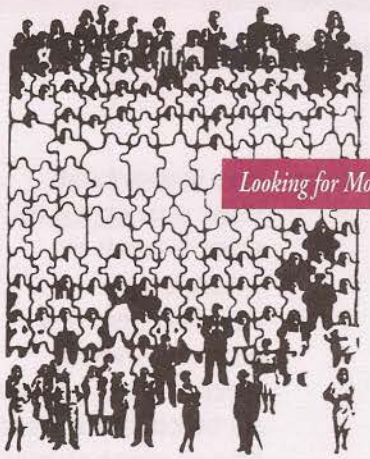

CLUE II

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.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CALL OUR OFFICE AT (301) 797-3589.

PLEASE COMPLETE THE SURVEY AND RETURN IT IN THE ENCLOSED POSTAGE-PAID ENVELOPE

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29175

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 **How tall are you (without shoes)?**
(Write in number, then fill in circles)

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

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

3 **How much do you weigh?**
(Write in number, then fill in 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.

4 **How many grades (years) of school, including college and post-graduate education, have you completed?**
(Write in grade, then fill in numbers)

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

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

HEALTH HISTORY

5 **In general, would you say your health is:**

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

---

6 **Compared to two years ago, how would you rate your health now?**

- ○ Better
- ○ Same
- ○ Worse

---

7 **Compared to two years ago, 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

---

8 **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

---

9 **During the past year, how much of the time has your emotional health/well-being interfered with your social activities?**

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

---

10 **Do you have difficulty with any of the following?**
Mark all that apply.

- ○ Walking
- ○ Preparing meals
- ○ Bathing
- ○ Taking medications
- ○ Dressing
- ○ Managing your finances
- ○ Eating
- ○ Using the telephone
- ○ Light housekeeping
- ○ Vision
- ○ Incontinence (poor bladder control)
- ○ Short-term memory

11 **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, write in the age when you were first diagnosed.**

	No	Yes	Age when first diagnosed (Please write in)
Heart or Blood Pressure			
Diabetes	○	○	
High blood pressure (excluding during pregnancy)	○	○	
High cholesterol	○	○	
High triglycerides	○	○	
Heart attack (myocardial infarction)	○	○	
Angina pectoris	○	○	
Stroke	○	○	
TIA (transient ischemic attack)	○	○	
Peripheral artery disease or claudication of legs (pain with walking or exercise) (not varicose veins)	○	○	
Arrythmias	○	○	
Blood clots (deep vein thrombosis)	○	○	
Congestive heart failure	○	○	
Bones			
Herniated lumbar disk	○	○	
Osteoporosis	○	○	
Hip fracture	○	○	
Wrist or Colles' fracture	○	○	
Vertebral body fracture	○	○	
Thyroid			
Hyperthyroid/Graves disease	○	○	
Hypothyroid disease	○	○	
Other Thyroid disease	○	○	

	No	Yes	Age when first diagnosed (Please write in)
Arthritis/Autoimmune Disease			
Rheumatoid arthritis	○	○	
Osteoarthritis	○	○	
Systemic lupus	○	○	
Gout	○	○	
Gastrointestinal			
Colon or rectal polyp (benign)	○	○	
Gallbladder disease/gallstones	○	○	
Gastric or duodenal ulcer	○	○	
Hiatal hernia	○	○	
Chronic indigestion	○	○	
Diverticulitis/diverticulosis	○	○	
Ulcerative colitis/Crohn's disease	○	○	
Barrett's esophagus	○	○	
Cancer			
Bladder	○	○	
Breast	○	○	
Cervix	○	○	
Cervix in situ	○	○	
Colon or rectum	○	○	
Esophageal	○	○	
Kidney	○	○	
Leukemia	○	○	
Lung	○	○	
Lymphoma or Hodgkins	○	○	
Melanoma	○	○	

PLEASE DO NOT WRITE IN THIS AREA

	No	Yes	Age when first diagnosed (Please write in)
Cancer (continued)			
Oral cavity	○	○	
Ovary	○	○	
Pancreas	○	○	
Prostate	○	○	
Skin-basal cell carcinoma	○	○	
Skin-squamous cell carcinoma	○	○	
Stomach	○	○	
Thyroid	○	○	
Uterus or endometrium	○	○	
Other (please specify): _____	○	○	
Kidney/Bladder			
End stage renal disease	○	○	
Kidney stones	○	○	
Lung			
Asthma	○	○	
Emphysema or chronic bronchitis	○	○	
Neurologic Conditions			
Migraine headaches	○	○	
Multiple Sclerosis	○	○	
Parkinson's disease	○	○	
ALS – Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	○	○	
Dementia	○	○	
Teeth			
Peridontal disease (gum disease)	○	○	
Tooth loss	○	○	

