1. Please write in your age and date of birth.
   Age [ ] Month [ ] Day [ ] Year [ ]

2. Since March 2011, have you had a:
   (Fill in all that apply.)
   - Physical exam
   - Blood sugar test
   - Eye exam
   - Pap smear
   - Mammogram
   - Breast biopsy
   - Bone mineral density test

3. Since March 2011, have you taken female hormones (like estrogen) for menopause?
   - No
   - Yes, if yes, how many months? [ ] Months
   Name of medication(s):

4. Since March 2011, have you had surgery to remove your ovaries or uterus?
   (Fill in all that apply.)
   - No
   - Yes, one ovary only removed
   - Yes, both ovaries removed
   - Yes, uterus removed

5. Have you ever smoked menthol cigarettes for at least a year?
   - No
   - Yes
   a. If yes, what age did you start smoking menthol cigarettes? [ ] age
   b. How many menthol cigarettes did you usually smoke each day? [ ]
   c. If you stopped smoking menthol cigarettes, at what age? [ ] age

6. Do you have noticeable hair loss:
   a. On the TOP of your scalp?  - No  - Yes
   b. On the SIDES of your scalp?  - No  - Yes

7. Are you lactose intolerant?
   - No
   - Yes, I was diagnosed by a doctor or other health professional
   - Yes, I diagnosed myself
   - Don't know

8. Please write in your current weight.
   Pounds [ ]

9. How many alcoholic beverages do you drink each week?
   [ ]

10. How often do you go to religious services?
    - Never
    - Less than once a month
    - About once a month
    - 2-3 times/month
    - Once a week
    - Several times/week

11. To what extent do you consider yourself:
    A religious person  - Not at all  - Slightly  - Moderately  - Very
    A spiritual person  - Not at all  - Slightly  - Moderately  - Very

12. 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
13. Since March 2011, 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. 2011)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer</td>
<td>O</td>
<td></td>
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<tr>
<td>Lung cancer</td>
<td>O</td>
<td></td>
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<tr>
<td>Colon cancer</td>
<td>O</td>
<td></td>
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<tr>
<td>Rectal cancer</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Uterine cancer (not including cervical cancer)</td>
<td>O</td>
<td></td>
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<tr>
<td>Other type of cancer. (Please write in the type)</td>
<td>O</td>
<td></td>
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<tr>
<td>Diabetes (sugar, sugar diabetes)</td>
<td>O</td>
<td></td>
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<tr>
<td>Heart attack</td>
<td>O</td>
<td></td>
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<tr>
<td>Stroke</td>
<td>O</td>
<td></td>
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<tr>
<td>Coronary bypass surgery</td>
<td>O</td>
<td></td>
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<tr>
<td>Angioplasty or stent for artery repair</td>
<td>O</td>
<td></td>
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<tr>
<td>Congestive heart failure (CHF)</td>
<td>O</td>
<td></td>
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<tr>
<td>Atrial fibrillation</td>
<td>O</td>
<td></td>
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<tr>
<td>End stage renal disease</td>
<td>O</td>
<td></td>
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<tr>
<td>Chronic kidney disease</td>
<td>O</td>
<td></td>
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<tr>
<td>Hypertension (high blood pressure)</td>
<td>O</td>
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<tr>
<td>High cholesterol</td>
<td>O</td>
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<tr>
<td>Endometriosis (cells normally in the uterus are found outside of the uterus, causing pelvic pain)</td>
<td>O</td>
<td></td>
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<tr>
<td>Fibroids in womb confirmed by ultrasound</td>
<td>O</td>
<td></td>
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<tr>
<td>Fibroids in womb confirmed by surgery</td>
<td>O</td>
<td></td>
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<tr>
<td>Lupus (Systemic lupus erythematosus)</td>
<td>O</td>
<td></td>
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<tr>
<td>Multiple sclerosis</td>
<td>O</td>
<td></td>
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<tr>
<td>Asthma</td>
<td>O</td>
<td></td>
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<tr>
<td>Colon or rectal polyp (benign)</td>
<td>O</td>
<td></td>
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<tr>
<td>Depression treated with medication</td>
<td>O</td>
<td></td>
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<tr>
<td>Sarcoiodosis</td>
<td>O</td>
<td></td>
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<tr>
<td>Rheumatoid arthritis</td>
<td>O</td>
<td></td>
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<tr>
<td>Hip fracture (broken hip)</td>
<td>O</td>
<td></td>
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<tr>
<td>Other serious illness</td>
<td>O</td>
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<td>Other serious illness</td>
<td>O</td>
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</tbody>
</table>

14. If you have diabetes, have you had any of the following complications?

- Failing sight or blindness
- Amputation
- Other:

15. Do you take any of the following medications or vitamins at least 3 days a week?

- Aspirin
- Tylenol (Acetaminophen)
- Ibuprofen, Naproxen, Aleve, or Motrin
- Pills to lower cholesterol
- Name:
- Injections for diabetes
- Metformin for diabetes
- Other pills for diabetes
- Name:
- Diuretics (water pills) for high blood pressure or other reasons
- Name:
- Other blood pressure pills
- Name:
- Multi-Vitamins
- Vitamin D
- Folic acid
- Calcium

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

16. How many cigarettes do you currently smoke each day? □ No □ Yes

Are they menthol cigarettes? □ No □ Yes
17. Have you EVER been diagnosed with any of the following conditions?

Yes Year

1. Hay fever
2. Sjogren's syndrome
3. Scleroderma

4. Crohn's disease (confirmed by biopsy)
5. Sickle cell disease
6. Sickle cell trait, not the disease

18. Have you had any of the following treatments?

Yes Year

1. Kidney transplant
2. Kidney dialysis

3. Bariatric surgery (weight loss surgery)
4. Hip replacement surgery

19. 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?

a) ○ Coughing, sneezing, laughing or doing physical activity
b) ○ A sudden urgent need to go to the bathroom
c) ○ Both a) and b) equally
d) ○ In other circumstances

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

Never Less than once per month 1-3 times per month About once per week Several times per week Nearly daily

a. Liquid stool
b. Solid stool

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

Excellent Very Good Good Fair Poor

22. In general, would you say your quality of life is:

23. In general, how would you rate your physical health?

24. In general, how would you rate your mental health, including your mood and your ability to think?

25. In general, how would you rate your satisfaction with your social activities and relationships?

26. 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.)

27. 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

Next page, please. →
28. 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

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

30. In the **past 7 days**, how would you rate your pain on average?  
- Worst imaginable pain  
- Pain  
- No pain

31. At different periods in your life, was there at least one time when your household:  
- did not have enough money for food or housing?  
- received public assistance or welfare?  

32. When you were growing up,  
- did people in your family show confidence in you and encourage you to achieve?  
- did you feel that there was someone to take care of you and protect you?

33. These questions are about your feelings and thoughts during the **past month**.  
- How often have you felt that you were unable to control the important things in your life?  
- How often have you felt confident about your ability to handle your personal problems?  
- How often have you felt that things were going your way?  
- How often have you felt difficulties were piling up so high that you could not overcome them?

34. During the **past year**, how often did you eat  
- bacon, sausage, hot dogs, or lunch meats (including ham, bologna, salami)?  
- beef (including hamburgers, steak, roasts, stew) or pork (including chops, roasts, dinner ham)?  

If you are willing to complete a full dietary questionnaire, please go to the BWHS website  
http://www.bu.edu/bwhs  
and click on the link to the BWHS 2013 Diet Questionnaire