1. Please write in your age and date of birth.

Age: 
Month: / Day: 19 Year: 
(example: June = 06)

2. Since March 2009, have you had a: 
(Fill in all that apply.)
- Physical exam
- Blood sugar test
- Eye exam
- Pap smear
- Mammogram
- Walking for exercise
- Vigorous exercise (e.g., jogging, aerobics)
- Walking to and from church, school, work

3. How many breast biopsies have you ever had?
   - number of biopsies
   - years old
   a. Your age at 1st biopsy
   - years old
   b. Your age at 2nd biopsy
   - years old

4. How many children have you given birth to?
   - Number of births

5. How many months in total have you breastfed your children? 
   (total for all)
   - Months
   a. What is the longest you breastfed any child?
   - Months

6. Since March 2009, have you taken female hormones (like estrogen) for menopause?
   - No
   - Yes. If yes, how many months?
   - Months
   - Name of medication(s):

7. Since March 2009, have you had surgery to remove your ovaries or uterus? 
   (Fill in all that apply.)
   - No
   - Both ovaries removed
   - One ovary only removed
   - Uterus removed

8. Are you enrolled in Medicare?
   - No
   - Yes
   - Don't know
   If yes, are you enrolled in (Fill in all that apply):
   - Medicare Part A
   - Medicare Part B
   - A Medicare Advantage Plan
   (a Medicare health plan offered by a private company, also called Medicare Part C)
   - a. Do you have other health insurance (for example through an employer, Medicaid)?
   - No
   - Yes
   - Don't know

9. Please write in your current weight.
   - Pounds

10. During the past year, how many hours each week did you spend (on average):
    - Walking for exercise
    - Vigorous exercise (e.g., jogging, aerobics)
    - Walking to and from church, school, work

   Please continue to Question 6

Please continue to Questions 10

Next page, please.
11. Since March 2009, if you were diagnosed with any of the following conditions, please fill in the circle for yes and write in the year it was first diagnosed. (e.g. 2009)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breast cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Lung cancer</td>
<td></td>
<td></td>
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<tr>
<td>3. Colon cancer</td>
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<td></td>
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<tr>
<td>4. Rectal cancer</td>
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<tr>
<td>5. Other type of cancer. (Please write in the type)</td>
<td></td>
<td></td>
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<tr>
<td>6. Diabetes (sugar, sugar diabetes)</td>
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<tr>
<td>7. Heart attack</td>
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<td></td>
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<tr>
<td>8. Stroke</td>
<td></td>
<td></td>
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<tr>
<td>9. Coronary bypass surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Angioplasty or stent for artery repair</td>
<td></td>
<td></td>
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<tr>
<td>11. Congestive heart failure (CHF)</td>
<td></td>
<td></td>
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<tr>
<td>12. Atrial fibrillation</td>
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<td></td>
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<tr>
<td>13. End stage renal disease</td>
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<td></td>
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<tr>
<td>14. Blood clot (lungs or legs)</td>
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<td></td>
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<tr>
<td>15. Hypertension (high blood pressure)</td>
<td></td>
<td></td>
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<tr>
<td>16. High cholesterol</td>
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<td></td>
</tr>
<tr>
<td>17. Endometriosis (confirmed by laparoscopy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18a. Fibroids in womb confirmed by ultrasound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18b. Fibroids in womb confirmed by surgery (e.g. hysterectomy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Lupus (not discoid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Multiple sclerosis (MS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Colon or rectal polyp (benign)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Depression treated with medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Glaucoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Cataracts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Sarcoïdosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Rheumatoid arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Hip Fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Osteoarthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Other serious illness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Do you have chronic kidney disease?
   ○ No ○ Yes. If yes, are you on dialysis?
      ○ No ○ Yes

13. Do you take any of the following medications or vitamins at least 3 days a week?
   (Fill in the circle for YES, leave blank for NO.)
   ○ Aspirin
   ○ Ibuprofen, Naproxen, Aleve, or Motrin
   ○ Pills to lower cholesterol Name:  
   ○ Injections for diabetes
   ○ Pills for diabetes Name:  
   ○ Diuretics (water pills) for high blood pressure or other reasons Name:  
   ○ Other blood pressure pills Name:  
   ○ Inhalers or pills for asthma Name:  
   ○ Multi-Vitamins ○ Folic acid by itself
   ○ Calcium ○ Vitamin D

   Please list all other medications or supplements that you currently take at least 3 days a week:

14. Overall, how would you rate the health of your teeth and gums?
   ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

15. In the past four (4) years, how many teeth have you lost?
   Teeth lost

16. Has a dentist ever told you that you have gum disease with bone loss?
   ○ No ○ Yes

17. What is your current work status: (Fill in all that apply.)
   ○ Full time ○ Part time ○ Homemaker ○ Student
   ○ Retired ○ Disabled ○ Unemployed

