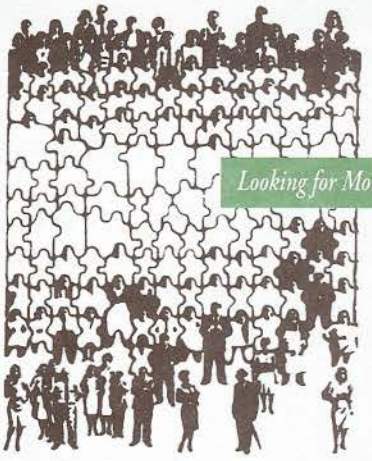

CLUE II

STUDY NO.

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

Please check the information above and correct any mistakes.

Is the birthdate indicated above correct?

○ No ➡ If no, please write correct date. ___/___/___ (MONTH DAY YEAR)

○ Yes, birth date is correct.

If this person is DECEASED, please provide the date of death: ___/___/___ (MONTH DAY YEAR)

INSTRUCTIONS

USE A NO. 2 PENCIL ONLY

THIS FORM IS DESIGNED TO BE READ BY OPTICAL SCANNING EQUIPMENT, SO IT IS IMPORTANT THAT YOU FOLLOW THESE DIRECTIONS:

1. Use **NO. 2 PENCIL**.
2. Make no stray marks on the survey.
3. Fill the circle completely with a dark mark. Please mark this way: ●
4. Mark a circle for each question.
5. Erase completely to change a response.

EXAMPLE: **Have you been told by a doctor or other health professional that you have any of the conditions listed below?**

Mark "No" or "Yes" *and* "Year of Diagnosis" for each illness.

FOR EXAMPLE:
Someone who was diagnosed with diabetes in September 1997, with high cholesterol in 1986, but who still has normal blood pressure would fill in the circles as shown.

	No	Yes	YEAR OF DIAGNOSIS: 1989 or before	1990–1994	1995 or after
Diabetes mellitus	○	●	○	○	●
High cholesterol	○	●	●	○	○
High blood pressure	●	○	○	○	○

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL OUR OFFICE AT (301) 791-3230.

PLEASE DO NOT WRITE IN THIS AREA

74933

1 **How long have you lived at your current address?**

- ○ Less than 1 year
- ○ 1–2 years
- ○ 3–5 years
- ○ 6–9 years
- ○ 10–14 years
- ○ 15–19 years
- ○ 20–24 years
- ○ 25 or more years

2 **What is your marital status?**

- ○ Never married
- ○ Married
- ○ Widowed
- ○ Divorced
- ○ Separated

3 **How many grades of school, including college, have you completed?**

GRADES

○ 0	○ 0
○ 1	○ 1
○ 2	○ 2
○ 3	
○ 4	
○ 5	
○ 6	
○ 7	
○ 8	
○ 9	

Note: It is important that you write in the grades of school completed in addition to completing the corresponding circles. This allows us to confirm that the correct circles have been filled in.

4 **How much do you weigh?**
(Write in number and darken circles)

POUNDS

○ 0	○ 0	○ 0
○ 1	○ 1	○ 1
○ 2	○ 2	○ 2
○ 3	○ 3	○ 3
○ 4	○ 4	○ 4
○ 5	○ 5	○ 5
	○ 6	○ 6
	○ 7	○ 7
	○ 8	○ 8
	○ 9	○ 9

Note: It is important that you write in your weight in addition to completing the corresponding circles. This allows us to confirm that the correct circles have been filled in.

5 **How many hours per week do you spend either sitting or lying down while watching TV, playing video/computer games or on the internet?**

Number of hours per week

0	Less than 1 hour	1	2–3	4–6	7–10	11–20	21–30	31–40	40+
▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
○	○	○	○	○	○	○	○	○	○

HEALTH HISTORY

6 **Have you been told that you have cancer?**

No	Yes	YEAR OF DIAGNOSIS: 1989 or before	1990–1994	1995 or after
○	○	○	○	○

→ *If "No", go to question 9.*

7 **If you had cancer, what type(s) of cancer did you have? (Please mark below)**

TYPES OF CANCER

- ○ Bladder
- ○ Breast
- ○ Cervix
- ○ Cervix in situ
- ○ Colon or rectum
- ○ Leukemia
- ○ Lung
- ○ Lymphoma or Hodgkins
- ○ Melanoma
- ○ Oral cavity
- ○ Esophageal
- ○ Ovary
- ○ Pancreas
- ○ Prostate
- ○ Skin (basal or squamous)
- ○ Uterus or endometrium
- ○ Thyroid
- ○ Stomach
- ○ Kidney
- ○ Other (Please specify) _____

