ILLINOIS WOMEN’S HEALTH REGISTRY

SECTION A: CONTACT INFORMATION

A1. First name:

A1. Last name:

A2. Address:

A3. City:

A4. State:

A5. Zip:

A6. County:

A7. Phone:

A7. Phone Type: Home Cell Work

A8. Email:

SECTION B: DEMOGRAPHICS

B1. Date of Birth: ___ ___ ___ / ___ ___/ ___ ___

B2. How did you first learn about this Registry? CHOOSE ALL THAT APPLY
   - Friend or family member
   - Advertisement
   - Doctor or health care professional
   - Internet
   - Health Fair
   - Other
   - Choose not to answer

B3. What race do you consider yourself to be? CHOOSE ALL THAT APPLY
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Hispanic or Latina
   - Native Hawaiian or Other Pacific Islander
   - White or Caucasian
   - Other
   - Choose not to answer
B4. Are you currently: CHOOSE ONLY ONE

- Working for pay at one job
- Working for pay at more than one job
- Working without pay in a family business
- Currently seeking work
- On layoff from a job
- Stay at home parent
- Student
- Retired
- Disabled/Unable to work
- Other
- Choose not to answer

B5. What sex were you assigned at birth? CHOOSE ONLY ONE

- Male
- Female
- Choose not to answer

B6. What is your current gender identity? CHOOSE ONLY ONE

- Male
- Female
- Transgender
- Do not identify as male, female or transgender
- Choose not to answer

B7. Do you consider yourself to be? CHOOSE ONLY ONE

- Heterosexual
- Bisexual
- Homosexual
- Other
- Do not know/ Not sure
- Choose not to answer

B8. What is your highest level of education? CHOOSE ONLY ONE

- Less than high school
- Some high school
- High School Diploma
- GED
- Some college
- Vocational or technical certificate or degree
- Associates degree
- Bachelor degree
- Post graduate degree
- Other
- Choose not to answer
B9. What type of medical insurance do you have? CHOOSE ALL THAT APPLY
- Private insurance / HMO/ PPO
- Medicaid
- Medicare
- VA
- Do not have insurance
- Do not know
- Choose not to answer

B10. Have you ever received any of the following benefits from the government?

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Received in past year</th>
<th>Received more than 1 yr ago</th>
<th>Did not receive</th>
<th>Choose not to Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Social Security / Disability</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>(b) SSI</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Supplemental Security Income</td>
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<tr>
<td>(c) TANF</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Temporary Assistance to Needy Families</td>
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<tr>
<td>(d) AFDC</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Aid to Families with Dependent Children</td>
<td></td>
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<td></td>
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<tr>
<td>(f) Food Stamps</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

SECTION C: GENERAL HEALTH HISTORY

C1. In general, would you say your health is:
- Excellent
- Very good
- Good
- Fair
- Poor
- Choose not to answer

C2. Your health:
- Allows full activity
- Limits your activities
- Choose not to answer

C3. Stress can be found both at home and in the workplace, in relationships, child rearing, elder care, health-related, financial, and for other reasons. How would you rate the amount of stress you are currently under?
- Small
- Moderate
- Large
- Overwhelming
- Choose not to answer
C4. Do you suffer from any of the following chronic health symptoms? CHOOSE ALL THAT APPLY
By chronic we mean that you suffer from these symptoms most of the time on most days for the past 3 months.
- [ ] Pain all over your body
- [ ] Pain in specific areas of your body
- [ ] Fatigue that limits your activities and does not improve with rest
- [ ] Sleep that does not refresh or restore your energy
- [ ] Problems with your memory or attention
- [ ] Problems with your nerves
- [ ] None of these
- [ ] Choose not to answer

C5. In the past 12 months, how many times have you been to a doctor or other healthcare professional?
CHOOSE ONLY ONE
- [ ] 0
- [ ] 1-4
- [ ] 5-10
- [ ] More than 10
- [ ] Choose not to answer

