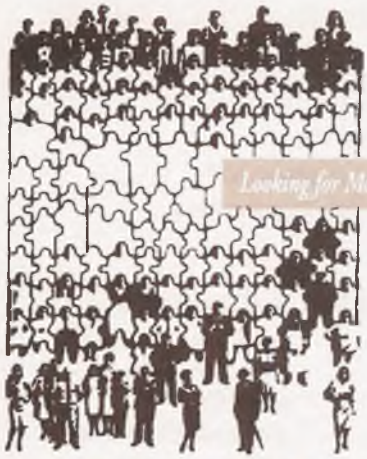

CLUE II

STUDY NO.

Please check the information above and correct any mistakes.

Is the birth date indicated above correct?

○No → If no, please write correct date. ___/___/___ MONTH DAY YEAR

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

○Yes, birth date is correct.

INSTRUCTIONS

USE A No. 2 PENCIL

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

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
- Do not use ink, ballpoint, or felt tip pens.
- Make solid marks that fill the response completely.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

CORRECT: ● INCORRECT: ✓ ✗ ◒ ◔

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

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

05/2007

DE Mark Reflex® forms by NCS Pearson EW-271273-1:654321 ED06 Printed in U.S.A.

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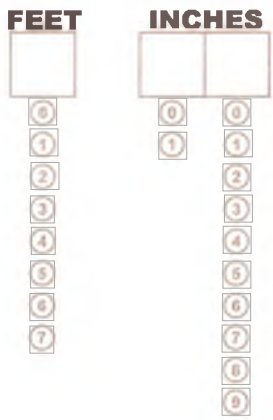
1. How long have you lived at your current address?

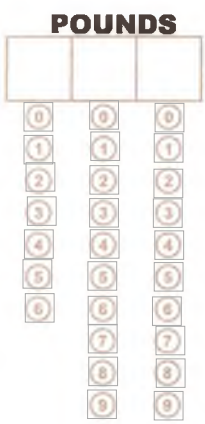
- ○ Less than 1 year
- ○ 1-2 years
- ○ 3-5 years
- ○ 6-9 years
- ○ 10-14 years
- ○ 15-19 years
- ○ 20-24 years
- ○ 25 or more years

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



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)



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 postgraduate education, have you completed?
(Write in number, then fill in circles)

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. 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)	○	○	
Arrhythmias	○	○	
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 - (overactive)	○	○	
Hypothyroid disease - (underactive)	○	○	
Other thyroid disease	○	○	

	No	Yes	Age when first diagnosed (Please write in)
Arthritis/Autoimmune Disease			
Rheumatoid arthritis	○	○	
Osteoarthritis	○	○	
Arthritis (unknown type)	○	○	
Systemic lupus	○	○	
Gout	○	○	
Gastrointestinal			
Colon or rectal polyp (benign)	○	○	
Gallbladder disease/gallstones	○	○	
Gastric or duodenal ulcer	○	○	
Hiatal hernia	○	○	
Chronic indigestion	○	○	
GERD or Reflux disease	○	○	
Barrett's esophagus	○	○	
Diverticulitis/diverticulosis	○	○	
Ulcerative colitis/Crohn's disease	○	○	
Celiac disease	○	○	
Kidney/Bladder			
End stage renal disease	○	○	
Kidney stones	○	○	
Neurologic Conditions			
Migraine headaches	○	○	
Multiple sclerosis	○	○	
Parkinson's disease	○	○	
Dementia	○	○	
Alzheimer's disease	○	○	

	No	Yes	Age when first diagnosed (Please write in)
Lung			
Asthma	○	○	_____
Emphysema or chronic bronchitis	○	○	_____
Teeth			
Periodontal disease (gum disease)	○	○	_____
Eyes			
Macular degeneration of the retina	○	○	_____
Cataract	○	○	_____
Glaucoma	○	○	_____
Skin Cancer			
Melanoma skin cancer	○	○	_____
If yes, how many different times? _____			
Non-Melanoma skin cancer	○	○	_____
○ Basal cell carcinoma If yes, how many different times? _____			
○ Squamous cell carcinoma If yes, how many different times? _____			
○ Other skin cancer (specify) _____ If yes, how many different times? _____			
○ Don't know type of skin cancer If yes, how many different times? _____			
If you have been diagnosed with non-melanoma skin cancer, where was it diagnosed?			
○ Physician's office Name of physician _____ Location (city/state) _____			
○ Other Name of facility _____ Location (city/state) _____			
Cancer			
Bladder	○	○	_____
Breast	○	○	_____
Cervix	○	○	_____
Cervix in situ	○	○	_____

