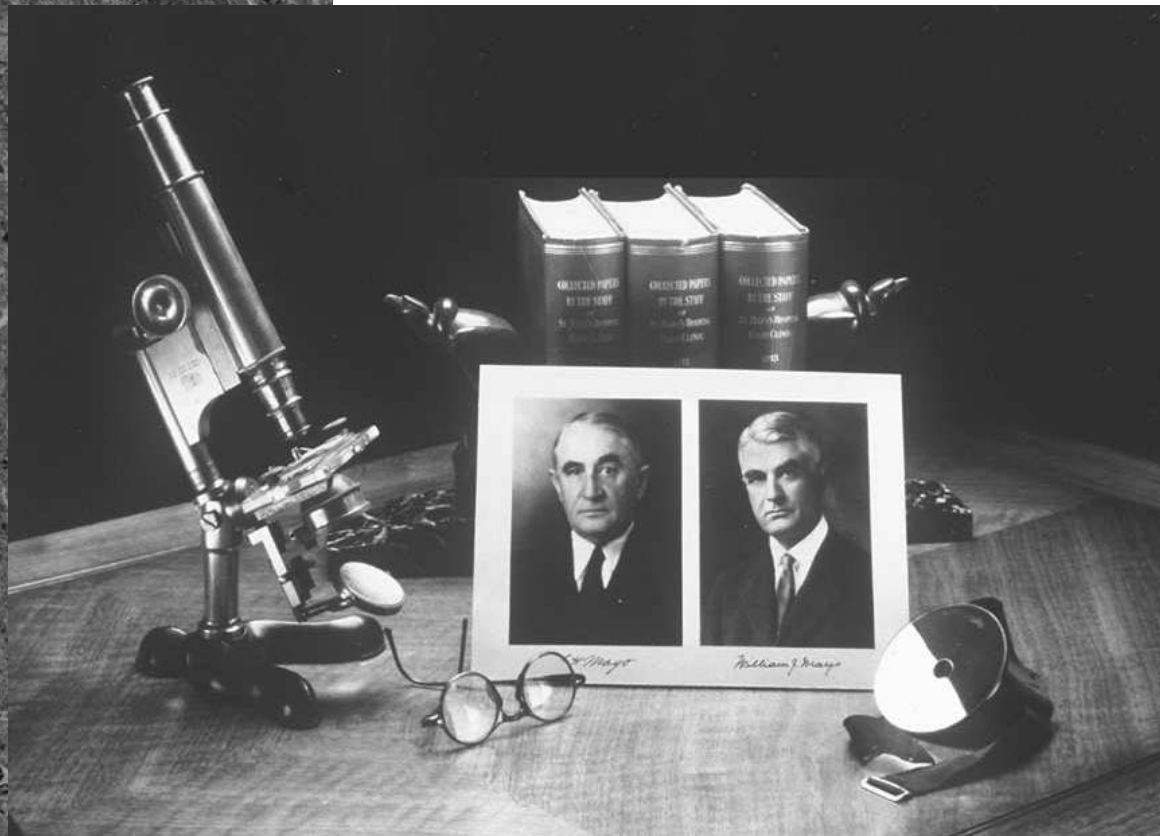


# *Mayo Clinic Biobank*



.....  
Survey Research Center



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

18\_

- 1  Better physical shape
- 2  About the same physical shape
- 3  Worse physical shape

**5. How would you describe...**

**your overall quality of life?**

19-20\_\_

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

As bad as  
it can be

As good as  
it can be

**your overall mental (intellectual) well-being?**

21-22\_\_

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

As bad as  
it can be

As good as  
it can be

**your overall physical well-being?**

23-24\_\_

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

As bad as  
it can be

As good as  
it can be

**your overall emotional well-being?**

25-26\_\_

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

As bad as  
it can be

As good as  
it can be

**your level of social activity?**

27-28\_\_

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

As bad as  
it can be

As good as  
it can be

**your overall spiritual well-being?**

29-30\_\_

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

As bad as  
it can be

As good as  
it can be



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

46\_

- 1  Not at all                      4  More than half the days  
2  Some                                5  Nearly every day  
3  Several days                      6  Don't know

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

47\_

- 1  Not at all                      4  More than half the days  
2  Some                                5  Nearly every day  
3  Several days                      6  Don't know

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

48\_

- 1  No                      2  Yes

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

49\_

- 1  No                      2  Yes

**If yes, how often does this or did this heartburn occur?**

50\_

- 1  Less than once a month  
2  About once a month  
3  About once a week  
4  Several times a week  
5  Daily

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

51\_

- 1  I do not take antacids for heartburn                      2  No                      3  Yes

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

52\_

- 1  No                      2  Yes

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

53\_

- 1  No                      2  Yes

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

54\_

1  No      2  Yes

If yes, do you experience acid regurgitation at least once a week?

55\_

1  No      2  Yes

15. Has your weight varied during the *past year*?

56\_

1  Remained stable      2  Increased more than 10 pounds      3  Decreased more than 10 pounds

Was this weight gain or loss intentional or unintentional?

57\_

1  Intentional      2  Unintentional

### PERSONAL AND FAMILY MEDICAL HISTORY

58\_

16. Are you adopted?      1  No      2  Yes

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

17. Is your father still living?

59\_

1  Yes, he is still living      2  No, he is deceased      3  I don't know

If deceased, what was his age at death?

60\_

1  Under 30      4  51 to 60      6  71 to 85  
2  30 to 40      5  61 to 70      7  Over 85  
3  41 to 50

18. Is your mother still living?

61\_

1  Yes, she is still living      2  No, she is deceased      3  I don't know

If deceased, what was her age at death?

62\_

1  Under 30      4  51 to 60      6  71 to 85  
2  30 to 40      5  61 to 70      7  Over 85  
3  41 to 50

19. For each of your blood relatives below, please tell us how many you have of each that are living and deceased.

	0	1	2	3	4	5	6	7+	Don't know
<b>Brothers</b>									
63_ Number living	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
64_ Number deceased	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
<b>Sisters</b>									
65_ Number living	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
66_ Number deceased	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
<b>Sons</b>									
67_ Number living	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
68_ Number deceased	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
<b>Daughters</b>									
69_ Number living	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
70_ Number deceased	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>

20. Please indicate the age you were first diagnosed with the following condition. If you have not been diagnosed with this condition, mark "None." In addition, please indicate whether or not your family members have had this condition by marking "Yes," "No," or "Don't know." We are only interested in relatives that are related to you by blood.

	<b>Self</b> Age when this condition was first diagnosed.						<b>Relatives</b> Do or did any of your first degree relatives (parents, sisters, brothers, children) have this condition?		
	None	19 or younger	20 to 49	50 to 64	65 to 79	80 or older	No	Yes	Don't know
<b>Rheumatologic</b>									
71:78 Arthritis (osteoarthritis)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
72:79 Arthritis (rheumatoid)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
73:80 Fibromyalgia	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
74:81 Autoimmune disorder (lupus, scleroderma)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<b>Gynecologic</b>									
75:82 Endometriosis	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<b>Liver</b>									
76:83 Hepatitis A, B, or C	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
77:84 Other liver disease	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Continues next page...

		<u>Self</u>						<u>Relatives</u>		
		Age when this condition was first diagnosed.						Do or did any of your first degree relatives (parents, sisters, brothers, children) have this condition?		
		None	19 or younger	20 to 49	50 to 64	65 to 79	80 or older	No	Yes	Don't know
<b><u>Hematologic</u></b>										
85:112	<b>Organ or bone marrow transplant</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
86:113	<b>Bleeding disorder</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
87:114	<b>Sickle cell anemia</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
88:115	<b>HIV (AIDS)</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
89:116	<b>Tuberculosis</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<b><u>Cancer</u></b>										
90:117	<b>Thyroid cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
91:118	<b>Lung cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
92:119	<b>Breast cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
93:120	<b>Esophageal cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
94:121	<b>Pancreatic cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
95:122	<b>Stomach cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
96:123	<b>Colon or rectal cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
97:124	<b>Liver cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
98:125	<b>Uterine/endometrial cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
99:126	<b>Cervical cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
100:127	<b>Ovarian cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
101:128	<b>Prostate cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
102:129	<b>Testicular cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
103:130	<b>Melanoma</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
104:131	<b>Nonmelanoma skin cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
105:132	<b>Sarcoma</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
106:133	<b>Bone cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
107:134	<b>Leukemia</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
108:135	<b>Lymphoma</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
109:136	<b>Kidney cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
110:137	<b>Urinary/bladder cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
111:138	<b>Other cancer</b> . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Continues next page...