C6. In the past 12 months, how many times have you been to the emergency room?
CHOOSE ONLY ONE
- [ ] 0
- [ ] 1-4
- [ ] 5-10
- [ ] More than 10
- [ ] Choose not to answer

C7. In the past 12 months, how many times have you been admitted to the hospital?
CHOOSE ONLY ONE
- [ ] 0
- [ ] 1-4
- [ ] 5-10
- [ ] More than 10
- [ ] Choose not to answer

C8. What type of provider do you use for the majority of your medical care?
CHOOSE ONLY ONE
- [ ] Public or low cost clinic
- [ ] Private physician / Private clinic
- [ ] Emergency Room or other acute care facility
- [ ] No regular source for care
- [ ] Choose not to answer
C9. Do you take medications as directed? CHOOSE ONLY ONE

- All of the time
- Most of the time
- Some of the time
- None of the time
- Don’t take medications
- Choose not to answer

SECTION D: SCREENING AND PREVENTION

D1. How often have you had the following screening tests?

<table>
<thead>
<tr>
<th>Screening Test</th>
<th>Yearly</th>
<th>Less often</th>
<th>Never</th>
<th>Choose not to answer</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer screening</td>
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<tr>
<td>(Colonoscopy, Sigmoidoscopy)</td>
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<tr>
<td>Blood pressure</td>
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<tr>
<td>Diabetes testing</td>
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<td>Cholesterol screening</td>
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<tr>
<td>Routine mammogram</td>
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<tr>
<td>Pap Smear</td>
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<tr>
<td>Chlamydia testing</td>
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</tbody>
</table>

D2. A bone density test uses a special machine to look for osteoporosis. Have you ever had a bone density test? CHOOSE ONLY ONE. A bone density test can include ultrasound, x-ray or DEXA and can be performed on the heel, finger, forearm/wrist, or spine. Bone density tests take about 15 minutes to perform and are not the same as bone scans which can take hours to perform and use injections.

- Yes
- No
- Not sure
- Choose not to answer

D3. Have you received any of the following inoculations or vaccines? CHOOSE ONE FOR EACH ROW

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Yes</th>
<th>No</th>
<th>Choose not to answer</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>HPV (Human Papilloma Virus)</td>
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<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Rubella</td>
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<tr>
<td>Pneumonia</td>
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<tr>
<td>Meningitis</td>
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<td></td>
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<tr>
<td>Shingles (Varicella-Zoster)</td>
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</tbody>
</table>
D4. Do you get a Flu shot? CHOOSE ONLY ONE
   ☐ Yearly
   ☐ Less than yearly
   ☐ No
   ☐ Choose not to answer

D5. Do you take aspirin to prevent heart disease? CHOOSE ONLY ONE
   Yes  No  Choose not to answer

SECTION E: PHYSICAL ACTIVITY, WEIGHT, AND EATING

E1. Think about a typical day of activities. How would you describe your level of activity on most days?
   Sedentary
   Spend most of your time sitting or lying down engaged in quiet activities such as reading or watching TV
   Moderately active
   Spend at least several hours each day on your feet or doing light activities such as walking, gardening, housework
   Very active
   Spend most of the time on your feet or using your muscles OR specifically do vigorous exercise
   Don’t know
   Choose not to answer

E2. Will you share your weight?
   ☐ Yes
   ☐ Choose not to answer

E2.How much do you weigh without your shoes (in pounds)?

____________ lbs

E3. Will you share your height?
   ☐ Yes
   ☐ Choose not to answer

E3. How tall are you without your shoes?