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	No	Yes	Age when first diagnosed (Please write in)
Cancer (continued)			
Colon or rectum	○	○	_____
Esophageal	○	○	_____
Kidney	○	○	_____
Leukemia	○	○	_____
Lung	○	○	_____
Lymphoma or Hodgkin's	○	○	_____
Oral Cavity	○	○	_____
Ovary	○	○	_____
Pancreas	○	○	_____
Prostate	○	○	_____
Stomach	○	○	_____
Thyroid	○	○	_____
Uterus or Endometrium	○	○	_____
Other (specify) _____	○	○	_____
Female Health			
Endometriosis	○	○	_____
Uterine fibroids	○	○	_____
Female infertility	○	○	_____
Fibrocystic disease or other benign breast disease	○	○	_____
Breast biopsy	○	○	_____
If yes to breast biopsy, where was your most recent breast biopsy performed? Name of physician _____ Location (city/state) _____			
Male Health			
Enlarged prostate (benign prostatic hyperplasia)	○	○	_____
Prostatitis or prostate infection	○	○	_____
Male infertility	○	○	_____
Erectile dysfunction	○	○	_____

SKIN & SUN EXPOSURE

6. How would you describe your complexion?

- ◯ Very fair
- ◯ Fair
- ◯ Medium
- ◯ Light brown
- ◯ Medium brown
- ◯ Dark brown
- ◯ Don't know

7. How much freckling do you have on your face?

- ◯ None
- ◯ Small amount
- ◯ Large amount
- ◯ Almost all

8. What is the natural color of your eyes?

- ◯ Blue
- ◯ Green
- ◯ Hazel
- ◯ Light Brown
- ◯ Dark Brown
- ◯ Other color (specify) _____

9. 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?

- ◯ Blistering sunburn
- ◯ Sunburn without blisters
- ◯ Mild sunburn that becomes a tan
- ◯ Tan or darken with no sunburn
- ◯ No change in skin color

10. Have you ever had a blistering sunburn?

- ◯ No *(If no, skip to question 11)*
- ◯ Yes

10a. How old were you the first time you had a blistering sunburn?

- ◯ Under 5 years old
- ◯ 5 - 14 years old
- ◯ 15 - 24 years old
- ◯ 25 - 39 years old
- ◯ 40 - 64 years old
- ◯ 65 years old or older

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10b. How old were you the last time you had a blistering sunburn?

- ◯ Under 5 years old
- ◯ 5 - 14 years old
- ◯ 15 - 24 years old
- ◯ 25 - 39 years old
- ◯ 40 - 64 years old
- ◯ 65 years old or older

10c. How many blistering sunburns have you had in your life?

- ◯ 1 or 2
- ◯ 3 or 4
- ◯ 5 - 9
- ◯ 10 - 19
- ◯ 20 or more

11. Have you ever used a solar blanket or a reflector?

- ◯ No
- ◯ Yes

12. Have you ever used a sunlamp or tanning booth?

- ◯ No *(If no, skip to question 13)*
- ◯ Yes

12a. How old were you the first time you used a sunlamp or tanning booth?

- ◯ Under 5 years old
- ◯ 5 - 14 years old
- ◯ 15 - 24 years old
- ◯ 25 - 39 years old
- ◯ 40 - 64 years old
- ◯ 65 years old or older

12b. How old were you the last time you used a sunlamp or tanning booth?

- ◯ Under 5 years old
- ◯ 5 - 14 years old
- ◯ 15 - 24 years old
- ◯ 25 - 39 years old
- ◯ 40 - 64 years old
- ◯ 65 years old or older

12c. During periods when you used a sunlamp or tanning booth, how many minutes did you usually use them each time?

- ◯ Less than 5 minutes
- ◯ 5 - 10 minutes
- ◯ 11 - 20 minutes
- ◯ 21 - 30 minutes
- ◯ 31 - 40 minutes
- ◯ 41 minutes or more

12d. How many times have you used a sunlamp or tanning booth?

- ○ Less than 10 times
- ○ 10 - 50 times
- ○ More than 50 times

13. Were you ever treated with UV lights for acne?

- ○ No
- ○ Yes

14. Do you take a vitamin D supplement?

- ○ No
- ○ Yes - less than once per week
- ○ Yes - every week, but not every day
- ○ Yes - every day

15. Have you ever heard of going out into the sun without sunscreen or skin protective clothing so that your body would make more vitamin D?

- ○ No
- ○ Yes

15a. Do you ever go out into the sun so that your body will make more vitamin D?