		<u>Self</u>						<u>Relatives</u>		
		Age when this condition was first diagnosed.						Do or did any of your first degree relatives (parents, sisters, brothers, children) have this condition?		
		None	19 or younger	20 to 49	50 to 64	65 to 79	80 or older	No	Yes	Don't know
<u>Neurologic</u>										
139:161	Alzheimer's disease . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
140:162	Parkinson's disease . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
141:163	Dementia . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
142:164	Migraine headaches . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
143:165	Stroke (CVA) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
144:166	TIA (mini stroke) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
145:167	Epilepsy (seizure disorder) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
146:168	Narcolepsy . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<u>Mental Health</u>										
147:169	Anxiety . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
148:170	Depression . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
149:171	Down syndrome . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
150:172	Bipolar disorder . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
151:173	Autism . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
152:174	Attention deficit/ hyperactivity disorder . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
153:175	Alcoholism . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
154:176	Other psychiatric or mental illness . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<u>Eye</u>										
155:177	Glaucoma . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
156:178	Cataracts . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
157:179	Abnormal distance vision . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
158:180	Lazy eye (amblyopia) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
159:181	Misalignment, crossing, or wandering of the eyes (strabismus) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
160:182	Macular degeneration . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Continues next page...

		<u>Self</u>						<u>Relatives</u>		
		Age when this condition was first diagnosed.						Do or did any of your first degree relatives (parents, sisters, brothers, children) have this condition?		
		None	19 or younger	20 to 49	50 to 64	65 to 79	80 or older	No	Yes	Don't know
<b><u>Cardiovascular</u></b>										
183:206	Heart attack/myocardial infarction . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
184:207	Congestive heart failure . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
185:208	Cardiomyopathy . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
186:209	Atrial fibrillation/arrhythmia . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
187:210	Congenital heart disease . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
188:211	High blood pressure (hypertension) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
189:212	High cholesterol (hyperlipidemia) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
190:213	Venous thromboembolism . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<b><u>Respiratory</u></b>										
191:214	Asthma . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
192:215	Chronic obstructive pulmonary disease (COPD) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
193:216	Sleep apnea . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
194:217	Asbestosis . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
195:218	Pulmonary fibrosis . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<b><u>Gastrointestinal</u></b>										
196:219	Acid reflux or gastroesophageal reflux disorder (GERD) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
197:220	Barrett's esophagus . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
198:221	Celiac disease . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
199:222	Irritable bowel disease (IBS) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
200:223	Crohn's disease or ulcerative colitis . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
201:224	Lynch syndrome or HNPCC . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
202:225	Other polyposis syndrome (FAP, Peutz-Jeghers, juvenile polyposis, etc.) . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
<b><u>Endocrine</u></b>										
203:226	Type 1 diabetes . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
204:227	Type 2 diabetes . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
205:228	Hyperthyroidism/hypothyroidism . . . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

21. Do you have any allergies? (Mark all that apply.)

- 229\_ 1  No allergies  
230\_ 1  Food allergies such as shellfish or nuts  
231\_ 1  Grasses, pollen, or dust  
232\_ 1  Pets  
233\_ 1  Insect stings or bites  
234\_ 1  Other, please specify: \_\_\_\_\_

22. Have you ever had 5 or more moderate to severe headaches that lasted at least 4 hours and which were accompanied by either nausea OR light and sound sensitivity?

- 235\_ 1  No 2  Yes

23. Have you ever experienced episodes of a shimmering visual disturbance or blind spot; unilateral numbness/tingling; OR an inability to think of the correct word or understand what is said to you, that lasted 5 to 60 minutes?

- 236\_ 1  No 2  Yes

24. Have you ever been treated with chemotherapy?

- 237\_ 1  No 2  Yes

25. Have you ever been treated for any condition by radiotherapy?

- 238\_ 1  No 2  Yes

**WOMEN ONLY** (Men — please skip to “MEN ONLY” section on page 13.)

26. How old were you when you started having menstrual periods?

- 239\_ 1  Less than 12  
2  12  
3  13  
4  14  
5  15 or older  
6  Don't know/don't remember  
7  Never started — Skip to question 28 on page 11.

27. Are you postmenopausal (no menstrual period for 12 months, usually 45 years of age or older, women who have had their uterus and/or ovaries removed)?