____________ feet
____________ inches

E4. How would you describe your current weight? CHOOSE ONLY ONE
   ☐ Too low
   ☐ About right
   ☐ A little overweight
   ☐ Fat
   ☐ Obese
   ☐ Choose not to answer
E5. Have you repeatedly gained and lost large amounts of weight (NOT associated with pregnancy)?
   CHOOSE ONLY ONE
   ☐ Yes
   ☐ No
   ☐ Choose not to answer

E6. Are you currently trying to lose weight?
   ☐ Yes
   ☐ No
   ☐ Choose not to answer

E7. Have you ever had any of the following patterns with your eating habits: CHOOSE ALL THAT APPLY
   ☐ Excessive dieting
   ☐ Feeling overweight even though others say you are too thin
   ☐ Overeating, then getting rid of the food by using laxatives or by making
     yourself vomit
   ☐ Compulsive overeating
   ☐ Periods of binge eating
   ☐ Other
   ☐ None
   ☐ Choose not to answer

E8. Do you follow any specific dietary regimes? CHOOSE ALL THAT APPLY
   ☐ Vegan (no animal products)
   ☐ Vegetarian (no animal flesh, may eat eggs or dairy)
   ☐ Gluten-free
   ☐ Lactose-free or non-dairy
   ☐ Sugar-free
   ☐ None
   ☐ Choose not to answer

SECTION F: GYNECOLOGICAL HISTORY

F1. How many times have you been pregnant?
   ☐ 0 - skip to F2
   ☐ 1
   ☐ 2
   ☐ 3
   ☐ 4
   ☐ 5 or more
   ☐ Choose not to answer - skip to F2

F1a. Are you currently pregnant or have you been pregnant within the past year?
   ☐ Yes
   ☐ No – skip to F1b
   ☐ Choose not to answer – skip to F1b
F1b. How many of your pregnancies resulted in live births?
   - 0 - skip to F2
   - 1
   - 2
   - 3
   - 4
   - 5 or more
   - Choose not to answer - skip to F2

F1c. How many of your live births were vaginal births?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5 or more
   - Choose not to answer

F1d. How many of your live births were Cesarean births?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5 or more
   - Choose not to answer

F1e. How many of your pregnancies resulted in miscarriages or stillbirths?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5 or more
   - Choose not to answer

F1f. How many of your pregnancies resulted in elective abortions?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5 or more
   - Choose not to answer
F1g. How many of your pregnancies were the result of assisted reproductive technology?
- 0
- 1
- 2
- 3
- 4
- 5 or more
- Choose not to answer

F1h. During your pregnancies, did you experience any of the following: CHOOSE ALL THAT APPLY
- Preterm labor
  Preterm labor: contractions and changes in your cervix between your 20th and 36th week of pregnancy, may lead to preterm birth.
- Preeclampsia or post-partum preeclampsia
  Preeclampsia: high blood pressure during pregnancy. Post-partum preeclampsia: high blood pressure following delivery.
- Gestational diabetes
  Gestational diabetes: high blood sugar during pregnancy
- Post-partum depression
  Post-partum depression: significant symptoms of depression, which women may experience up to 1 year after birth.
- Multiple pregnancies (twins, triplets, etc.)
- Bleeding during 3rd trimester
- None
- Choose not to answer

F2. Have you tried assisted reproductive technology?
- Yes
- No
- Choose not to answer

F3. Have you had any of the following gynecological surgeries? CHOOSE ALL THAT APPLY
- Uterus removed
- One ovary removed
- Both ovaries removed
- Tubal ligation
- Removal of endometriosis
- No
- Choose not to answer

F4. How long has it been since your last period or menstrual cycle? CHOOSE ONLY ONE
- Within the past 2 months – skip to F5
- Between 2 months to 1 year
- Between 1-3 years
- Between 3-5 years
- More than 5 years ago
- Never had a period
- Do not know
- Choose not to answer
F4a. Have you ever taken hormone replacement therapy (HRT, estrogen, etc.) for menopause? 
CHOOSE ONLY ONE
- Yes
- No – skip to E5
- Do not know – skip to E5
- Choose not to answer – skip to E5