- ○ No
- ○ Yes - seldom
- ○ Yes - sometimes
- ○ Yes - often

16. During the summer, how many days per week do you go outside in direct sunlight for 60 minutes or more?

- ○ Never
- ○ 1 day per week or less
- ○ 2 - 3 days per week
- ○ 4 - 5 days per week
- ○ 6 - 7 days per week

17. When you go out into the sun, do you use sunscreen (or lotions containing sunscreen)?

- ○ Never *(If never, skip to question 18)*
- ○ Yes - rarely
- ○ Yes - sometimes
- ○ Yes - often or always

17a. If you use sunscreen, what SPF level do you usually use?

- ○ SPF 10 or less
- ○ SPF 15
- ○ SPF 30
- ○ SPF 45 or more

17b. On days you use sunscreen, do you ever reapply sunscreen?

- ☐ No
- ☐ Yes

18. Do you protect your skin from sun exposure with clothing (hat, long sleeves, long pants, umbrella)?

- ☐ Never
- ☐ Yes - rarely
- ☐ Yes - sometimes
- ☐ Yes - often or always

Please answer the following questions about your exposure to the sun at different periods of your life. When we refer to "mid-day sun", it means those hours when the sun is more than halfway up in the sky. For most of the United States, that would be between the hours of 10 AM and 4 PM Daylight Savings Time.

19. On a typical *weekday* in the summer, about how many hours did you generally spend in the mid-day sun when you were in your . . .

Teens?	Twenties?	Thirties?	Past 10 years?
☐ 0	☐ 0	☐ 0	☐ 0
☐ 1	☐ 1	☐ 1	☐ 1
☐ 2	☐ 2	☐ 2	☐ 2
☐ 3	☐ 3	☐ 3	☐ 3
☐ 4	☐ 4	☐ 4	☐ 4
☐ 5	☐ 5	☐ 5	☐ 5
☐ 6	☐ 6	☐ 6	☐ 6

20. On a typical *weekend* day in the summer, about how many hours did you generally spend in the mid-day sun when you were in your . . .

Teens?	Twenties?	Thirties?	Past 10 years?
☐ 0	☐ 0	☐ 0	☐ 0
☐ 1	☐ 1	☐ 1	☐ 1
☐ 2	☐ 2	☐ 2	☐ 2
☐ 3	☐ 3	☐ 3	☐ 3
☐ 4	☐ 4	☐ 4	☐ 4
☐ 5	☐ 5	☐ 5	☐ 5
☐ 6	☐ 6	☐ 6	☐ 6

21. How many months a year did you usually have a tan when you were in your . . .

Teens?	Twenties?	Thirties?	Past 10 years?
☐ 0	☐ 0	☐ 0	☐ 0
☐ 1-2	☐ 1-2	☐ 1-2	☐ 1-2
☐ 3-4	☐ 3-4	☐ 3-4	☐ 3-4
☐ 5-6	☐ 5-6	☐ 5-6	☐ 5-6
☐ 7-8	☐ 7-8	☐ 7-8	☐ 7-8
☐ ≥9	☐ ≥9	☐ ≥9	☐ ≥9

HEALTH SCREENING

Sigmoidoscopy and **colonoscopy** are exams in which a tube is inserted in the rectum to view the bowel for signs of cancer or other health problems.
Sigmoidoscopy is usually performed in the doctor's office without anesthesia.
Colonoscopy is usually performed in a hospital, endoscopy or surgical center with anesthesia.

22. Have you ever had either a colonoscopy or sigmoidoscopy?

- ○ No *(If no, skip to question 23)*
- ○ Yes
- ○ Don't know

22a. Have you ever had a colonoscopy?

- ○ No
- ○ Yes
- ○ Don't know

If you had a colonoscopy, write in your age at the procedure, starting with youngest age first.	Was a polyp found?	Name & location of physician
_____ yrs old	○ No ○ Yes ○ Don't know	_____ M.D. _____ (city/state)
_____ yrs old	○ No ○ Yes ○ Don't know	_____ M.D. _____ (city/state)
_____ yrs old	○ No ○ Yes ○ Don't know	_____ M.D. _____ (city/state)

22b. Have you ever had a sigmoidoscopy?