240\_

1  No — Skip to question 28 below.

2  Yes

How old were you when you entered menopause?

\_\_\_\_ Years old

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

1  Natural menopause (change of life)

2  Because of hysterectomy or removal of ovaries (or both)

3  Took medication that stopped my period

4  Radiation/chemotherapy

5  Other, please specify: \_\_\_\_\_

241-242

243\_

28. Have you ever been pregnant?

244\_

1  No — Skip to question 29 on page 12.

2  Yes

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

245\_

1    2    3    4    5    6    7    8    9 or more

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

246\_

0 — Skip to question 29 on page 12.

1    2    3    4    5    6    7    8    9 or more

What was your age when your first child was born?

247\_

1  17 or younger

3  19

5  25 to 29

7  35 to 39

2  18

4  20 to 24

6  30 to 34

8  40 or older

How many of your children did you breastfeed for more than one month?

248\_

1  Did not breastfeed any

3  3 to 5 children

5  11 children or more

2  1 to 2 children

4  6 to 10 children

What was your age when your last child was born?

249\_

1  17 or younger

3  19

5  25 to 29

7  35 to 39

2  18

4  20 to 24

6  30 to 34

8  40 or older

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

250\_

1  No

2  Yes, currently

3  Yes, but not currently

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

251\_

1  6 months or less

4  3 to 5 years

2  7 to 11 months

5  6 to 11 years

3  1 to 2 years

6  11 years or more

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

252\_

1  No

2  Yes, currently

3  Yes, but not currently

**What type?**

253\_

1  Estrogen alone

2  Estrogen and progesterone combination (e.g., Provera or Prempro)

3  Don't know

**How old were you when you first began taking it?**

254-255

\_\_ \_\_ Years old

**How many years have you taken it?**

256-257

\_\_ \_\_ Number of years

31. Have you ever taken tamoxifen (Nolvadex)?

258\_

1  No

2  Yes, currently

3  Yes, but not currently

4  Don't know

**How long have you taken tamoxifen?**

259\_

1  1 month or less

4  1 to 2 years

7  Don't know how long

2  1 to 6 months

5  3 to 5 years

3  7 to 11 months

6  5 years or more

32. Do you perform regular breast self exams?

260\_

1  No

2  Yes

**MEN ONLY** — Women continue with “HEALTH BEHAVIORS” section below.

261\_ 33. Do you perform regular testicular self-exams?

- 1  No      2  Yes

262\_ 34. Have you ever had a prostate specific antigen (PSA) blood test?

- 1  No      2  Yes, it was normal      3  Yes, it was abnormal      4  Don't know

263\_ **When was the last time you had an abnormal test?**

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

**HEALTH BEHAVIORS**

264\_ 35. Have you seen a dentist for a general check-up and teeth cleaning within the last 12 months?

- 1  No      2  Yes

265\_ 36. How often do you protect your skin from the sun by using a sunblock lotion (SPF 15 or greater), or by wearing protective clothing such as a hat and long-sleeved shirt when you go outside?

- 1  Always      2  Sometimes      3  Never

266\_ 37. How often do you wear a seatbelt when driving or riding in a motor vehicle?

- 1  Always      2  Sometimes      3  Never

267\_ 38. How often do you drive or ride in a motor vehicle when the driver (you or someone else) has been using alcohol or drugs (3 or more drinks or “driving under the influence”)?

- 1  Daily      2  Rarely to weekly      3  Never

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

268\_

- 1  Always  
2  Sometimes  
3  Never  
4  I do not participate in these activities

40. Is there a firearm in or around your home?

269\_

- 1  No    2  Yes    3  Don't know

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

270\_

- 1  No    2  Yes    3  Don't know

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

271\_

- 1  0 to 1    2  2    3  3 or more

43. How many servings of fruit do you eat during a typical day? (One serving: 1 medium piece of fruit or 3/4 cup fruit juice.)

272\_

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

44. How many servings of vegetables do you eat during a typical day? (One serving: 1 cup raw, leafy vegetables, 1/2 cup cooked vegetables, or 3/4 cup vegetable juice.)

273\_

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

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

274\_

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

**46. How many servings of diet soft drinks do you have per day?**

(A serving size is one can or glass.)

275\_

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

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

(A serving size is one can or glass.)