F4b. Do you CURRENTLY use any of the following menopause therapies? CHOOSE ALL THAT APPLY.
- Oral progesterone only – skip to E6
- Estrogen hormone replacement therapy – skip to E6
- Estrogen-Progesterone combination hormone replacement therapy – skip to E6
- Soy or herbal menopause treatment – skip to E6
- Bioidentical hormone replacement therapy – skip to E6
- Testosterone – skip to E6
- Estrogen-Testosterone combination – skip to E6
- Raloxifene (Evista) – skip to E6
- Topical estrogen, for example sprays or gels – skip to E6
- None – skip to E6
- Choose not to answer – skip to E6

F5. Do you CURRENTLY use any of the following hormone or birth control treatments? CHOOSE ALL THAT APPLY
- Birth control pills
- Birth control patch
- Mirena/Paragard T – intrauterine contraceptive or IUD
- Depo Provera
- Implanon (formerly Norplant Implant)
- Emergency contraception pills
- Oral progesterone only
- Testosterone
- Estrogen – Testosterone combination
- Topical estrogen
- NuvaRing / Birth control ring
- Any hormones designed to treat infertility
- Tubal ligation
- None
- Choose not to answer
F6. Have you ever been diagnosed with any of the following conditions? CHOOSE ALL THAT APPLY
- PMS (Premenstrual syndrome) / PMDD (Premenstrual Dysphoric Disorder)
- Fibroids
- Endometriosis
- Infertility
  - Infertility: have had regular sex for 1 year without birth control and have not gotten pregnant. Birth control includes birth control pills, diaphragm, condoms or rhythm. Infertility also means being unable to carry a pregnancy long enough so the baby can survive after birth.
- Abnormal Pap smear
- Polycystic ovarian syndrome
- Ectopic pregnancies
- Uterine prolapse
- Uterine polyps
- Pelvic adhesions
- Frequent yeast infections
  - Greater than 3 per year
- Frequent vaginal infections
  - Greater than 3 per year
- None
- Choose not to answer

F7. During the past year, did you experience any of the following? CHOOSE ALL THAT APPLY
- Painful menses or period (menstrual cramps)
- Prolonged / heavy menses or period
- Irregular or absent periods
- Vulvar pain/ Vulvodynia
  - Vulvar pain: consists of pain at the entryway to the vagina or a burning or pain on the vulva
- Pain with intercourse
- Low sex drive
- Generalized pelvic pain
- Mood swings with your period
- Vaginal dryness
- Severe hot flashes
- None
- Choose not to answer

F8. Have you ever had any of the following sexually transmitted diseases? CHOOSE ALL THAT APPLY
- Genital herpes
- Human papilloma virus (HPV) or genital warts
- Gonorrhea
- Chlamydia
- Syphilis
- Human immunodeficiency virus (HIV) or AIDs
- Other
- None
- Choose not to answer
SECTION G: CANCER
1. Have you ever had any of the following types of cancer? CHOOSE ALL THAT APPLY
   □ Bladder
   □ Bone
   □ Brain
   □ Breast
   □ Cervical
   □ Colon
   □ Esophageal
   □ Head (not brain), neck, oral cavity (mouth) tumors
   □ Kidney
   □ Leukemia
   □ Liver
   □ Lung
   □ Lymphoma
   □ Multiple myeloma
   □ Ovarian
   □ Pancreatic
   □ Skin
   □ Stomach
   □ Thyroid
   □ Uterine
   □ Vulvar
   □ Other
   □ None - skip to section H
   □ Choose not to answer - skip to section H

G2. Have you ever had any of the following cancer treatments? CHOOSE ALL THAT APPLY
   □ Radiation
   □ Surgical treatment
   □ Bone marrow transplant
   □ Chemotherapy
   □ Other
   □ None
   □ Do not know
   □ Choose not to answer
SECTION H: ALLERGIES AND AUTOIMMUNITY

H1. Do you have allergies to any of the following items? CHOOSE ALL THAT APPLY
- Food
- Drugs
- Animals / insects
- Latex
- Environmental (such as pollens, grasses, mold)
- Other
- None
- Choose not to answer

H2. Have you ever had any of the following autoimmune conditions? CHOOSE ALL THAT APPLY
- Rheumatoid arthritis
- Lupus
- Sjögren’s syndrome
- Scleroderma
- Polymyositis or dermatomyositis
- Raynaud’s disease
- Vasculitis
  - Includes giant cell or temporal arteritis, Wegener’s granulomatosis, polyarteritis nodosa
- Myasthenia Gravis
- Other
- None
- Choose not to answer

SECTION I: RESPIRATORY AND SINUS

I1. Have you ever had any of the following respiratory disorders? CHOOSE ALL THAT APPLY
- Asthma
- Chronic bronchitis
- Chronic sinusitis
- Emphysema
- Chronic obstructive pulmonary disease (COPD)
- Other
- None
- Choose not to answer

I2. Do you have any of the following symptoms? CHOOSE ALL THAT APPLY
- Cough every day or most days
- Produce sputum or phlegm every day or most days
- Wheezing when you don’t have a cold or respiratory infection
- Shortness of breath when walking on a level surface with people your own age
- Can’t breathe through the nose
- Loss of ability to smell
- None
- Choose not to answer
I3. Have you been exposed to smoke, vapors, dust, fumes or gases at your home or workplace? CHOOSE ONLY ONE
   □ Yes
   □ No
   □ Choose not to answer

SECTION J: CARDIOVASCULAR

J1. Do you have high blood pressure (greater than 140 / 90)? CHOOSE ONLY ONE
   □ Yes
   □ No
   □ Choose not to answer

J2. Do you take medication to control your blood pressure? CHOOSE ONLY ONE
   □ Yes
   □ No
   □ Choose not to answer

J3. Do you have high cholesterol (total greater than 200)? CHOOSE ONLY ONE
   □ Yes
   □ No
   □ Choose not to answer

J4. Do you take medication to control your cholesterol? CHOOSE ONLY ONE
   □ Yes
   □ No
   □ Choose not to answer

J5. Have you ever had any of the following? CHOOSE ALL THAT APPLY
   □ Angina
      Angina or Angina Pectoris: a feeling of lightheadedness, pressure, squeezing, or pain in the chest, especially with exercise or emotional stress. It happens when the heart does not get enough oxygen rich blood
   □ Heart attack
   □ Heart failure
      Heart failure: you develop shortness of breath and swelling related to your heart not pumping very well
   □ Irregular heart beat or arrhythmia
   □ Mitral valve prolapse
   □ Rheumatic fever
   □ Heart murmur
   □ Aortic aneurysm
   □ Peripheral vascular disease or claudication
      Claudication: Pain in your legs only when you walk that goes away quickly after you rest
   □ Congenital (present at birth) heart disease
   □ Other
   □ None
   □ Choose not to answer
J6. Have you ever had any of the following surgeries or treatments? CHOOSE ALL THAT APPLY
□ Coronary artery bypass surgery/ coronary angioplasty/ coronary stent
□ Aortic surgery
□ Pacemaker placement
□ Lower extremity bypass surgery or stenting
□ Heart catheterization
□ Heart valve replacement or repair
□ Stent placement
□ Cardiac defibrillator implantation
□ Echocardiogram
□ Stress test
□ None
□ Choose not to answer

SECTION K: BLOOD/ CLOTTING DISORDERS

K1. Have you ever had any of the following blood disorders? CHOOSE ALL THAT APPLY
□ Anemia
□ Sickle cell anemia
□ Platelet disorders
□ Blood clots or deep vein thrombosis (DVT)
   Deep vein thrombosis or “DVT”: a blood clot that forms inside a vein. DVT usually occurs in the legs or pelvis, but may also occur in other parts of the body
□ Pulmonary embolism
   Pulmonary embolism: a blood clot that blocks an artery in the lung, also called a “PE”
□ Other
□ None
□ Choose not to answer