→ **Age at diagnosis of FIRST cancer (excluding skin cancer):**

- ○ Under 20
- ○ 20–39
- ○ 40–49
- ○ 50–59
- ○ 60–69
- ○ 70 or over

8 **Where was the cancer diagnosed?**

- ○ Washington County Hospital
- ○ Other (Please specify hospital or office and city, state) _____

9 **Please mark below if your mother, father, sisters, or brothers have had the following:**

	Colorectal cancer	Prostate cancer	Breast cancer	Other Cancer	Heart attacks	Diabetes
Biological Mother	○		○	○	○	○
Biological Father	○	○	○	○	○	○
Blood-related Sisters	○		○	○	○	○
Blood-related Brothers	○	○	○	○	○	○

PLEASE DO NOT WRITE IN THIS AREA

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10 **Have you ever been told by a doctor or other health professional that you have any of the conditions listed below? (If you don't recognize the term below, you probably haven't been diagnosed with it.) Mark either no or yes for each item. If yes, mark year of diagnosis.**

	No	Yes	YEAR OF DIAGNOSIS: 1989 or before	1990–1994	1995 or after
Heart or Blood Pressure					
a. Diabetes	☐	☐	☐	☐	☐
b. High blood pressure (excluding during pregnancy)	☐	☐	☐	☐	☐
c. High cholesterol	☐	☐	☐	☐	☐
d. High triglycerides	☐	☐	☐	☐	☐
e. Heart attack	☐	☐	☐	☐	☐
f. Angina pectoris	☐	☐	☐	☐	☐
g. Stroke	☐	☐	☐	☐	☐
h. TIA (transient ischemic attack)	☐	☐	☐	☐	☐
i. Peripheral artery disease or claudication of legs (pain with walking or exercise) (not varicose veins)	☐	☐	☐	☐	☐
j. Arrythmias	☐	☐	☐	☐	☐
k. Blood clots (deep vein thrombosis)	☐	☐	☐	☐	☐
Bones					
l. Osteoporosis	☐	☐	☐	☐	☐
m. Hip fracture	☐	☐	☐	☐	☐
n. Herniated lumbar disk	☐	☐	☐	☐	☐
o. Wrist or Colles' fracture	☐	☐	☐	☐	☐
p. Vertebral body fracture	☐	☐	☐	☐	☐
Thyroid					
q. Hyperthyroid/Graves disease	☐	☐	☐	☐	☐
r. Hypothyroid disease	☐	☐	☐	☐	☐
s. Thyroid nodule	☐	☐	☐	☐	☐

	No	Yes	YEAR OF DIAGNOSIS 1989 or before	1990–1994	1995 or after
Arthritis/Autoimmune Disease					
t. Rheumatoid arthritis	☐	☐	☐	☐	☐
u. Osteoarthritis	☐	☐	☐	☐	☐
v. Systemic lupus	☐	☐	☐	☐	☐
w. Gout	☐	☐	☐	☐	☐
Gastrointestinal					
x. Colon or rectal polyp (benign)	☐	☐	☐	☐	☐
y. Gallbladder disease/gallstones	☐	☐	☐	☐	☐
z. Gastric or duodenal ulcer	☐	☐	☐	☐	☐
aa. Hiatal hernia	☐	☐	☐	☐	☐
bb. Chronic indigestion	☐	☐	☐	☐	☐
cc. Diverticulitis/diverticulosis	☐	☐	☐	☐	☐
dd. Ulcerative colitis/Crohn's disease	☐	☐	☐	☐	☐
ee. Barrett's esophagus	☐	☐	☐	☐	☐
Kidney/Bladder					
ff. End stage renal disease	☐	☐	☐	☐	☐
gg. Kidney stones	☐	☐	☐	☐	☐
Lung					
hh. Asthma	☐	☐	☐	☐	☐
ii. Emphysema or chronic bronchitis	☐	☐	☐	☐	☐
Neurologic Conditions					
jj. Migraine headaches	☐	☐	☐	☐	☐
kk. Multiple Sclerosis	☐	☐	☐	☐	☐
ll. Parkinson's disease	☐	☐	☐	☐	☐