276\_

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

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

277\_

- 1  None — **Skip to question 50 on page 16.**
- 2  Less than 1 cup per month
- 3  1 cup per week
- 4  2 to 4 cups per week
- 5  5 to 6 cups per week
- 6  1 cup per day
- 7  2 to 3 cups per day
- 8  4 to 5 cups per day
- 9  6 or more cups per day

**49. How often is the coffee you drink decaffeinated?**

278\_

- 1  Never or almost never
- 2  About 1/4 of the time
- 3  About 1/2 of the time
- 4  About 3/4 of the time
- 5  Always or almost always

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

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
279_	<b>Sitting</b> .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
280_	<b>Standing</b> .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
281_	<b>Walking</b> .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
282_	<b>Light manual labor</b> .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
283_	<b>Heavy manual labor</b> .....	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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

		None	1 time	2 times	3 times	4 times	5 times	6 times	7 times	8 times or more
284_	<b>Strenuous exercise (heart beats rapidly)</b> ..... (i.e., running, jogging, vigorous swimming, vigorous long distance bicycling, hockey, basketball, cross country skiing, soccer)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
285_	<b>Moderate exercise (not exhausting)</b> ..... (i.e., fast walking, easy swimming, alpine skiing, popular and folk dancing, tennis, easy bicycling, baseball, volleyball,)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>
286_	<b>Mild exercise (minimal effort)</b> ..... (i.e., easy walking, archery, bowling, horseshoes, golf, snowmobiling)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>

52. How often did you have a drink containing alcohol in the past year? (Consider a "drink" to be a can or bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor — like scotch, gin, or vodka.)

287\_

1  Never — Skip to question 54 below.

2  Once a month or less

3  2 to 4 times a month

4  2 to 3 times a week

5  4 to 5 times a week

6  6 or more times a week



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

288\_

1  0 to 2 drinks

2  3 to 4 drinks

3  5 to 6 drinks

4  7 to 9 drinks

5  10 or more drinks

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

289\_

1  Never

2  Less than monthly

3  Monthly

4  Weekly

5  Daily or almost daily

53. Have you used any of these tobacco products for 12 months or longer?

290\_

291-292

**Cigar** ..... 1  No

2  Yes

For how many years? \_\_\_ Years

293\_

294-295

**Pipe** ..... 1  No

2  Yes

For how many years? \_\_\_ Years

296\_

297-298

**Snuff** ..... 1  No

2  Yes

For how many years? \_\_\_ Years

299\_

300-301

**Chewing tobacco** .... 1  No

2  Yes

For how many years? \_\_\_ Years

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

302\_

- 1  No      2  Yes      3  Don't know/not sure

If yes, how old were you when you first started smoking cigarettes on a regular basis?

303-304

\_\_ \_\_ Age

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

305\_

- 1  1 to 10 per day      4  31 to 40 per day  
2  11 to 20 per day      5  41 or more per day  
3  21 to 30 per day

306\_

Do you currently smoke cigarettes?      1  No      2  Yes

307-310

If no, what year did you quit?      \_\_ \_\_ \_\_ \_\_ Year

55. Did you ever live in the same household with someone who smoked cigarettes regularly while in your presence?

311\_

- 1  No      2  Yes

For how many years altogether was this the case?      \_\_ \_\_ Years

312-313

Generally speaking, how many hours each day were or are you around people from your household while they were or are smoking?

314-315

\_\_ \_\_ Hours per day

56. Did you ever work in an area where others smoked regularly in your presence?

316\_

- 1  No      2  Yes

For how many years altogether was this the case?      \_\_ \_\_ Years

317-318

Generally speaking, how many hours each day were or are you in the same work area as others while they were or are smoking?

319-320

\_\_ \_\_ Hours per day

57. During the past 12 months, which vitamins, minerals, or supplements have you taken regularly (2 times a week for at least 3 months)? (Mark all that apply.)

