeding, what was your **usual** weight when you were in your 20's and 30's (Check 'Not applicable' if you have not yet reached that age)

In your 20's (20-29):
- ☐ Not applicable
- ☐ _____lb.
- ☐ ____kg.

In your 30's (30-39):
- ☐ Not applicable
- ☐ _____lb.
- ☐ ____kg.

6. How many times in your life did you intentionally lose 4.5 or more kilograms/10 or more pounds? (Do not include times when you were pregnant or sick)

- ☐ None, or never
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ More than 10 times

7. How many times in your life have you regained as much as 4.5 or more kilograms/10 or more pounds that you previously have lost?

- ☐ None, or never
- ☐ 1-2
- ☐ 3-5
- ☐ 6-10
- ☐ More than 10 times

8. What is the most weight you have ever lost on purpose in your life? (If none, select 0)

- ☐ 0 lb.
- ☐ 1-5 lb.
- ☐ 6-10 lb.
- ☐ 11-20 lb.
- ☐ 21-30 lb.
- ☐ 31-40 lb.
- ☐ 41-50 lb.
- ☐ 51-60 lb.
- ☐ 61-70 lb.
- ☐ 71-80 lb.
- ☐ 81-90 lb.
- ☐ 91-100 lb.
- ☐ More than 100 lb.
- ☐ Don't know

- ☐ 0 kg.
- ☐ 1-2 kg.
- ☐ 3-4 kg.
- ☐ 5.0-9.0 kg.
- ☐ 10-13 kg.
- ☐ 14.0-18.0 kg.
- ☐ 19-22 kg.
- ☐ 23-27 kg.
- ☐ 28-31 kg.
- ☐ 32-36 kg.
- ☐ 37-40 kg.
- ☐ 41-45 kg.
- ☐ More than 45 kg.
- ☐ Don't know

9. What was your weight one year ago?

- ☐ _____lb.
- ☐ _____kg.

10. Over the last year has your weight changed by 5 pounds (2.5 kg) or more, excluding a change due to pregnancy?

- ☐ Yes
- ☐ No→ *go to Question 13*

11. Did you gain or lose weight? (Check all that apply)

☐ Gained weight
☐ Lost weight

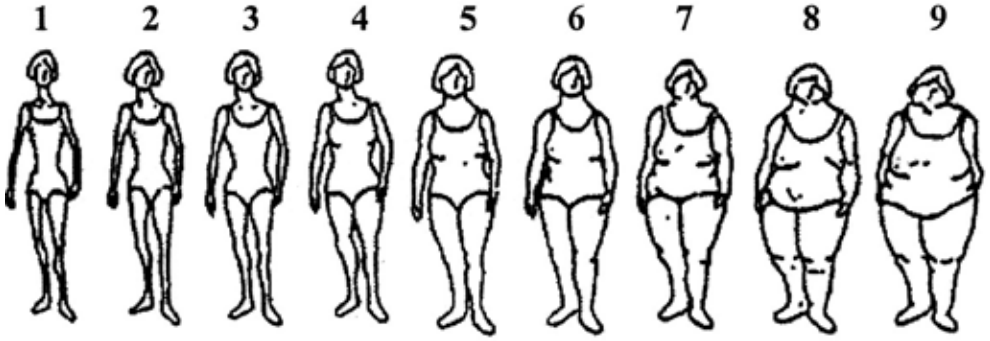
12. Was this weight change intentional or unintentional?

☐ Intentional weight gain
☐ Unintentional weight gain
☐ Intentional weight loss
☐ Unintentional weight loss

13. When you gain weight, where on your body do you mostly add the weight?

☐ Waist or upper body
☐ Hips or upper thighs
☐ Evenly over body
☐ I don't gain weight

14. Which of these pictures do you think best represents your body type at each age? *(For each age, please select one answer. Select "N/A" for 'Not applicable' if you have not yet reached that age)*



Female

	1	2	3	4	5	6	7	8	9	N/A
Currently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At age 10	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At age 15	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At age 20	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At age 25	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At age 30	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At age 35	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

E4. Your Neighborhood

In the following questions, we would like to find out what you think about the neighborhood of your primary home. If you live in more than one neighborhood, think about the neighborhood where you spend most of your time.

By "neighborhood," we mean your street and the streets within a 10-15 minute walk of your home.

1. What is the most common type of housing in your neighborhood?

- ☐ Detached single family housing
- ☐ Townhouses, row houses, apartments, or condos of 2-3 stories
- ☐ Mix of single-family residences and townhouses, row houses, apartments, or condos
- ☐ Apartments or condos of 4-12 stories
- ☐ Apartments or condos of more than 12 stories
- ☐ Don't know

2. Please fill in the table below for your neighborhood.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree	Don't know
Many shops, stores, markets, or other places to buy things are within easy walking distance of my home.	☐	☐	☐	☐	☐
My home is within a 10-15 minute walk of a transit stop (bus, subway, streetcar, trolley).	☐	☐	☐	☐	☐
There are sidewalks on most of the streets in my neighborhood.	☐	☐	☐	☐	☐
In or near my neighborhood, there are special bicycle lanes, separate paths or trails, or shared use paths for bicycles and pedestrians.	☐	☐	☐	☐	☐
My neighborhood has several free or low cost recreation facilities, such as parks, walking trails, bike paths, recreation centers, playgrounds, public swimming pools etc.	☐	☐	☐	☐	☐
The crime rate in my neighborhood makes it unsafe to go on walks at night.	☐	☐	☐	☐	☐
There are many four-way intersections in my neighborhood.	☐	☐	☐	☐	☐
There is so much traffic on the streets that it makes it difficult or unpleasant to walk in my neighborhood.	☐	☐	☐	☐	☐
Many people are physically active in my neighborhood.	☐	☐	☐	☐	☐

There are many interesting things to look at while walking in my neighborhood.	☐	☐	☐	☐	☐
The fresh fruits and vegetables in my neighborhood are of high quality.	☐	☐	☐	☐	☐
A large selection of fresh fruits and vegetables is available in my neighborhood.	☐	☐	☐	☐	☐
A large selection of low-fat food products is available in my neighborhood.	☐	☐	☐	☐	☐

The next questions concern your opinion about safety in your neighborhood.

3. Do you feel that you are safe when walking in your neighborhood?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

4. Do you believe there is enough street lighting in your neighborhood?

- ☐ Yes
- ☐ No
- ☐ There is no street lighting in my neighborhood
- ☐ Don't know
- ☐ Prefer not to answer

5. Do you consider your neighborhood to be safe from crime?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer