This PDF version of the questionnaire form is a viewable version only and is not to be sent to Mayo Clinic Biobank staff for enrollment.

If you are interested in enrolling in the Biobank, please go to the link provided on the Contact Us page to email Biobank study staff and they will send you the appropriate materials.

Mayo Clinic Biobank Questionnaire

Your name:

First Name/Middle Initial Last Name

Your date of birth: __ __/__ __/__ __ __ __

Month Day Year

Please enter today's date and your clinic number.

TODAY'S DATE		
MONTH	DAY	YEAR
○ Jan		
○ Feb		
○ Mar	0 0	0 0 0 0
○ Apr	1 1	1 1 1 1
○ May	2 2	2 2 2 2
○ June	3 3	3 3 3 3
○ July	4	4 4 4 4
○ Aug	5	5 5 5 5
○ Sept	6	6 6 6 6
○ Oct	7	7 7 7 7
○ Nov	8	8 8 8 8
○ Dec	9	9 9 9 9

CLINIC NUMBER						
		–			–	
0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9

3/8" SPINE PERF

Place barcode label here.

INSTRUCTIONS

- Please take the time to read and answer each question carefully by marking the response that best represents your answer.
- If you are not *exactly* sure of an answer, please provide your best guess.
- When completed, **mail the survey** to the Mayo Clinic Biobank, Harwick Building, 6th Floor, in the pre-addressed, pre-paid envelope provided. Rochester (only) participants also have the option to **drop the survey off** at Desk CA in the Hilton Building subway.

MARKING INSTRUCTIONS

- Use a No. 2 pencil or a blue or black ink pen only.
- Do not use pens with ink that soaks through the paper.
- Make solid marks that fill the response completely.
- If you select the wrong response and cannot erase completely, please place an X through the incorrect response and mark the correct response.
- Make no stray marks on this form.

CORRECT: ● **INCORRECT:** ✓ ✗ ◒ ◒

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

1. In general, would you say your health is...

⬭ Excellent ⬭ Very good ⬭ Good ⬭ Fair ⬭ Poor

2. <u>Compared to one year ago</u>, how would you rate your health in general <u>now</u>?

⬭ Much better now than one year ago
⬭ Somewhat better now than one year ago
⬭ About the same
⬭ Somewhat worse now than one year ago
⬭ Much worse now than one year ago

3. 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?

⬭ Better physical shape
⬭ About the same physical shape
⬭ Worse physical shape

4. How would you describe...

your overall quality of life?

As bad as it can be ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your overall mental (intellectual) well-being?

As bad as it can be ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your overall physical well-being?

As bad as it can be ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your overall emotional well-being?

As bad as it can be ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your level of social activity?

As bad as it can be ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

your overall spiritual well-being?

As bad as it can be ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ As good as it can be

5. How much do you agree or disagree with the following statements? (Please be as honest and accurate as you can throughout. Try not to let your response to one statement influence your responses to other statements. There are no "correct" or "incorrect" answers. Answer according to your own feelings, rather than how you think "most people" would answer.)

	I agree a lot	I agree a little	I neither agree nor disagree	I disagree a little	I disagree a lot
In uncertain times, I usually expect the best.	⬭	⬭	⬭	⬭	⬭
If something can go wrong for me, it will.	⬭	⬭	⬭	⬭	⬭
I'm always optimistic about my future.	⬭	⬭	⬭	⬭	⬭
I hardly ever expect things to go my way.	⬭	⬭	⬭	⬭	⬭
I rarely count on good things happening to me.	⬭	⬭	⬭	⬭	⬭
Overall, I expect more good things to happen to me than bad.	⬭	⬭	⬭	⬭	⬭

6. What is your level of fatigue today with 0 = "No fatigue" to 10 = "Greatest possible fatigue"?

No fatigue ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Greatest possible fatigue

7. How much of the time . . .	None of the time	A little of the time	Some of the time	Most of the time	All of the time
is there someone available to you whom you can count on to listen to you when you need to talk?	⬭	⬭	⬭	⬭	⬭
is there someone available to you to give you good advice about a problem?	⬭	⬭	⬭	⬭	⬭
is there someone available to you who shows you love and affection?	⬭	⬭	⬭	⬭	⬭
is there someone available to help with daily chores?	⬭	⬭	⬭	⬭	⬭
can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?	⬭	⬭	⬭	⬭	⬭
do you have as much contact as you would like with someone you feel close to, someone in whom you can trust and confide in?	⬭	⬭	⬭	⬭	⬭

8. During the *past 12 months*, would you say your <u>emotional or psychological</u> health has been . . .

⬭ Excellent ⬭ Very good ⬭ Good ⬭ Fair ⬭ Poor ⬭ Don't know

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

3/8" SPINE PERF

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

○ Not at all ○ Some ○ Several days ○ More than half the days ○ Nearly every day ○ Don't know

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

○ Not at all ○ Some ○ Several days ○ More than half the days ○ Nearly every day ○ Don't know

11. 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?

○ No ○ Yes

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

○ No ○ Yes

How often does this or did this heartburn occur?

○ Less than once a month
○ About once a month
○ About once a week
○ Several times a week
○ Daily

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

○ I do not take antacids for heartburn ○ No ○ Yes

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

○ No ○ Yes

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

○ No ○ Yes

13. 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?

○ No ○ Yes

Do you experience acid regurgitation <u>at least once a week</u>?

○ No ○ Yes

14. Has your weight varied during the *past 12 months*?

○ Remained stable ○ Gone up more than 10 pounds ○ Gone down more than 10 pounds

Was this weight gain intentional or unintentional?
○ Intentional
○ Unintentional

Was this weight loss intentional or unintentional?
○ Intentional
○ Unintentional

PERSONAL AND FAMILY MEDICAL HISTORY

15. Are you adopted? ○ No ○ Yes

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

16. Is your father alive? ○ Yes, he is alive ○ No, he is dead ○ I don't know

If dead, what was his age at death?
○ Under 30 ○ 30 to 40 ○ 41 to 50 ○ 51 to 60 ○ 61 to 70 ○ 71 to 85 ○ Over 85

17. Is your mother alive? ○ Yes, she is alive ○ No, she is dead ○ I don't know

If dead, what was her age at death?
○ Under 30 ○ 30 to 40 ○ 41 to 50 ○ 51 to 60 ○ 61 to 70 ○ 71 to 85 ○ Over 85

18. For each kind of relative below, please tell us how many you have who are alive and how many have died.

		0	1	2	3	4	5	6	7+	Don't know
Brothers:	Number alive	○	○	○	○	○	○	○	○	○
	Number dead	○	○	○	○	○	○	○	○	○
Sisters:	Number alive	○	○	○	○	○	○	○	○	○
	Number dead	○	○	○	○	○	○	○	○	○
Sons:	Number alive	○	○	○	○	○	○	○	○	○
	Number dead	○	○	○	○	○	○	○	○	○
Daughters:	Number alive	○	○	○	○	○	○	○	○	○
	Number dead	○	○	○	○	○	○	○	○	○

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

3/8" SPINE PERF

19. Please indicate the age you were first diagnosed with the following conditions. If you have not been diagnosed with this condition, mark "None."

In addition, please indicate whether or not your family members have had this condition by marking "Yes," "No," or "Don't know." We are only interested in relatives that are related to you by blood.

	Self: Age when this condition was first diagnosed.						Relatives: Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition?		
	None	19 or younger	20 to 49	50 to 64	65 to 79	80 or older	No	Yes	Don't know
Rheumatologic									
Arthritis (osteoarthritis)	○	○	○	○	○	○	○	○	○
Arthritis (rheumatoid)	○	○	○	○	○	○	○	○	○
Fibromyalgia	○	○	○	○	○	○	○	○	○
Autoimmune disorder (lupus, scleroderma)	○	○	○	○	○	○	○	○	○
Gynecologic									
Endometriosis	○	○	○	○	○	○	○	○	○
Liver									
Hepatitis A, B, or C	○	○	○	○	○	○	○	○	○
Other liver disease	○	○	○	○	○	○	○	○	○
Hematologic									
Organ or bone marrow transplant	○	○	○	○	○	○	○	○	○
Bleeding disorder	○	○	○	○	○	○	○	○	○
Sickle cell anemia	○	○	○	○	○	○	○	○	○
Infectious Diseases									
HIV (AIDS)	○	○	○	○	○	○	○	○	○
Tuberculosis	○	○	○	○	○	○	○	○	○
Cancer									
Thyroid cancer	○	○	○	○	○	○	○	○	○
Lung cancer	○	○	○	○	○	○	○	○	○
Breast cancer	○	○	○	○	○	○	○	○	○
Esophageal cancer	○	○	○	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○	○	○	○
Colon or rectal cancer	○	○	○	○	○	○	○	○	○
Liver cancer	○	○	○	○	○	○	○	○	○
Uterine/endometrial cancer	○	○	○	○	○	○	○	○	○
Cervical cancer	○	○	○	○	○	○	○	○	○
Ovarian cancer	○	○	○	○	○	○	○	○	○
Prostate cancer	○	○	○	○	○	○	○	○	○

Continues on next page...

	Self: Age when this condition was first diagnosed.						Relatives: 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
Cancer (continued)									
Testicular cancer	○	○	○	○	○	○	○	○	○
Melanoma	○	○	○	○	○	○	○	○	○
Nonmelanoma skin cancer	○	○	○	○	○	○	○	○	○
Sarcoma	○	○	○	○	○	○	○	○	○
Bone cancer	○	○	○	○	○	○	○	○	○
Leukemia	○	○	○	○	○	○	○	○	○
Lymphoma	○	○	○	○	○	○	○	○	○
Kidney cancer	○	○	○	○	○	○	○	○	○
Urinary/bladder cancer	○	○	○	○	○	○	○	○	○
Other cancer	○	○	○	○	○	○	○	○	○
Neurologic									
Alzheimer's disease	○	○	○	○	○	○	○	○	○
Parkinson's disease	○	○	○	○	○	○	○	○	○
Dementia	○	○	○	○	○	○	○	○	○
Migraine headaches	○	○	○	○	○	○	○	○	○
Stroke (CVA)	○	○	○	○	○	○	○	○	○
TIA (mini stroke)	○	○	○	○	○	○	○	○	○
Epilepsy (seizure disorder)	○	○	○	○	○	○	○	○	○
Narcolepsy	○	○	○	○	○	○	○	○	○
Mental Health									
Anxiety	○	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○	○
Down syndrome	○	○	○	○	○	○	○	○	○
Bipolar disorder	○	○	○	○	○	○	○	○	○
Autism	○	○	○	○	○	○	○	○	○
Attention deficit/hyperactivity disorder	○	○	○	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○	○	○	○
Other psychiatric or mental illness	○	○	○	○	○	○	○	○	○

Continues on next page...

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

3/8" SPINE PERF

	Self: Age when this condition was first diagnosed.						Relatives: 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
Eye									
Glaucoma	○	○	○	○	○	○	○	○	○
Cataracts	○	○	○	○	○	○	○	○	○
Abnormal distance vision	○	○	○	○	○	○	○	○	○
Lazy eye (amblyopia)	○	○	○	○	○	○	○	○	○
Misalignment, crossing, or wandering of the eyes (strabismus)	○	○	○	○	○	○	○	○	○
Macular degeneration	○	○	○	○	○	○	○	○	○
Cardiovascular									
Heart attack/myocardial infarction	○	○	○	○	○	○	○	○	○
Coronary artery disease	○	○	○	○	○	○	○	○	○
Congestive heart failure	○	○	○	○	○	○	○	○	○
Cardiomyopathy	○	○	○	○	○	○	○	○	○
Atrial fibrillation/arrhythmia	○	○	○	○	○	○	○	○	○
Congenital heart disease	○	○	○	○	○	○	○	○	○
High blood pressure (hypertension)	○	○	○	○	○	○	○	○	○
High cholesterol (hyperlipidemia)	○	○	○	○	○	○	○	○	○
Blood clots in a vein	○	○	○	○	○	○	○	○	○
Respiratory									
Asthma	○	○	○	○	○	○	○	○	○
Chronic obstructive pulmonary disease (COPD)	○	○	○	○	○	○	○	○	○
Sleep apnea	○	○	○	○	○	○	○	○	○
Asbestosis	○	○	○	○	○	○	○	○	○
Pulmonary fibrosis	○	○	○	○	○	○	○	○	○
Gastrointestinal									
Acid reflux or gastroesophageal reflux disorder (GERD)	○	○	○	○	○	○	○	○	○
Barrett's esophagus	○	○	○	○	○	○	○	○	○
Celiac disease	○	○	○	○	○	○	○	○	○
Irritable bowel syndrome (IBS)	○	○	○	○	○	○	○	○	○
Crohn's disease or ulcerative colitis	○	○	○	○	○	○	○	○	○
Lynch syndrome or HNPCC	○	○	○	○	○	○	○	○	○
Other polyposis syndrome (FAP, Peutz-Jeghers, juvenile polyposis, etc.)	○	○	○	○	○	○	○	○	○

Continues on next page...

	Self: Age when this condition was first diagnosed.						Relatives: Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition?		
Endocrine	None	19 or younger	20 to 49	50 to 64	65 to 79	80 or older	No	Yes	Don't know
Type 1 diabetes	○	○	○	○	○	○	○	○	○
Type 2 diabetes	○	○	○	○	○	○	○	○	○
Hyperthyroidism/hypothyroidism	○	○	○	○	○	○	○	○	○

20. Do you have any allergies? ○ No ○ Yes

What kind of allergies do you have? (Mark all that apply.)

○ Food allergies such as shellfish or nuts ○ Grasses, pollen, or dust ○ Pets ○ Insect stings or bites ○ Other

21. 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?

○ No ○ Yes

22. 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?

○ No ○ Yes

23. Have you ever been treated with chemotherapy (for cancer)?

○ No ○ Yes

24. Have you ever been treated with radiation for any condition?

○ No ○ Yes

WOMEN ONLY **(Men — please skip to "MEN ONLY" section on page 12.)**

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

○ Less than 12
○ 12
○ 13
○ 14
○ 15 or older
○ Don't know/don't remember
○ Never started — **Skip to question 27 on page 10.**

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

3/8" SPINE PERF

26. Have you had your uterus removed or was your last menstrual period more than 12 months ago?

- ○ No — **Skip to question 27 below.**
- ○ Yes

How old were you when you entered menopause? → AGE

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

- ○ Natural menopause (change of life)
- ○ Because of hysterectomy or removal of ovaries (or both)
- ○ Took medication that stopped my period
- ○ Radiation/chemotherapy
- ○ Other

27. Have you ever been pregnant?

- ○ No — **Skip to question 28 on page 11.**
- ○ Yes

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

○ 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.)

- ○ 0 — **Skip to question 28 on page 11.**

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 or more

What was your age when your first child was born?

- ○ 17 or younger
- ○ 18
- ○ 19
- ○ 20 to 24
- ○ 25 to 29
- ○ 30 to 34
- ○ 35 to 39
- ○ 40 or older

How many of your children did you breast-feed for more than one month?

- ○ Did not breast-feed any
- ○ 1 to 2 children
- ○ 3 to 5 children
- ○ 6 to 10 children
- ○ 11 children or more

What was your age when your last child was born?

- ○ 17 or younger
- ○ 18
- ○ 19
- ○ 20 to 24
- ○ 25 to 29
- ○ 30 to 34
- ○ 35 to 39
- ○ 40 or older

Are you pregnant right now?

○ No ○ Yes ○ Don't know

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

○ No ○ Yes, currently ○ 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.)

○ 6 months or less
○ 7 to 11 months
○ 1 to 2 years
○ 3 to 5 years
○ 6 to 11 years
○ 11 years or more

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

○ No ○ Yes, currently ○ Yes, but not currently

What type are you taking now or most recently? (Mark all that apply.)

○ Estrogen alone
○ Estrogen and progesterone combination (eg, Provera or Prempro)
○ Other
○ Don't know

How old were you when you first began taking any hormone therapy? → **AGE**

How many years have you taken any hormone therapy? → **NUMBER OF YEARS**

30. Have you ever taken tamoxifen (Nolvadex)?

○ No ○ Yes, currently ○ Yes, but not currently ○ Don't know

How long have you taken tamoxifen?

○ 1 month or less
○ 1 to 6 months
○ 7 to 11 months
○ 1 to 2 years
○ 3 to 5 years
○ 5 years or more
○ Don't know how long

31. Do you perform monthly breast self-exams? ○ No ○ Yes

MEN ONLY (Women — continue with "HEALTH BEHAVIORS" section below.)

32. Do you examine your own testicles monthly?

○ No ○ Yes

33. Have you ever had a prostate-specific antigen (PSA) blood test?

○ No
○ Yes → **Did you ever have an abnormal test?**
○ Don't know

- ○ No
- ○ Yes → **When was the last time you had an abnormal test?**
- ○ Don't know

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

HEALTH BEHAVIORS

34. Have you seen a dentist for a general check-up and teeth cleaning within the *last 12 months*?

○ No ○ Yes

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

○ Always ○ Sometimes ○ Never

36. How often do you wear a seatbelt when driving or riding in a motor vehicle?

○ Always ○ Sometimes ○ Never

37. How often do you drive or ride in a car or other motor vehicle when the driver has been using drugs, has had 3 or more drinks, or is driving under the influence?

○ Daily ○ Rarely to weekly ○ Never

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

○ Always ○ Sometimes ○ Never ○ I do not participate in these activities

39. Do you have a working fire extinguisher in your home?

○ No ○ Yes ○ Don't know ○ Prefer not to answer

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

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

○ No ○ Yes ○ Don't know

41. 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?

○ 0 to 1 ○ 2 ○ 3 or more

42. How many servings of fruit do you eat during a typical day?
(One serving: 1 medium piece of fruit or ¾ cup fruit juice.)

○ 0 to 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

43. How many servings of vegetables do you eat during a typical day?
(One serving: 1 cup raw, leafy vegetables, ½ cup cooked vegetables, or ¾ cup vegetable juice.)

○ 0 to 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

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

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

45. How many servings of <u>diet</u> soft drinks do you have per day? (A serving size is 1 can or glass.)

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

46. How many servings of regular (nondiet) soft drinks do you have per day?
(A serving size is 1 can or glass.)

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

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

○ None — **Skip to question 48 on page 14.**

○ Less than 1 cup per month
○ 1 cup per week
○ 2 to 4 cups per week
○ 5 to 6 cups per week
○ 1 cup per day
○ 2 to 3 cups per day
○ 4 to 5 cups per day
○ 6 or more cups per day

How often is the coffee you drink decaffeinated?

○ Never or almost never
○ About ¼ of the time
○ About ½ of the time
○ About ¾ of the time
○ Always or almost always

48. For the job (includes homemaking) you have held the longest, approximately how much of 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
Sitting	⬭	⬭	⬭	⬭	⬭
Standing	⬭	⬭	⬭	⬭	⬭
Walking	⬭	⬭	⬭	⬭	⬭
Light manual labor	⬭	⬭	⬭	⬭	⬭
Heavy manual labor	⬭	⬭	⬭	⬭	⬭

49. 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
Strenuous exercise (heart beats rapidly) (ie, running, jogging, vigorous swimming, vigorous long-distance bicycling, hockey, basketball, cross-country skiing, soccer)	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Moderate exercise (not exhausting) (ie, fast walking, easy swimming, alpine skiing, popular and folk dancing, tennis, easy bicycling, baseball, volleyball)	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭
Mild exercise (minimal effort) (ie, easy walking, archery, bowling, horseshoes, golf, snowmobiling)	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭

50. How often did you have a drink containing alcohol in the *past 12 months*?
(Consider a "drink" to be a can or bottle of beer, a glass of wine, a wine cooler, or 1 cocktail or a shot of hard liquor, eg, scotch, gin, or vodka.)

⬭ Never **— Skip to question 51 on page 15.**

⬭ Once a month or less
⬭ 2 to 4 times a month
⬭ 2 to 3 times a week
⬭ 4 to 5 times a week
⬭ 6 or more times a week

How many drinks did you have on a typical day when you were drinking in the *past 12 months*?

⬭ 0 to 2 drinks
⬭ 3 to 4 drinks
⬭ 5 to 6 drinks
⬭ 7 to 9 drinks
⬭ 10 or more drinks

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

⬭ Never
⬭ Less than monthly
⬭ Monthly
⬭ Weekly
⬭ Daily or almost daily

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

51. Have you used any of these tobacco products for 12 months or longer?
(Please mark a response for each tobacco product.)

Cigar	Pipe	Snuff	Chewing tobacco
○ No	○ No	○ No	○ No
○ Yes → For how many years?	○ Yes → For how many years?	○ Yes → For how many years?	○ Yes → For how many years?
NUMBER OF YEARS (00–99)	NUMBER OF YEARS (00–99)	NUMBER OF YEARS (00–99)	NUMBER OF YEARS (00–99)

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

○ No ○ Yes ○ Don't know/not sure

How old were you when you first started smoking cigarettes on a regular basis? → AGE (00–99)

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

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

Do you currently smoke cigarettes?

- ○ No → **What year did you quit?** → YEAR (0000–9999)
- ○ Yes

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

- ○ No
- ○ Yes →

For how many years altogether was this the case? → NUMBER OF YEARS

Please indicate the amount of secondhand exposure per day by the approximate number of cigarettes or packs smoked by the person(s) from your household.

- ○ 1 to 10 cigarettes (up to ½ pack)
- ○ 11 to 20 cigarettes (½ to 1 pack)
- ○ 21 to 40 cigarettes (1 to 2 packs)
- ○ 41 to 60 cigarettes (2 to 3 packs)
- ○ More than 60 cigarettes (3 packs or more)

At what age(s) were you exposed to secondhand smoke from your household? (Mark all that apply.)

- ○ Younger than 5
- ○ 5 to 9
- ○ 10 to 19
- ○ 20 to 29
- ○ 30 to 39
- ○ 40 to 49
- ○ 50 to 59
- ○ 60 to 69
- ○ 70 to 79
- ○ 80 and older

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

- ○ No
- ○ Yes →

For how many years altogether was this the case? → NUMBER OF YEARS

Please indicate the amount of secondhand exposure per day by the approximate number of cigarettes or packs smoked by the person(s) from your work area.

- ○ 1 to 10 cigarettes (up to ½ pack)
- ○ 11 to 20 cigarettes (½ to 1 pack)
- ○ 21 to 40 cigarettes (1 to 2 packs)
- ○ 41 to 60 cigarettes (2 to 3 packs)
- ○ More than 60 cigarettes (3 packs or more)

At what age(s) were you exposed to secondhand smoke from your work area? (Mark all that apply.)