	No	Yes	Age when first diagnosed (Please write in)
Eyes			
Macular degeneration of the retina	○	○	
Cataract	○	○	
Glaucoma	○	○	
Breast/Gynecologic Conditions			
Fibrocystic disease of the breast or other benign breast disease	○	○	
Endometriosis	○	○	
Uterine fibroids	○	○	
Infertility	○	○	
Prostate			
Enlarged prostate (Benign prostatic hyperplasia)	○	○	
Male Infertility	○	○	
Other Major Medical Condition			
Other (specify condition)_____	○	○	

	No	Yes	Age at surgery (Please write in)
Surgical Procedures			
Cardiac catheterization (angiogram)	○	○	
Coronary angioplasty or bypass	○	○	
Carotid or cerebral angiogram	○	○	
Carotid surgery – endarterectomy	○	○	

12 **If you spent an hour in the mid-day sun for the first time without sunscreen, which of these reactions best describes what would happen to your skin?**

○ A blistering sunburn ○ A mild sunburn that becomes a tan ○ No change in skin color

○ A sunburn without blisters ○ A tan with no sunburn

13 **How many blistering sunburns have you gotten in your life?**

○ None ○ 1 or 2 ○ 3 or 4 ○ 5–9 ○ 10–19 ○ 20 or more

PLEASE DO NOT WRITE IN THIS AREA

14 **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	Dementia or Alzheimers
Biological Mother	○		○	○	○	○	○
Biological Father	○	○	○	○	○	○	○
Blood-related Sisters	○		○	○	○	○	○
Blood-related Brothers	○	○	○	○	○	○	○

15 **What are the ages of your parents and grandparents; provide current age, or, if deceased, their age at death.**

	Alive? No	Alive? Yes	Current age/Age at death (Please write in)	If deceased, cause of death (Please write in)
Biological Mother	○	○		
Biological Father	○	○		
Biological Grandparents				
Mother's mother	○	○		
Mother's father	○	○		
Father's mother	○	○		
Father's father	○	○		

MEDICATION, VITAMIN AND SUPPLEMENT USE

16 **Please mark the vitamins and supplements you take on a regular basis.**

- ○ Multi-vitamin
- ○ Vitamin A
- ○ Beta-carotene
- ○ Vitamin C
- ○ Vitamin D alone
- ○ Vitamin D w/Calcium
- ○ Calcium (Include calcium in Tums, etc.) (1 Tum = 200mg elemental calcium)
- ○ B-Complex
- ○ Vitamin B_6
- ○ Folic Acid
- ○ Vitamin B_{12}
- ○ Vitamin E
- ○ Selenium
- ○ Niacin
- ○ Zinc
- ○ Iron
- ○ Potassium
- ○ Magnesium
- ○ Melatonin
- ○ Black Cohosh
- ○ DHEA
- ○ SAMe (S-adenosylmethionine)
- ○ Coenzyme Q10
- ○ Gingko Biloba
- ○ Antioxidant supplements
- ○ St. Johns Wort
- ○ Saw Palmetto
- ○ Echinacea
- ○ Chromium
- ○ Lecithin
- ○ Soy supplements
- ○ Fish oil
- ○ Ginseng
- ○ Flaxseed or oil
- ○ Metamucil/Citrucil
- ○ Blue Green algae
- ○ Garlic supplements
- ○ Bee pollen
- ○ Glucosamine/chondroitin
- ○ Shark cartilage
- ○ Cod liver oil
- ○ Other (please specify) _____

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

	No	Yes
Colonoscopy	○	○
Sigmoidoscopy	○	○
Fecal occult blood test	○	○
CT scan for screening	○	○
Blood sugar test for diabetes	○	○
Cholesterol test	○	○
For Men		
PSA test	○	○
For Women		
Pelvic exam	○	○
Pap smear test	○	○
Breast exam by a health professional	○	○
Mammogram	○	○

LIFESTYLE/DIET

18 Have you ever used any tobacco products?

○ No → *(If no, go to Question 22.)* ○ Yes

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

	Cigarettes	Cigars	Pipe	Snuff	Chewing tobacco
Previously used, but quit at age _____ years	○	○	○	○	○
Currently use	○	○	○	○	○

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

○ Never smoked cigarettes → *(Go to Question 21.)*
○ Less than 1
○ 1–4
○ 5–14
○ 15–24
○ 25–34
○ 35 or more