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	No	Yes	YEAR OF DIAGNOSIS 1989 or before	1990–1994	1995 or after
Teeth					
mm. Peridontal disease (gum disease)	☐	☐	☐	☐	☐
nn. Tooth loss	☐	☐	☐	☐	☐
Eyes					
oo. Macular degeneration of the retina	☐	☐	☐	☐	☐
pp. Cataract	☐	☐	☐	☐	☐
Breast/gynecologic conditions					
qq. Fibrocystic disease of the breast or other benign breast disease	☐	☐	☐	☐	☐
rr. Endometriosis	☐	☐	☐	☐	☐
ss. Uterine fibroids	☐	☐	☐	☐	☐
tt. Infertility	☐	☐	☐	☐	☐
Prostate					
uu. Enlarged prostate (Benign prostatic hyperplasia)	☐	☐	☐	☐	☐
Other major medical condition					
vv. Other (Specify condition) _____	☐	☐	☐	☐	☐

11 **In the past two years, have you had any of the following tests of your colon (large intestine)? (Please mark all that apply.)**

☐ None → *If "None", go to question 13.* ☐ Fecal occult blood test ☐ Sigmoidoscopy ☐ Colonoscopy

12 **Why did you have the colonoscopy or sigmoidoscopy? (Mark all that apply.)**

☐ Saw blood in stool
☐ Diarrhea or constipation
☐ Abnormal barium enema
☐ Abdominal pain
☐ Positive test for blood in stool
☐ Previous polyp
☐ Family history of colon or rectal cancer
☐ Routine or follow-up screening (no symptoms)
☐ Previous colon or rectal cancer

13 **Have you had your cholesterol level checked within the past 2 years?**

☐ No ☐ Yes → (What was your level?_____) *Was it high?* ☐ No ☐ Yes

14 **During the past two years on average, how often have you taken the following medications? How many tablets have you taken on average?**
(Please answer each item below.)

Medications	Never or less than one a month	1–3 per month	1–3 per week	4–6 per week	1 per day	2 per day	3 per day	4 or more per day
Aspirin—Baby or low-dose (162 mg or less)	○	○	○	○	○	○	○	○
Aspirin—Regular or extra-strength aspirin—For example: Bufferin, Anacin, Bayer, Excedrin, Ecotrin, etc.	○	○	○	○	○	○	○	○
Acetaminophen—For example: Tylenol, Phenaphen, etc.	○	○	○	○	○	○	○	○
Anti-inflammatory analgesics (Cox-2 inhibitors)—Celebrex (celecoxib), Vioxx (rofecoxib)	○	○	○	○	○	○	○	○
Other Anti-inflammatory analgesics (other than aspirin)—For example: Ibuprofen, Motrin, Advil, Naprosyn, Anaprox, Aleve, Voltaren, Feldene, Toradol, Indocin, etc.	○	○	○	○	○	○	○	○

15 **Have you ever taken any of the following medications: Mark either no or yes for each item. If yes, write year.**

FOR HEART OR BLOOD PRESSURE: Medications	No	Yes	If "Yes"	Year started	No. of years taken
Calcium Channel Blocker—For example: Procardia, Cardizem, Norvase, Calan, Adalat, Sudar, Yerapamil, Amlodipine, etc.	○	○		____	____
Beta Blocker—For example: Lopressor, Tenormin, Inderal, Atenolol, Metroprolol, etc.	○	○		____	____
ACE Inhibitor—For example: Vasotec, Zestril, Capoten, Prinivil, Lotensin, Accupril, Monopril, Captopril, etc.	○	○		____	____
Diuretic—For example: Lasix, Lozol, Triamterene, HCTZ, Turosemide, Thiazides, etc.	○	○		____	____
Other (Specify name) _____	○	○		____	____

TO REDUCE CHOLESTEROL: Medications	No	Yes	If "Yes"	Year started	No. of years taken
Pravachol (Pravastatin)	○	○		____	____
Lipitor (Atorvastatin)	○	○		____	____
Mevacor (Lovastatin)	○	○		____	____
Lescol (Fluvstatin)	○	○		____	____
Zocor (Simvastatin)	○	○		____	____
Other (Specify name) _____	○	○		____	____

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FOR OSTEOPOROSIS: Mark either no or yes for each item. If yes, write year.