- ○ No
- ○ Yes
- ○ Don't know

If you had a sigmoidoscopy, write in your age at the procedure, starting with youngest age first.	Was a polyp found?	Name & location of physician
_____ yrs old	○ No ○ Yes ○ Don't know	_____ M.D. _____ (city/state)
_____ yrs old	○ No ○ Yes ○ Don't know	_____ M.D. _____ (city/state)
_____ yrs old	○ No ○ Yes ○ Don't know	_____ M.D. _____ (city/state)

22c. Why did you have a sigmoidoscopy or colonoscopy?
(Mark all that apply)

- ○ Saw blood in stool
- ○ Abdominal pain
- ○ Family history of colon cancer
- ○ Diarrhea or constipation
- ○ Positive test for blood in stool
- ○ Routine or follow-up screening
- ○ Abnormal barium enema
- ○ Previous polyp
- ○ Previous colon or rectal cancer
- ○ Other (specify) _____

TOBACCO & ALCOHOL USE

23. Have you ever used any tobacco products?

- ◯ No *(If no, skip to question 30)*
- ◯ Yes

24. Indicate your use of these tobacco products.

Cigarettes	◯ Use now	◯ Previously used, quit at age _____	◯ Never used
Cigars	◯ Use now	◯ Previously used, quit at age _____	◯ Never used
Pipe	◯ Use now	◯ Previously used, quit at age _____	◯ Never used
Snuff	◯ Use now	◯ Previously used, quit at age _____	◯ Never used
Chewing Tobacco	◯ Use now	◯ Previously used, quit at age _____	◯ Never used

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

- ◯ Never smoked cigarettes *(If never, skip to question 30)*
- ◯ Less than 1
- ◯ 1 - 4
- ◯ 5 - 14
- ◯ 15 - 24
- ◯ 25 - 34
- ◯ 35 or more

26. In the past year, how often did you smoke cigarettes?

- ◯ Not at all
- ◯ Some days
- ◯ Every day

27. In the past 30 days, how often did you smoke cigarettes?

- ◯ Not at all
- ◯ Some days
- ◯ Every day

28. Have you ever tried to quit smoking?

- ◯ No *(If no, skip to question 30)*
- ◯ Yes

28a. Have you ever tried to quit smoking using any of the following methods? Mark each method you have tried and how long you used it.

Method	<1 month	1-6 months	7-12 months	>12 months
○ Individual/group counseling	○	○	○	○
○ Telephone quitline	○	○	○	○
○ Computer/internet cessation programs	○	○	○	○
○ Nicotine gum (Nicorette)	○	○	○	○
○ Nicotine patch (Habitrol, Nicoderm CQ, Nictorol, ProStep)	○	○	○	○
○ Nicotine nasal spray (Nicotrol NS)	○	○	○	○
○ Nicotine inhaler (Nicotrol)	○	○	○	○
○ Nicotine lozenge (Commit)	○	○	○	○
Non-nicotine medications				
○ Bupropion, Zyban or Wellbutrin	○	○	○	○
○ Varenicline or Chantix	○	○	○	○
○ Rimonabant, Acomplia, or Zimulti	○	○	○	○
○ Hypnosis	○	○	○	○
○ Acupuncture	○	○	○	○
○ Quitting on your own - "Cold Turkey"	○	○	○	○
○ Other *(specify)* _____	○	○	○	○

29. If you marked TWO or MORE choices listed above, which was the MOST successful 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
- ○ Telephone quitline
- ○ Computer/internet cessation programs
- ○ Nicotine gum
- ○ Nicotine patch
- ○ Nicotine lozenge
- ○ Nicotine nasal spray
- ○ Nicotine inhaler
- ○ Bupropion or Zyban or Wellbutrin
- ○ Varenicline or Chantix
- ○ Rimonabant or Acomplia or Zimulti
- ○ Hypnosis
- ○ Acupuncture
- ○ Quitting on your own - "Cold Turkey"
- ○ Other *(specify)* _____
- ○ None of the above

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30. During the past year, how often did you drink the following?

	Never or less than once a month	1-3 times a month	1-3 times a week	4-6 times a week	1-3 times a day	4-5 times a day	6+ times a day
Red wine (5 oz. glass)	○	○	○	○	○	○	○
White wine (5 oz. glass)	○	○	○	○	○	○	○
Beer (1 glass, can, or bottle)	○	○	○	○	○	○	○
Liquor (1 oz. shot)	○	○	○	○	○	○	○