SECTION L: LIVER

L1. Have you ever had any of the following liver disorders? CHOOSE ALL THAT APPLY
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Hepatitis D
□ Jaundice
□ Cirrhosis
□ Elevated liver enzymes
□ Fatty Liver Disease
□ Other
□ Don’t know
□ None
□ Choose not to answer
SECTION M: GASTROINTESTINAL

M1. Have you ever had any of the following (not related to pregnancy)? CHOOSE ALL THAT APPLY
  ☐ Ulcers
  ☐ Gastritis/Eosophagitis
  ☐ Chronic nausea and vomiting
    By chronic we mean on most days for more than 3 months
  ☐ Chronic constipation
    By chronic we mean on most days for more than 3 months
  ☐ Chronic acid reflux
    By chronic we mean on most days for more than 3 months
  ☐ Chronic diarrhea
    By chronic we mean on most days for more than 3 months
  ☐ Irritable bowel syndrome
  ☐ Diverticulitis or diverticulosis
  ☐ Celiac disease
  ☐ Gallstones
  ☐ Pancreatitis
  ☐ Crohn’s disease or ulcerative colitis
  ☐ Colon polyps
  ☐ Fecal incontinence
    Accidentally lose your bowels / stool
  ☐ H. Pylori infection
  ☐ Other
  ☐ None
  ☐ Choose not to answer

M2. Have you ever had any of the following surgeries or treatments? CHOOSE ALL THAT APPLY
  ☐ Gallbladder removal
  ☐ Splenectomy
    Removal of the spleen
  ☐ Appendectomy
    Removal of the appendix
  ☐ Bowel resection
    Removal of any portion of your small intestine or colon
  ☐ Gastric bypass surgery or other weight reduction surgery
  ☐ Other
  ☐ None
  ☐ Choose not to answer
SECTION N: ENDOCRINE

N1. Have you ever had any of the following endocrine disorders? CHOOSE ALL THAT APPLY
   □ Hyperthyroid / Graves disease
   □ Hypothyroid
   □ Parathyroid disease
   □ Hashimoto’s thyroiditis
   □ Goiter
   □ Pituitary disorder
   □ Adrenal disorder
   □ Hyperprolactemia
   □ Other
   □ None
   □ Choose not to answer

N2. Do you have any form of diabetes? CHOOSE ONLY ONE
   □ Insulin resistance, glucose intolerance, or pre-diabetes
   □ Type I diabetes
   □ Type II diabetes, diet controlled only
   □ Type II diabetes, taking pills
   □ Type II diabetes, on insulin
   □ Type II diabetes, taking both pills and insulin
   □ Yes, but don’t know what type
   □ No
   □ Choose not to answer

SECTION O: KIDNEY AND BLADDER

O1. Have you ever had any of the following kidney or bladder disorders? CHOOSE ALL THAT APPLY
   □ Kidney stones
   □ Blood in your urine
   □ Interstitial cystitis
   □ Kidney Failure
   □ Pyelonephritis
   □ Hydronephrosis
   □ Cystitis
   □ Other
   □ None
   □ Choose not to answer
O2. Have you experienced any of the following bladder disorders within the past year (not related to pregnancy)? CHOOSE ALL THAT APPLY

☐ Urinary retention
  Unable to empty your bladder
☐ Bladder spasm or urgency
☐ Bladder infection
☐ Weak urinary stream
☐ Urinary intermittency
  Stream starts and stops
☐ Urinary retention
  Feeling of incomplete emptying
☐ Difficulty in starting urination
☐ Frequent urinary tract infections
  Greater than 3 per year
☐ Urinary frequency
  Voiding more than 8 times a day
☐ Nocturia
  Up to void more than 2 times through the night
☐ Other
☐ Choose not to answer

SECTION P: MUSCULOSKELETAL

P1. Do you currently have any of the following types of arthritis? CHOOSE ALL THAT APPLY