Medications	No	Yes	If "Yes"	Year started	No. of years taken
Evista (Raloxifene)	☐	☐			
Miacalcin (Calcitonin)	☐	☐			
Fosamax (Alendronate)	☐	☐			
Didronel	☐	☐			
Tamoxifen	☐	☐			
Calcium	☐	☐			
Vitamin D	☐	☐			
Other (Specify name) _____	☐	☐			

HORMONES

Medications	No	Yes	If "Yes"	Year started	No. of years taken
Testosterone (Androderm, Android)	☐	☐			
Estrogen alone (e.g., Premarin, Estrace, Estradiol)	☐	☐			
Estrogen and progesterone (e.g., Premarin and Provera, Prempro)	☐	☐			
Tamoxifen (Nolvadex)	☐	☐			
Raloxifene (Evista)	☐	☐			
Other (Specify name of hormone) _____	☐	☐			

16 Have you ever had any of the following procedures?

Procedure	What year did you have this procedure?	Where was it done?
Coronary bypass or angioplasty ☐ No ☐ Yes	_____ Year	_____
Carotid surgery (endarterectomy) ☐ No ☐ Yes	_____ Year	_____
Cardiac catherization (angiogram) ☐ No ☐ Yes	_____ Year	_____
Cerebral or carotid angiogram ☐ No ☐ Yes	_____ Year	_____
Dialysis (for kidney disease) ☐ No ☐ Yes	_____ Year	_____

17 In general, would you say your health is:

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

18 Does pain usually interfere with your normal work (including both work outside the home and housework)?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

19 During the past year, how much of the time has your physical health interfered with your social activities (like visiting with friends, relatives, etc.)?

○ None of the time ○ A little of the time ○ Some of the time ○ Most of the time ○ All of the time

20 What types of health care coverage or insurance do you currently use to pay for <u>most</u> of your medical care? (Mark only the most important)

○ Medicare plus other insurance

○ Medicare plus Medicaid

○ Medicare only

○ A plan provided by your employer

○ A plan provided by someone else's employer

○ A plan that you or someone else buys on your own

○ Medicaid, Medical Assistance, Health Choice, or Maryland Children's Health Program

○ The military, CHAMPUS, or the VA, Tricare

○ Some other source (Specify) _____

○ Don't have health care coverage or health insurance

Is any of your coverage/insurance through an HMO, MCO, POS? ○ No ○ Yes

21 Are there particular clinics, health centers, doctor's offices or other places that you usually go to if you are sick or need advice about your health?

○ No → *If "No", Go to Question 23.* ○ Yes ○ Don't know/Not sure

22 Is this place a clinic, a hospital, a doctor's office, or some other place? (Mark all that apply.)

○ Physician's office

○ Community Free Clinic

○ Potomac Street Clinic or Walnut Street Community Health Clinic

○ Health Department

○ Hospital Express Care

○ Hospital Emergency Room

○ Martinsburg VA Center

○ Hagerstown VA Center (Western Maryland Hospital)

○ Other (specify) _____

○ Don't know/Not sure

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TOBACCO USE

23A Have you ever used any tobacco products?

☐ No → *(If no, go to Question 26.)* ☐ Yes

23B Indicate your use of these tobacco products. Mark all that apply.

	Cigarettes	Cigars	Pipe	Snuff	Chewing Tobacco
Previous use, but quit	☐	☐	☐	☐	☐
Current use	☐	☐	☐	☐	☐

24 If you have ever smoked cigarettes, how many do you or did you smoke each day?

☐ Never smoked cigarettes → *(Go to Question 26.)*
☐ Less than 1
☐ 1–4
☐ 5–14
☐ 15–24
☐ 25–34
☐ 35 or more

25 Have you ever tried to quit smoking using any of the following methods? Mark either no or yes for each item. If yes, mark how long you used it.

Method	No	Yes	If "Yes" → <1 month	1–6 months	7–12 months	>12 months
Individual/group counseling	☐	☐	☐	☐	☐	☐
Nicotine gum (Nicorette)	☐	☐	☐	☐	☐	☐
Nicotine patch (Habitrol, Nicoderm CQ, Nicotrol, ProStep)	☐	☐	☐	☐	☐	☐
Nicotine nasal spray (Nicotrol NS)	☐	☐	☐	☐	☐	☐
Nicotine inhaler (Nicotrol)	☐	☐	☐	☐	☐	☐
Non-nicotine medication (e.g., Zyban, Wellbutrin)	☐	☐	☐	☐	☐	☐
Hypnosis	☐	☐	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐	☐	☐
Quitting on your own – "Cold turkey"	☐	☐	☐	☐	☐	☐

If you marked "Yes" to TWO OR MORE choices listed above, which was the MOST successful in helping you to quit smoking?