PLEASE DO NOT WRITE IN THIS AREA

21 **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" → If yes, for how long did you use it? <1 month	1–6 months	7–12 months	>12 months
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)	○	○	○	○	○	○
Other: _____	○	○	○	○	○	○

22 **In the past year, about how often did you eat the following foods from restaurants or carry-outs:**

	Never in past year	1–4 times past year	5–11 times past year	1–3 times a month	Once a week	2–4 times a week	Almost every day
Fried chicken	○	○	○	○	○	○	○
Burgers	○	○	○	○	○	○	○
Pizza	○	○	○	○	○	○	○
Chinese food	○	○	○	○	○	○	○
Mexican food	○	○	○	○	○	○	○
Fried fish	○	○	○	○	○	○	○
All-you-can-eat buffets	○	○	○	○	○	○	○
Subs or Deli	○	○	○	○	○	○	○
Other restaurants (Please specify) _____	○	○	○	○	○	○	○

23 **How often do you drink soda?**

○ Never/less than 1/month ○ 1 can per week ○ 1 can per day ○ more than 3 cans per day

○ 1–3 cans per month ○ 2–6 cans per week ○ 2–3 cans per day

24 When you drink soda, what type do you usually drink?

○ Regular ○ Diet ○ Don't usually drink soda

---

25 In the past year, have you been given advice about weight? By a doctor, nurse, nutritionist, weight loss program, etc.

○ No ○ Yes, lose weight ○ Yes, gain weight ○ Yes, maintain current weight

---

26 Have you ever tried to lose weight?

○ No → *(If no, go to Question 29.)* ○ Yes

---

27 About how many times have you gone on a diet to lose weight?

○ Never ○ 3–5 ○ 9–11

○ 1–2 ○ 6–8 ○ 12 or more times

---

28 What are you doing (have done) to lose weight? Mark all that apply.

○ Eating less food (amount)

○ Switching to foods with lower calories

○ Eating less fat

○ Exercising

○ Skipping meals

○ Eating "diet" foods or products

○ Using a liquid diet formula such as Slimfast or Optifast

○ Joined a weight loss program such as Weight Watchers, Jenny Craig, TOPS, or Overeaters Anonymous

○ Taking diet pills prescribed by a doctor

○ Taking other pills, medicines, herbs, or supplements not needing a prescription

○ Taking laxatives or vomiting

○ Other (specify) _____

○ Refused

○ Don't know

29 Do you agree or disagree with the following statements?

	Agree	Disagree
Everything you eat is bad for you so why bother changing.	○	○
I enjoy the things I eat and don't want to change.	○	○
There are so many different recommendations, it's hard for me to know which ones to follow.	○	○
I eat out so much that making changes would be hard.	○	○
Making changes in the kind of food I eat would be expensive.	○	○
I would like to change, but the rest of my family won't change.	○	○
The things I eat are healthy so there is no reason to make changes.	○	○
What people eat or drink has little effect on whether they will develop major diseases.	○	○
By eating the right kinds of food people can reduce their chances of developing major diseases.	○	○

30 On average in the past two years, how frequently do you take aspirin?

- ○ Never
- ○ 1–3 days/month
- ○ 1–2 days/week
- ○ 3–4 days/week
- ○ 5–6 days/week
- ○ Daily

31 What type (dose) of Aspirin do you usually take?

- ○ None
- ○ Baby
- ○ Regular/Extra Strength

32 What type of anti-inflammatory or pain medication, other than aspirin, do you usually take?

- ○ None
- ○ Cox-2 Inhibitors – for example, Celebrex, Vioxx
- ○ Other anti-inflammatory medications (other than aspirin) – for example, Ibuprofen, Motrin, Advil, Naprosyn, Aleve
- ○ Tylenol (acetominophen)

PLEASE DO NOT WRITE IN THIS AREA

29175

33 Please mark the medication you take on a regular basis.

Heart/Blood Pressure

- ☐ Calcium channel blocker (e.g., Calan, Procardia, Cardizem)
- ☐ Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)
- ☐ Other antihypertensive (e.g., Aldomet, Apresoline)
- ☐ Digoxin
- ☐ Antiarrhythmic

Asthma/COPD

- ☐ Inhaled steroids
- ☐ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)
- ☐ Inhaled Bronchodilator

Diabetes

- ☐ Insulin
- ☐ Oral hypoglycemic medicine

Osteoporosis

- ☐ Evista (Raloxifene)
- ☐ Miacalcin (Calcitonin)
- ☐ Fosamax (Alendronate, Didronel – or other Calcium Metabolism drugs)
- ☐ Other (specify name) _____