- ○ Younger than 16
- ○ 16 to 19
- ○ 20 to 29
- ○ 30 to 39
- ○ 40 to 49
- ○ 50 to 59
- ○ 60 to 69
- ○ 70 to 79
- ○ 80 and older

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

- ○ None
- ○ Multivitamins
- ○ Prenatal vitamin
- ○ Vitamin A
- ○ B vitamins
- ○ Vitamin C
- ○ Vitamin D
- ○ Vitamin E
- ○ Beta carotene
- ○ Calcium
- ○ Folate
- ○ Iron
- ○ Selenium
- ○ Zinc
- ○ 5-HTP
- ○ Acidophilus
- ○ Bee pollen or royal jelly
- ○ Chondroitin
- ○ CoQ10
- ○ DHEA
- ○ Fiber supplement (Metamucil, etc.)
- ○ Fish oil/omega fatty acids/EPA/DHA
- ○ Glucosamine
- ○ Melatonin
- ○ Progesterone cream
- ○ SAM-e
- ○ Xanadrine
- ○ Other vitamins, minerals, or supplements

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

56. During the *past 12 months*, have you used the following medicines on a regular basis, that is, at least once per week? If so, please indicate how long you have taken each medication.

	Less than 1 year	1 to 5 years	6 to 10 years	11 years or more
Advil, Aleve, Motrin, or other nonsteroidal, anti-inflammatory drugs	○	○	○	○
Celebrex, Vioxx, or Bextra	○	○	○	○
Aspirin — full dose or extra strength	○	○	○	○
Tylenol	○	○	○	○
Other drug taken for pain relief	○	○	○	○
Aspirin — low dose or baby strength taken for prevention of heart disease or stroke	○	○	○	○
Insulin	○	○	○	○
Glucophage	○	○	○	○
DiaBeta, Diabinese, Glucotrol, or Micronase	○	○	○	○
Actos, Avandia, or Rezulin	○	○	○	○
Other drug taken for diabetes mellitus (sugar diabetes)	○	○	○	○

○ None of these

ENVIRONMENT

57. What is the nature of the business or industry where you have worked during the majority of your life? (Please select **one**.)

- ○ Active Duty Military
- ○ Construction
- ○ Farming, Forestry, Fishing, and Hunting
- ○ Finance, Insurance, Real Estate, and Rental and Leasing
- ○ Information and Communications
- ○ Manufacturing/Production
- ○ Mining
- ○ Public Administration
- ○ Retail Trade
- ○ Services: Arts, Entertainment, Recreation, Accommodations, and Food
- ○ Services: Educational, Health, and Social
- ○ Services: Professional, Scientific, Management, and Administrative
- ○ Services: Waste Management
- ○ Services: Other (except Public Administration)
- ○ Telecommunications
- ○ Transportation and Warehousing
- ○ Utilities
- ○ Wholesale Trade
- ○ Other, please specify: _____
- ○ None of the above

58. Are, or were you ever, regularly exposed to any of the following substances? (Please mark a response for each substance.)

	No	Yes	Don't know
Asbestos	○	○	○
Benzene or derivatives	○	○	○
Chlorinated hydrocarbons (CHC), solvents, or related compounds	○	○	○
Chromium/chromium compounds	○	○	○
Coal dust	○	○	○
Nickel/nickel compounds	○	○	○
Radioactive substance	○	○	○
Taconite	○	○	○

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

- ⬭ On a working farm or ranch
- ⬭ In a rural home or hobby farm, not a working farm or ranch
- ⬭ In a suburb, city, or village
- ⬭ Other

60. Have you ever lived on a working farm?

- ⬭ No
- ⬭ Yes → **What type of farm was it?** (Mark all that apply.)
  - ⬭ Commercial
  - ⬭ Dairy
  - ⬭ Cattle
  - ⬭ Agricultural

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

- ⬭ No
- ⬭ Yes

How many years did you personally mix or apply fertilizers?
(One growing season = 1 year.)