☐ Individual/group counseling by itself
☐ Individual/group counseling along with a nicotine product
☐ Individual/group counseling along with a non-nicotine medication
☐ Nicotine gum
☐ Nicotine patch
☐ Nicotine nasal spray
☐ Nicotine inhaler
☐ Non-nicotine medication
☐ Hypnosis
☐ Acupuncture
☐ Quitting on your own – "Cold turkey"

VITAMINS

26 **Do you currently take a multi-vitamin? (Please report other individual vitamins in Question 27.)**

☐ No ☐ Yes →

a. How many do you take per week?

☐ 2 or less ☐ 3–5 ☐ 6–9 ☐ 10 or more

b. What specific brand do you usually use? _____

27 **Do you take the following separate supplements? DO NOT REPORT CONTENTS OF MULTI-VITAMINS MENTIONED ABOVE. Mark either no or yes for each item. If yes, mark dose.**

A. Vitamin A	☐ No	☐ Yes →	Dose per day	☐ less than 8,000 IU	☐ 8,000 to 12,000 IU	☐ 13,000 to 22,000 IU	☐ 23,000 IU or more	☐ Don't know
B. Beta-carotene	☐ No	☐ Yes →	Dose per day	☐ less than 8,000 IU	☐ 8,000 to 12,000 IU	☐ 13,000 to 22,000 IU	☐ 23,000 IU or more	☐ Don't know
C. Vitamin C	☐ No	☐ Yes →	Dose per day	☐ less than 400 mg	☐ 400 to 700 mg	☐ 750 to 1250 mg	☐ 1300 mg or more	☐ Don't know
D. B-Complex	☐ No	☐ Yes						
E. Vitamin B_6	☐ No	☐ Yes →	Dose per day	☐ less than 10 mg	☐ 10 to 39 mg	☐ 40 to 79 mg	☐ 80 mg or more	☐ Don't know
F. Folic Acid	☐ No	☐ Yes →	Dose per day	☐ less than 400 mcg	☐ 400 to 799 mcg	☐ 800 to 1199 mcg	☐ 1200 mcg or more	☐ Don't know
G. Vitamin B_{12}	☐ No	☐ Yes →	Dose per day	☐ less than 100 mcg	☐ 100 to 249 mcg	☐ 250 to 499 mcg	☐ 500 mcg or more	☐ Don't know
H. Vitamin E	☐ No	☐ Yes →	Dose per day	☐ less than 100 IU	☐ 100 to 250 IU	☐ 300 to 500 IU	☐ 600 IU or more	☐ Don't know
I. Calcium (Include calcium in Tums, etc.) (1 Tum = 200 mg elemental calcium)	☐ No	☐ Yes →	Dose per day (elemental calcium)	☐ less than 400 mg	☐ 400 to 900 mg	☐ 901 to 1300 mg	☐ 1301 mg or more	☐ Don't know
J. Selenium	☐ No	☐ Yes →	Dose per day	☐ less than 80 mcg	☐ 80 to 130 mcg	☐ 140 to 250 mcg	☐ 260 mcg or more	☐ Don't know
K. Niacin	☐ No	☐ Yes →	Dose per day	☐ less than 50 mg	☐ 50 to 300 mg	☐ 400 to 800 mg	☐ 900 mg or more	☐ Don't know
L. Zinc	☐ No	☐ Yes →	Dose per day	☐ less than 25 mg	☐ 25 to 74 mg	☐ 75 to 100 mg	☐ 101 mg or more	☐ Don't know

M. Are there <u>other</u> supplements that you take on a regular basis?

○ Iron	○ Magnesium	○ Soy supplements	○ Bee pollen
○ SAMe (S-adenosylmethionine)	○ Melatonin	○ Fish oil	○ Shark cartilage
○ Coenzyme Q10	○ DHEA	○ Ginseng	○ Cod liver oil
○ Gingko biloba	○ Saw Palmetto	○ Flaxseed or oil	○ Vitamin D
○ Antioxidant supplements	○ Echinacea	○ Metamucil/Citrucil	○ Other (please specify)
○ St. Johns wort	○ Chromium	○ Blue Green algae	_____
○ Potassium	○ Lecithin	○ Garlic supplements	_____