Hormones

- ☐ Testosterone
- ☐ Estrogen alone, (e.g., Premarin, Estrace, Estradiol)
- ☐ Estrogen and Progesterone (e.g., Premarin and Provera, Prempro)
- ☐ Estratest (combination estrogen and progesterone)
- ☐ Tamoxifen (Nolvadex)
- ☐ Natural, plant estrogens, Raloxifene (Evista)
- ☐ Oral contraceptives
- ☐ Other (specify name) _____

Gastrointestinal

- ○ Cimetidine (Tagamet)
- ○ Other H2 blocker (e.g., Zantac, Pepcid, Nexium, Prilosec)
- ○ Other (specify name) _____

Other

- ○ Coumadin
- ○ Lasix
- ○ Thiazide diuretic
- ○ Antidepressant (e.g., Elavil, Prozac, Zoloft, Paxil)
- ○ Cholesterol-lowering drug – Statin (e.g., Lipitor, Pravachol)
- ○ Other regular medications (write in please) _____
- ○ No regular medications

SOCIAL SUPPORT

34 How many close friends do you have?

○ None ○ 1 or 2 ○ 3–5 ○ 6–9 ○ 10 or more

35 How many of these friends do you see at least once a month?

○ None ○ 1 or 2 ○ 3–5 ○ 6–9 ○ 10 or more

36 How often do you go to religious meetings or services?

○ Never or almost never ○ More than once a week ○ Once a week ○ Twice a month to once a year

37 How many hours each week do you participate in any volunteer, church, or other community group?

○ None ○ 1–2 hours ○ 3–5 hours ○ 6–10 hours ○ 11–15 hours ○ 16 or more hours

38 What is your living arrangement: Mark all that apply.

○ Alone ○ With other family ○ Other (specify) _____

○ With spouse or partner ○ Nursing home

PLEASE DO NOT WRITE IN THIS AREA

WOMEN'S HEALTH

Reproductive History

39 **How old were you when you first started having menstrual periods?**

(Write in age and darken circles)

○ Unknown

Age

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

40 **What was the date of your last menstrual period?**

(Write in date and darken circles)

Month		Day		Year	
0	0	0	0	0	0
1	1	1	1	1	1
	2	2	2	2	2
	3	3	3	3	3
	4		4	4	4
	5		5	5	5
	6		6	6	6
	7		7	7	7
	8		8	8	8
	9		9	9	9

---

41 **Have you gone through menopause?**

○ No ➡ ***(If no, go to Question 45.)***

○ Yes

○ Not sure

42 How old were you when you went through menopause?

(Write in age and darken circles)

○ Unknown

Age

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

43 Why did you go through menopause?

- ○ Natural menopause (change of life)
- ○ Hysterectomy (removal of uterus)
- ○ Removal of both ovaries – with or without hysterectomy
- ○ Radiation/Chemotherapy
- ○ Other (specify)

_____

_____

_____

44 a.) Have you ever had hot flashes?

- ○ No → *(If no, go to Question 45.)*
- ○ Yes

b.) How long did you have hot flashes?

○ Less than 1 year ○ 1–2 years ○ 3–5 years ○ 6–10 years ○ More than 10 years

c.) At their worst, how many hot flashes did you have during a 24 hour period?

○ 1–2 ○ 3–5 ○ 6–10 ○ More than 10

45 Have you ever been pregnant?

- ○ No
- ○ Yes

46 **For each time you became pregnant, please mark the outcome of the PREGNANCY.**

	Pregnancy Outcome				
	Live birth	Stillborn	Miscarriage	Abortion	Age (please write in)
1st Pregnancy	○	○	○	○	
2nd Pregnancy	○	○	○	○	
3rd Pregnancy	○	○	○	○	
4th Pregnancy	○	○	○	○	
5th Pregnancy	○	○	○	○	
6th Pregnancy	○	○	○	○	
7th Pregnancy	○	○	○	○	
8th Pregnancy	○	○	○	○	
9th Pregnancy	○	○	○	○	
10th Pregnancy	○	○	○	○	
11th Pregnancy	○	○	○	○	

47 **Did you breast feed any of your children?**

- ○ No
- ○ Yes

48 **In total, how many months of your life have you spent breastfeeding?**
(Write in months and darken circles)

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

COMMENTS

THANK YOU

PLEASE CHECK TO MAKE SURE YOU HAVE NOT ACCIDENTALLY SKIPPED ANY PAGES.

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