**Vitamins/Minerals**

**Supplements**

321:336  
322:337  
323:338  
324:339  
325:340  
326:341  
327:342  
328:343  
329:344  
330:345  
331:346  
332:347  
333:348  
334:349  
335:350

- 1  Multivitamin
- 1  Prenatal vitamin
- 1  Vitamin A
- 1  B Vitamins
- 1  Vitamin C
- 1  Vitamin D
- 1  Vitamin E
- 1  Beta carotene
- 1  Calcium
- 1  Folate
- 1  Iron
- 1  Selenium
- 1  Zinc
- 1  None
- 1  Other vitamins/minerals: \_\_\_\_\_

- 1  5-HTP
- 1  Acidophilus
- 1  Bee pollen or royal jelly
- 1  Chondroitin
- 1  CoQ10
- 1  DHEA
- 1  Fiber supplement (Metamucil, etc.)
- 1  Fish oil/omega fatty acids/EPA/DHA
- 1  Glucosamine
- 1  Melatonin
- 1  Progesterone cream
- 1  SAM-e
- 1  Xanadrine
- 1  None
- 1  Other supplements: \_\_\_\_\_

**ENVIRONMENT**

58. What is the nature of the businesses or industries where you have worked during the majority of your life? (Please select one.)

351-352

- 1  Active Duty Military
- 2  Construction
- 3  Farming, Forestry, Fishing, and Hunting
- 4  Finance, Insurance, Real Estate, and Rental and Leasing
- 5  Information and Communications
- 6  Manufacturing/Production
- 7  Mining
- 8  Public Administration
- 9  Retail Trade
- 10  Services: Arts, Entertainment, Recreation, Accommodations, and Food
- 11  Services: Educational, Health, and Social
- 12  Services: Professional, Scientific, Management, and Administrative
- 13  Services: Waste Management
- 14  Services: Other (except Public Administration)
- 15  Telecommunications
- 16  Transportation and Warehousing
- 17  Utilities
- 18  Wholesale Trade
- 19  Other, please specify: \_\_\_\_\_
- 20  None of the above

59. Are, or were you ever, regularly exposed to any of the following substances?

	No	Yes	Don't know
353_ Asbestos .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
354_ Benzene or derivatives .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
355_ Chlorinated hydrocarbons (CHC), solvents, or related compounds .	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
356_ Chromium/chromium compounds .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
357_ Coal dust .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
358_ Nickel/nickel compounds .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
359_ Radioactive substance .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
360_ Taconite .....	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
361_ Other, please specify: _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

60. Where do you currently live most of the year?

362\_ 1  On a working farm or ranch      3  In a suburb, city, or village  
 2  In a rural home or hobby farm, not a working farm or ranch      4  Other, specify: \_\_\_\_\_

61. Have you ever lived on a working farm?

363\_ 1  No      2  Yes

If yes, what type of farm was it? (Mark all that apply.)

364:366 1  Hobby      1  Dairy      1  Agricultural  
 365:367 1  Commercial      1  Cattle

62. Have you ever personally mixed or applied fertilizer to add nutrients to the soil? (Include fertilizer used for farm use, commercial application, and/or personal use in your home or garden.)

369\_ 1  No      2  Yes

If yes, how many years did you personally mix or apply fertilizers? (One growing season = 1 year.)

370\_ 1  1 year or less  
 2  2 to 5 years  
 3  6 to 10 years  
 4  11 to 20 years  
 5  21 to 30 years  
 6  31 years or more

63. **Have you ever personally mixed or applied any pesticides to kill insects?** (Include crop, livestock, and structural insecticides and fumigants. Include pesticides used for farm use, commercial application, and/or personal use in your home or garden.)

371\_

1  No      2  Yes

**If yes, how many years did you personally mix or apply pesticides?**  
(One growing season = 1 year.)

372\_

- 1  1 year or less
- 2  2 to 5 years
- 3  6 to 10 years
- 4  11 to 20 years
- 5  21 to 30 years
- 6  31 years or more

64. **Have you ever personally mixed or applied herbicides or fungicides to kill weeds, mold, or fungus?** (Include crop, livestock herbicides or fungicides for farm use, commercial application, and/or personal use in your home or garden.)

373\_

1  No      2  Yes

**If yes, how many years did you personally mix or apply herbicides or fungicides?** (One growing season = 1 year.)

374\_

- 1  1 year or less
- 2  2 to 5 years
- 3  6 to 10 years
- 4  11 to 20 years
- 5  21 to 30 years
- 6  31 years or more

## ABOUT YOU

65. **Are you currently...**

375\_

- 1  Married
- 2  Living with someone in a marriage-like relationship
- 3  Separated
- 4  Divorced
- 5  Widowed
- 6  Never been married

66. Which of the following best describes you?

376\_

- 1  Working full time for pay (35 or more hours a week)
- 2  Working part-time for pay
- 3  Not working for pay at present

Are you...