PHYSICAL FUNCTION & QUALITY OF LIFE

31. By yourself, that is, without help from another person or special equipment, how difficult is it for you to:

	Not difficult	A little difficult	Somewhat difficult	Very difficult	Can't do this activity	Don't do this activity	Don't know
Walk a quarter of a mile (about 2 - 3 city blocks)	○	○	○	○	○	○	○
Walk up 10 steps without resting	○	○	○	○	○	○	○
Shop for personal items, such as medicine or toilet items	○	○	○	○	○	○	○
Do light housework, such as washing dishes, straightening up or light cleaning	○	○	○	○	○	○	○
Prepare own meals	○	○	○	○	○	○	○
Manage money, such as paying bills or keeping a bank account	○	○	○	○	○	○	○
Manage your medications	○	○	○	○	○	○	○
Bathe or shower	○	○	○	○	○	○	○
Get in and out of bed or a chair	○	○	○	○	○	○	○
Get dressed	○	○	○	○	○	○	○
Use the toilet, including getting to the toilet	○	○	○	○	○	○	○
Eating, for example holding a fork, cutting your food, or drinking from a glass	○	○	○	○	○	○	○
Walk across a small room	○	○	○	○	○	○	○

32. In general, would you say your health is:

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

33. Compared to one year ago, how would you rate your health now?

- ○ Better
- ○ Same
- ○ Worse

34. During the past year, has pain interfered with your normal work (including both work outside the home and housework)?

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

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

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

36. During the past year, how much of the time has your emotional health/well-being interfered with your social activities (like visiting friends, relatives, etc.)?

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

37. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? *(If zero, fill in circle for none)*

○ None _____Number of days ○ Don't know

38. Now thinking about your mental health, which includes stress, depression and problems with emotions, how many days during the past 30 days was your mental health not good? *(If zero, fill in circle for none)*

○ None _____Number of days ○ Don't know

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39. During the past 30 days, about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? *(If zero, fill in circle for none)*

○ None _____Number of days ○ Don't know

SLEEP HABITS

40. Do you snore?

○ No
○ Yes
○ Don't know

40a. If yes, has your snoring ever bothered other people?

○ No
○ Yes
○ Don't know

41. How many hours do you usually sleep at night (or your main sleep period) on weekdays or workdays?

○ Less than 6 hours
○ 6 hours
○ 7 hours
○ 8 hours
○ 9 hours
○ 10 hours
○ More than 10 hours

42. How many hours do you usually sleep at night (or your main sleep period) on weekends or your non-work days?

○ Less than 6 hours
○ 6 hours
○ 7 hours
○ 8 hours
○ 9 hours
○ 10 hours
○ More than 10 hours

43. On average, during the past year, how often have you felt sleepy during the day, no matter how much sleep you had?

○ Never
○ 1 day per month or less
○ 2-4 days per month
○ 5-15 days per month
○ 16-30 days per month

44. On average, during the past year, how often did you take sleeping pills, melatonin, or other medicine to help you sleep?

- ○ Never
- ○ 1 day per month or less
- ○ 2-4 days per month
- ○ 5-15 days per month
- ○ 16-30 days per month

FAMILY HEALTH HISTORY

45. Were either of your parents, your blood-related brother(s) or sister(s), or your children ever diagnosed with non-melanoma skin cancer or other cancers?

	Non-melanoma skin cancer	Other cancers	*(Please list type of cancer)*
Mother	○ No ○ Yes	○ No ○ Yes	_____
Father	○ No ○ Yes	○ No ○ Yes	_____
Blood-related brother(s)	○ No ○ Yes	○ No ○ Yes	_____
Blood-related sister(s)	○ No ○ Yes	○ No ○ Yes	_____
Children	○ No ○ Yes	○ No ○ Yes	_____

46. Have either of your parents, your blood-related brother(s) or sister(s), or your children ever experienced the conditions listed below?

	Mother	Father	Blood-related brother(s)	Blood-related sister(s)	Children
Heart attack, stroke, blood clots, arrhythmias, congestive heart failure	○	○	○	○	○
High blood pressure	○	○	○	○	○
High cholesterol	○	○	○	○	○
Diabetes	○	○	○	○	○
Arthritis, osteoporosis, other bone problem	○	○	○	○	○
Mental illness, depression, mania	○	○	○	○	○
Thyroid disorder, other hormone disorder	○	○	○	○	○
Nerve-muscle disorder	○	○	○	○	○
Weight problems, obesity, anorexia	○	○	○	○	○

WOMEN

47. Has your menstrual period stopped permanently or for at least one year?

- ☐ No, still menstruating
  Date of last menstrual period _____
- ☐ No, menstrual period is irregular, but had at least one period within the last year
  Date of last menstrual period _____
- ☐ Yes, menstrual periods have stopped permanently
  Date or year of last menstrual period _____
  Age at last period _____

COMMENTS

THANK YOU!

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

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