☐ Osteoarthritis / degenerative arthritis
☐ Gout/ Pseudo gout
☐ Yes, but don’t know what type
☐ Other
☐ None
☐ Choose not to answer

P2. Do you have any of the following bone disorders? CHOOSE ALL THAT APPLY

☐ Joint pain (other than arthritis)
☐ Osteopenia or osteoporosis (bone thinning)
☐ Scoliosis
☐ Degenerative disc disease
☐ Other
☐ None
☐ Choose to answer
P3. Do you currently have any of the following musculoskeletal disorders? CHOOSE ALL THAT APPLY
- Chronic back pain
  By chronic, we mean most of the time on most days for the past 3 months
- Chronic neck pain
  By chronic, we mean most of the time on most days for the past 3 months
- Sciatica
- Carpal tunnel syndrome
- Tendonitis
- Fibromyalgia
- Chronic fatigue syndrome
- Other
- None
- Choose not to answer

P4. Have you had any of the following surgeries or treatments? CHOOSE ALL THAT APPLY
- Joint surgery
- Spine and disc surgery
- None
- Choose not to answer

SECTION Q: EYES AND EARS

Q1. Do you currently have any of the following hearing or balance disorders? CHOOSE ALL THAT APPLY
- Deafness (total or partial)
- Hard of hearing / hearing loss
- Vertigo / dizziness / lightheadedness
- Ringing
- Other
- None
- Choose not to answer

Q2. Do you currently have any of the following eye disorders? CHOOSE ALL THAT APPLY
- Cataracts
- Glaucoma
- Double vision
- Lazy eye
- Macular degeneration
- Dry eyes
- Retinal detachment
- Retinitis pigmentosa
- Other
- None
- Choose not to answer

Q3. Are you legally blind?
- Yes
- No
- Choose not to answer
SECTION R: DENTAL

R1. In the **past 3 months** have you experienced any of the following facial, mouth or dental problems? **CHOOSE ALL THAT APPLY**
- ☐ Chronic mouth or face pain
  By chronic, we mean most of the time on most days for the past 3 months
- ☐ Any pain or restriction problems when opening your mouth or moving your lower jaw
- ☐ Any tooth pain in the past 3 months
- ☐ Any “TMJ” pain in the past 3 months
  Temporomandibular Joint (TMJ) Syndrome
- ☐ Loose Teeth
- ☐ Bleeding gums
- ☐ Sores or lesions in your mouth that persist or reappear from time to time
- ☐ None
- ☐ Choose not to answer

SECTION S: NEUROLOGICAL AND SLEEP

S1. Do you have or have you had any of the following neurological disorders? **CHOOSE ALL THAT APPLY**
- ☐ Seizures / epilepsy
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Multiple sclerosis
- ☐ Parkinson’s disease
- ☐ Alzheimer’s disease
- ☐ Encephalitis
- ☐ Transient ischemic attack (TIA)
- ☐ Tremors
- ☐ Neuropathy (pain / numbness / tingling)
- ☐ Brain aneurysm
- ☐ Brain injury due to head trauma
- ☐ Spinal cord injury
- ☐ Brain tumor
- ☐ Back pain
- ☐ Sciatica
- ☐ Cervical root disease
- ☐ Other
- ☐ None
- ☐ Choose not to answer

S2. Have you ever had any of the following? **CHOOSE ALL THAT APPLY**
- ☐ Migraines
- ☐ Cluster headaches
- ☐ Tension headaches
- ☐ None
- ☐ Choose not to answer
S3. Have you ever had any of the following chronic sleep disorders? CHOOSE ALL THAT APPLY by chronic, we mean most of the time on most days for the past 3 months.