DIETARY QUESTIONS

28 During the past year how often did you eat or drink the following:

	Never or less than once a month	1–3 times a month	1–2 times a week	3–4 times a week	5–6 times a week	1 time a day	2+ times a day
100% orange juice	○	○	○	○	○	○	○
100% grapefruit juice	○	○	○	○	○	○	○
Other 100% fruit juices (not counting fruit drinks)	○	○	○	○	○	○	○
Dried fruits, like raisins, apricots, dates	○	○	○	○	○	○	○
Any other fruit (fresh, canned, or frozen) but not counting juices	○	○	○	○	○	○	○
100% vegetable juice, like tomato or V8	○	○	○	○	○	○	○
Green salad, like lettuce or spinach	○	○	○	○	○	○	○
Spaghetti sauce or tomato sauce	○	○	○	○	○	○	○
Vegetable soup or stew with vegetables	○	○	○	○	○	○	○
Beans, like baked beans, pinto or kidney beans, lentils (cooked from dried beans or canned), but not including green beans	○	○	○	○	○	○	○
French fries or fried potatoes	○	○	○	○	○	○	○
Baked, boiled or mashed potatoes	○	○	○	○	○	○	○
Any other vegetables, like green beans, peas, corn, broccoli, tomatoes (fresh, frozen, or canned)	○	○	○	○	○	○	○

PLEASE DO NOT WRITE IN THIS AREA

29 **During the past year, how often did you drink a glass or a cup of . . .**

	Never or less than once a month	1–3 times a month	1 time a week	2–3 times a week	4–6 times a week	2–3 times a day	4–5 times a day	6+ times a day
Red wine	☐	☐	☐	☐	☐	☐	☐	☐
White wine	☐	☐	☐	☐	☐	☐	☐	☐
Beer (1 glass, can, or bottle)	☐	☐	☐	☐	☐	☐	☐	☐
Liquor (1 ounce shot)	☐	☐	☐	☐	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	☐	☐	☐	☐
Green tea (hot or iced)	☐	☐	☐	☐	☐	☐	☐	☐
Black tea (hot or iced)	☐	☐	☐	☐	☐	☐	☐	☐
Water	☐	☐	☐	☐	☐	☐	☐	☐
Milk	☐	☐	☐	☐	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐	☐	☐	☐	☐
Other (Specify) _____	☐	☐	☐	☐	☐	☐	☐	☐

30 **When you drink coffee, tea, or soda, about how often do you drink them without caffeine?**

☐ Never ☐ Half the time ☐ Always

☐ Rarely ☐ Usually

MEN'S HEALTH

The following questions are important for our learning about the causes of prostate cancer, and other prostate diseases.

31 **In the past two years, has a physician checked your prostate by rectal examination?**

☐ No ☐ Yes ☐ Don't know

32 **During the past two years, have you had a blood test (PSA) to see if you had prostate cancer?**

☐ No **(If no, go to Question 35)** ☐ Yes **(Continue with Question 33)**

33 Was the PSA blood test abnormal?

- ○ No (If no, go to Question 35)
- ○ Yes (Continue with Question 34)

34 Abnormal PSA followed up by: (Mark all that apply.)

- ○ Not followed up
- ○ Biopsy
- ○ Hormone treatment
- ○ Repeat test
- ○ Surgical operation
- ○ Ultrasound
- ○ Radiation

35 On average, how many times per night do you usually get up to urinate?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5+

36 During the past month, please indicate how frequently you had these urinary symptoms:

	% of time experienced symptoms					
	Never	10%	25%	50%	75%	100%
Sensation of incomplete bladder emptying	○	○	○	○	○	○
Having to urinate again after less than 2 hours	○	○	○	○	○	○
Stopping and starting several times during urination	○	○	○	○	○	○
Found it difficult to postpone urinating	○	○	○	○	○	○
Weak urinary stream	○	○	○	○	○	○
Had to push or strain to begin urination	○	○	○	○	○	○

37 In the past two years, have you regularly taken medication to treat an enlarged prostate or to treat the urinary symptoms of benign prostatic hyperplasia (BPH)? Mark either no or yes for each item.