1 <input type="checkbox"/> A full-time homemaker	1 <input type="checkbox"/> Disabled
1 <input type="checkbox"/> A seasonal worker	1 <input type="checkbox"/> Retired
1 <input type="checkbox"/> In school	1 <input type="checkbox"/> Other, please specify: _____

377:380

378:381

379:382

67. What is the highest grade or level of school you have completed?

383\_

- 1  8th grade or less
- 2  Some high school
- 3  High school graduate or GED
- 4  Vocational, technical, or business school
- 5  Some college or Associates degree (including community college)
- 6  Four year college graduate (Bachelor's degree)
- 7  Graduate or professional school
- 8  Other, please specify: \_\_\_\_\_

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

384\_

- 1  No
- 2  Yes

**From the following, please select the group (or groups) that best describe your Hispanic origin or ancestry. (Mark all that apply.)**

- 1  Puerto Rican
- 1  Dominican (Republic)
- 1  Mexican/Mexicano
- 1  Mexican American
- 1  Chicano
- 1  Cuban
- 1  Cuban American
- 1  Central or South American
- 1  Other Latin American, please specify: \_\_\_\_\_
- 1  Other Hispanic, please specify: \_\_\_\_\_
- 1  Don't know

385\_

386\_

387\_

388\_

389\_

390\_

391\_

392\_

393\_

394\_

395\_

**69. Which of the following best describes you? (Mark all that apply.)**

- 396\_      1  White
- 397\_      1  Black/African/African American
- 398\_      1  Indian (American)
- 399\_      1  Alaskan Native
- 400\_      1  Native Hawaiian
- 401\_      1  Guamanian
- 402\_      1  Samoan
- 403\_      1  Other Pacific Islander, please specify: \_\_\_\_\_
- 404\_      1  Asian Indian
- 405\_      1  Chinese
- 406\_      1  Filipino
- 407\_      1  Japanese
- 408\_      1  Korean
- 409\_      1  Vietnamese
- 410\_      1  Hmong
- 411\_      1  Other Asian, please specify: \_\_\_\_\_
- 412\_      1  Some other race, please specify: \_\_\_\_\_
- 413\_      1  Don't know

**70. Were you born in the United States?**

- 414\_      1  No      2  Yes

**How long have you lived in the United States?**

415-416      \_\_\_ \_\_\_ Years

**What country were you born in?**

417-418      \_\_\_\_\_ Country

**71. If you have an e-mail address and are willing to let us contact you, please provide your e-mail address below:**

419\_      \_\_\_\_\_

**Thank you for taking the time to complete the survey!**

**Question 6: Measure of Optimism and Pessimism (LOT-R).** Scheier, M. F., Carver, C. S., and Bridges, M. W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self mastery, and self-esteem): A re-evaluation of the Life Orientation Test. *Journal of Personality and Social Psychology*, 67, 1063-1078.

**Question 7: Measurement of Fatigue.** Anna L. Schwartz, Paula M. Meek, Lillian M. Nail, James Fargo, Margaret Lundquist, Melissa Donofrio, Marilyn Grainger, Terry Throckmorton, and Magdalena Mateo. Measurement of fatigue: determining minimally important clinical differences. *Journal of Clinical Epidemiology*, Volume 55, Issue 3, March 2002, Pages 239-244.

**Question 8: Social Support Measure.** Enhancing recovery in coronary heart disease patients (ENRICHHD): study design and methods. The ENRICHHD investigators. *Am Heart J*. 2000;139:1-9. [[PubMed](#)]

**Question 51: Godin Measure of Physical Activity.** G. Godin and R. J. Shephard, A simple method to assess exercise behavior in the community, *Can. J. Appl. Sport Sci.* 10(1985), pp. 141-146. [View Record in Scopus](#) | [Cited By Scopus \(526\)](#).



---

200 First Street SW  
Rochester, Minnesota 55905  
[www.mayoclinic.org](http://www.mayoclinic.org)

MC4269-##

© 2002, Mayo Foundation for Medical Education and Research (MFMER). All rights reserved.  
MAYO, MAYO CLINIC and the triple-shield Mayo logo are trademarks and service marks of MFMER.