Next page, please.
18. During the past year, how often have you leaked or lost control of your urine?
- Never
- Less than once/month
- Once/month
- 2-3 times/month
- About once/week
- Almost every day

When you lose your urine, how much usually leaks?
- A few drops
- Enough to wet your underwear
- Enough to wet your outer clothing
- Enough to wet the floor

When you lose urine, what is the usual cause?
- Coughing, sneezing, laughing or doing physical activity
- A sudden urgent need to go to the bathroom
- Both a) and b) equally
- In other circumstances

19. On average, how often in the past year have you experienced any amount of accidental bowel leakage?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Less than once per month</th>
<th>1-3 per month</th>
<th>About once per week</th>
<th>Several times per week</th>
<th>Nearly daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Liquid stool</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>b. Solid stool</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

20. How many hours each week do you participate in any groups such as a social or work group, church-connected group, self-help group, charity, public service or community group?
- None
- 1-2 hours
- 3-5 hours
- 6-10 hours
- 11-15 hours
- 16 or more hours

21. Apart from your children, how many relatives do you have with whom you feel close?
- None
- 1-2
- 3-5
- 6-9
- 10 or more

22. How many close friends do you have?
- None
- 1
- 2
- 3 or more

23. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?
- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

24. How many people can you count on to provide you with emotional support?
- None
- 1
- 2
- 3 or more

25. With whom do you live? (Fill in all that apply.)
- Alone
- With spouse/partner
- With 1 or more children
- With 1 or more parents
- With other family
- With 1 or more friends

26. Outside of your employment, how many hours per week do you provide regular care to any of the following?

<table>
<thead>
<tr>
<th>Hourly Range</th>
<th>a. Your disabled child or grandchild</th>
<th>b. Your other children or grandchildren</th>
<th>c. Disabled or ill spouse/partner</th>
<th>d. Disabled or ill parent or other person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero hours</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>1-8 hours</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>9-20 hours</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>21-35 hours</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>36-72 hours</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>73+ hours</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

27. How stressful would you say your caretaking responsibilities are?
- Not applicable
- Not at all
- Just a little bit
- Moderately
- Extremely

28. How rewarding would you say your caretaking responsibilities are?
- Not applicable
- Not at all
- Just a little bit
- Moderately
- Extremely

Next page, please.
29. In general, would you say your health is:  
   - Excellent  
   - Very Good  
   - Good  
   - Fair  
   - Poor

30. In general, would you say your quality of life is:  
   - Excellent  
   - Very Good  
   - Good  
   - Fair  
   - Poor

31. In general, how would you rate your physical health?  
   - Excellent  
   - Very Good  
   - Good  
   - Fair  
   - Poor

32. In general, how would you rate your mental health, including your mood and your ability to think?  
   - Excellent  
   - Very Good  
   - Good  
   - Fair  
   - Poor

33. In general, how would you rate your satisfaction with your social activities and relationships?  
   - Excellent  
   - Very Good  
   - Good  
   - Fair  
   - Poor

34. In general, please rate how well you carry out your usual social activities and roles.  
   - (At home, at work, your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)
   - Completely  
   - Mostly  
   - Moderately  
   - A little  
   - Not at all

35. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?  
   - Completely  
   - Mostly  
   - Moderately  
   - A little  
   - Not at all

36. In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?  
   - Never  
   - Rarely  
   - Sometimes  
   - Often  
   - Always

37. In the past 7 days, how would you rate your fatigue on average?  
   - None  
   - Mild  
   - Moderate  
   - Severe  
   - Very severe

38. In the past 7 days, how would you rate your pain on average?  
   - No pain  
   - 0  
   - 1  
   - 2  
   - 3  
   - 4  
   - 5  
   - 6  
   - 7  
   - 8  
   - 9  
   - 10

39. Please answer the following questions about your eating habits over the past year:  
   - Definitely true  
   - Mostly true  
   - Mostly false  
   - Definitely false

   a. When I feel anxious, blue or lonely, I find myself eating.  
   - Definitely true  
   - Mostly true  
   - Mostly false  
   - Definitely false

   b. Sometimes when I start eating, I just can't seem to stop.  
   - Definitely true  
   - Mostly true  
   - Mostly false  
   - Definitely false

   c. I consciously hold back at meals in order not to gain weight.  
   - Definitely true  
   - Mostly true  
   - Mostly false  
   - Definitely false

   d. How often do you feel hungry?  
   - Only at meal time  
   - Sometimes between meals  
   - Often between meals  
   - Almost always