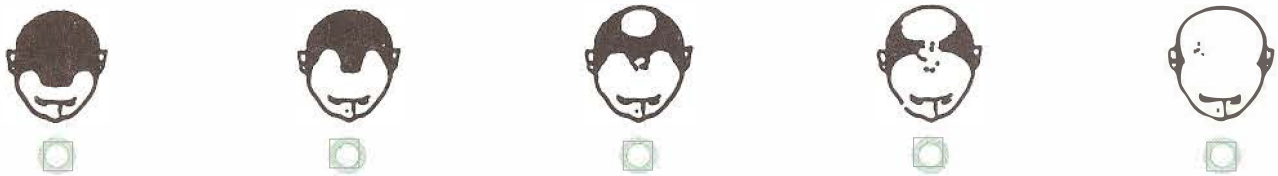
	No	Yes
Finasteride (e.g., Proscar)	○	○
Doxazosin (Cardura)	○	○
Terazosin (Hytrin)	○	○
Tamsulosin (Flomax)	○	○
Saw Palmetto	○	○
Other (Specify name) _____	○	○

PLEASE DO NOT WRITE IN THIS AREA

38 **Have you ever been diagnosed with prostatitis or a prostate infection?**

☐ No ☐ Yes, once ☐ Yes, more than once

39 **Please mark your hair pattern at age 45 or your hair pattern now if you are under age 45.**



☐ None or minimal ☐ ☐ ☐ ☐

40 **Have you ever had a vasectomy (Male Sterilization)?**

☐ No ☐ Yes

What year did you have the surgery?

_____ Year

Where was the surgery done?

☐ Washington County Hospital

☐ Other, specify doctor's office or hospital, city, state:

_____

_____

41 **Have you ever had PROSTATE SURGERY?**

☐ No ☐ Yes

If yes, what type of surgery?

Transurethral Resection (TURP)

☐ No ☐ Yes

What year did you have the surgery?

_____ Year

Where was the surgery done?

☐ Washington County Hospital

☐ Other, specify doctor's office or hospital, city, state:

_____

_____

Biopsy

☐ No ☐ Yes

_____ Year

☐ Washington County Hospital

☐ Other, specify doctor's office or hospital, city, state:

_____

_____

Prostatectomy (removal of the prostate gland)

☐ No ☐ Yes

_____ Year

☐ Washington County Hospital

☐ Other, specify doctor's office or hospital, city, state:

_____

_____

WOMEN'S HEALTH

42 During the past two years, have you had a:

	No	Yes
Pelvic exam	○	○
Pap smear test	○	○
Breast exam by a health professional	○	○
Mammogram	○	○

43 Have your MENSTRUAL PERIODS stopped permanently?

- ○ No, still menstruating. → *Go to question 46.*
- ○ Had menopause, but now have periods due to hormone replacement therapy.
- ○ Yes, menstrual periods stopped.

44 How old were you when your natural MENSTRUAL PERIODS stopped?

Age periods stopped
(Write in number and darken circles)

Age

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

45 Why did your natural MENSTRUAL PERIODS stop?

- ○ Surgical menopause (hysterectomy or removal of ovaries and/or uterus)
- ○ Natural menopause (Change of Life)
- ○ Radiation/Chemotherapy
- ○ Other, specify _____

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46 **Have you ever had any of the following procedures?**

Procedure	What year(s) did you have this procedure?	Where was the procedure done?
BREAST BIOPSY WITH A NEEDLE OR SURGERY (Do not count removing fluid with a needle.) ☐ No ☐ Yes **IF YES,** number of biopsies ☐ One ☐ Two ☐ Three or more Did any biopsy show breast cancer? ☐ No ☐ Yes	_____ Year _____ _____	☐ Washington County Hospital ☐ Other, specify doctor's office or hospital, city, state: _____ _____ _____
HYSTERECTOMY (removal of uterus) ☐ No ☐ Yes	_____ Year	☐ Washington County Hospital ☐ Other, specify doctor's office or hospital, city, state: _____ _____ _____
OOPHORECTOMY (removal of ovaries) ☐ No ☐ Yes ☐ One ovary ☐ Both ovaries	_____ Year	☐ Washington County Hospital ☐ Other, specify doctor's office or hospital, city, state: _____ _____ _____
TUBAL LIGATION (tubes tied) ☐ No ☐ Yes	_____ Year	☐ Washington County Hospital ☐ Other, specify doctor's office or hospital, city, state: _____ _____ _____

COMMENTS

THANK YOU

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