☐ Sleep apnea
☐ Narcolepsy
☐ Restless leg syndrome
☐ Other
☐ None
☐ Choose not to answer

SECTION T: SKIN

T1. Have you had any of the following skin conditions? CHOOSE ALL THAT APPLY

☐ Psoriasis
☐ Acne
☐ Eczema
☐ Rosacea
☐ Other
☐ None
☐ Choose not to answer

SECTION U: INFECTIOUS DISEASES

U1. Have you ever had any of the following infectious diseases? CHOOSE ALL THAT APPLY

☐ Lyme disease
☐ Tuberculosis
☐ HIV/AIDS
☐ Polio
☐ Other
☐ None
☐ Choose not to answer

SECTION V: MENTAL HEALTH

V1. Have you ever had ANY mental health problem? CHOOSE ONLY ONE

☐ Yes
☐ No
☐ Choose not to answer

V2. Has there been a period of at least two straight weeks when you have: CHOOSE ALL THAT APPLY

<table>
<thead>
<tr>
<th>Condition</th>
<th>In my lifetime</th>
<th>In the past 12 months</th>
<th>No</th>
<th>Choose not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt down, depressed or hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had little interest or pleasure in doing things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Had trouble concentrating on things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had panic or episodes of panic attacks?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
V3. Have you had excessive anxiety or worry? CHOOSE ALL THAT APPLY
☐ Yes, in the past 12 months
☐ Yes, in my lifetime
☐ No
☐ Choose not to answer

V4. Have you ever been exposed to a traumatic event that involved intense fear or horror which changed your sleep or behavior patterns? CHOOSE ONLY ONE
☐ Yes
☐ No
☐ Choose not to answer

V5. How difficult have problems with your nerves or mental health made it for you to do your work, take care of things at home, or get along with other people? CHOOSE ONLY ONE
☐ Not difficult at all
☐ Somewhat difficult
☐ Very difficult
☐ Extremely difficult
☐ Don’t know/ Choose not to answer

V6. What type of care have you received for your nerves, depression or low mood from a doctor, nurse or other health care provider? CHOOSE ALL THAT APPLY
☐ Medication
☐ Counseling
☐ Hospitalization
☐ Other
☐ None
☐ Choose not to answer

SECTION W: SMOKING, ALCOHOL, AND DRUGS

W1. Are you a current, former or nonsmoker? CHOOSE ONLY ONE
☐ Current - skip to W1b
☐ Former – skip to W1a
☐ Nonsmoker –skip to W2

W1a. How old were you when you last smoked?

__________ years old
Choose not to answer

W1b. How old were you when you started smoking?

__________ years old
Choose not to answer
W1c. On AVERAGE, considering all the years of your smoking, how much do / did you smoke in a typical day? 1 pack = 20 cigarettes
☐ Less than ½ pack
☐ ½ pack
☐ 1 pack
☐ 1 ½ packs
☐ 2 packs or more
☐ Choose not to answer

W2. Do you drink alcoholic beverages?
☐ Yes, in the past twelve months
☐ Yes, in my lifetime
☐ No - Skip to W3
☐ Choose not to answer - Skip to W3

W2a. During the past 12 months, how often have you usually had a drink containing alcohol? CHOOSE ONLY ONE
☐ Almost every day
☐ 1-3 times per week
☐ 1-2 times per month
☐ Less often
☐ I used to drink, but quit
☐ Never in the past 12 months
☐ Other
☐ Choose not to answer

W3. Have you used any of the following drugs? CHOOSE ALL THAT APPLY

<table>
<thead>
<tr>
<th>Drug</th>
<th>In your lifetime</th>
<th>In the past 2 months</th>
<th>Never</th>
<th>Choose not to answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>☐</td>
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<tr>
<td>Methamphetamine</td>
<td>☐</td>
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<td></td>
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<tr>
<td>Including other amphetamines or speed</td>
<td>☐</td>
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<td></td>
</tr>
<tr>
<td>Ecstasy</td>
<td>☐</td>
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<td></td>
<td></td>
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<tr>
<td>Marijuana</td>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription drugs obtained illegally</td>
<td>☐</td>
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