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

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

- ⬭ No
- ⬭ Yes

How many years did you personally mix or apply insecticides?
(One growing season = 1 year.)

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

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

- ⬭ No
- ⬭ Yes

How many years did you personally mix or apply herbicides or fungicides?
(One growing season = 1 year.)

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

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

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

- ○ No, not Hispanic/Latino
- ○ Yes, Hispanic/Latino →

Are you...

- ○ Mexican-American
- ○ Mexican
- ○ Ecuadorian
- ○ Puerto Rican
- ○ Other, please specify: _____

65. Which of the following do you consider yourself? (Mark all that apply.)

- ○ Asian
- ○ Black or African American
- ○ White
- ○ American Indian or Alaskan Native
- ○ Native Hawaiian or other Pacific Islander
- ○ Other, please specify: _____

Are you...

- ○ Cambodian
- ○ Laotian
- ○ Hmong
- ○ Vietnamese
- ○ Other, please specify: _____

Are you...

- ○ Somali
- ○ Amharic
- ○ Nigerian
- ○ Oromo
- ○ Liberian
- ○ U.S.-born
- ○ Other, please specify: _____

66. If you checked more than one in the previous question, with which do you identify the most? (Mark only one.)

- ○ Asian
- ○ Black or African American
- ○ White
- ○ American Indian or Alaskan Native
- ○ Native Hawaiian or other Pacific Islander
- ○ Multi-racial
- ○ Other

67. Are you currently...

- ○ Married
- ○ Living with someone in a marriage-like relationship
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Never been married

68. Were you born in the United States?

- ○ No →

How many years have you lived in the United States? → NUMBER OF YEARS

- ○ Yes

What country were you born in? _____

69. What is your current height and weight?
(Please round to the nearest whole number.
If you are currently pregnant, report your pre-pregnancy weight.)

HEIGHT		WEIGHT
FEET	INCHES	POUNDS
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

70. Which of the following best describes you?

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

If you are not working for pay at present, are you... (Mark all that apply.)

- ○ A full-time homemaker
- ○ A seasonal worker
- ○ In school
- ○ Disabled
- ○ Retired
- ○ Other

71. Which is the highest grade or level of school you have completed?

- ○ 8th grade or less
- ○ Some high school
- ○ High school graduate or GED
- ○ Vocational, technical, or business school
- ○ Some college or Associate's degree (including community college)
- ○ Four-year college graduate (Bachelor's degree)
- ○ Graduate or professional school
- ○ Other

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

_____

Thank you for taking the time to complete the survey!

Question 4: Linear Analogue Self Assessment (LASA). Used with permission of Jeff Sloan, PhD, Mayo Clinic.

Question 5: 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 6: 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 7: Social Support Measure. Enhancing recovery in coronary heart disease patients (ENRICHD): study design and methods. The ENRICHD investigators. Am Heart J. 2000;139:1-9. [PubMed]

Questions 9 and 10: The Patient Health Questionnaire-2 (PHQ-2). Korenke, K, Spitzer, RL, and Williams, JB (2003). Validity of a two-item depression screener. Medical Care. 41(11),1284-92.

Question 49: Godin Leisure-Time Exercise Questionnaire. G. Godin and R. J. Shephard, A simple method to assess exercise behavior in the community, taken with permission from *Can. J. Appl. Sport Sci.* 10(1985), pp. 141-146. Published by NRC Research Press.

Question 50: The Alcohol Use Disorders Identification Test (AUDIT). Babor, TF, Bohn, MJ, Kranzler, HR. Validation of a screening instrument for use in medical settings. J Stud Alcohol 56(4):423-432,1995.

PLEASE DO NOT WRITE IN THIS AREA

SERIAL

3/8" SPINE PERF