

Black Women's Health Study 2019

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

Age	

Month		Day		Year			
(example: June = 06)							

2. **Since March 2017**, have you had a:

(Fill in all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Physical exam | <input type="checkbox"/> Breast biopsy |
| <input type="checkbox"/> Blood sugar test | <input type="checkbox"/> Colonoscopy |
| <input type="checkbox"/> Pap smear | <input type="checkbox"/> Dental cleaning |
| <input type="checkbox"/> Mammogram | |

4. How many cigarettes do you currently smoke **each day**?

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5. Have you ever used e-cigarettes, vapes or Juuls?

- No Yes If **yes**, age started?

 years old

If **yes**, used for how long?

 years

3. Please write in your current weight.

Pounds		

6. How many alcoholic beverages do you drink **each week**?

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7. In general:

Excellent Very good Good Fair Poor

How would you rate your physical health?

How would you rate your mental health, including your mood and your ability to think?

How would you rate the health of your teeth and gums?

Please rate how well you carry out your usual social activities and roles.

8. 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

9. Have you been treated unfairly due to your race in any of the following circumstances?

(Mark all that apply.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Job (hiring, promotion, firing) | <input type="checkbox"/> Police (stopped, searched, threatened) | <input type="checkbox"/> At school |
| <input type="checkbox"/> Housing (renting, buying, mortgage) | <input type="checkbox"/> In the courts | <input type="checkbox"/> Getting medical care |

10. In your day-to-day life, how often have any of the following things happened to you?

Never A few times a year Once a month Once a week Almost every day

You received poorer service than other people at restaurants or stores.

People act as if they think you are not intelligent.

People act as if they are afraid of you.

People act as if they think you are dishonest.

People act as if they are better than you.

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11. If you were EVER 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., 2019).

	Yes	Year
1. Breast cancer	<input type="radio"/>	<input type="text"/>
2. Lung cancer	<input type="radio"/>	<input type="text"/>
3. Colon cancer	<input type="radio"/>	<input type="text"/>
4. Rectal cancer	<input type="radio"/>	<input type="text"/>
5. Pancreatic cancer	<input type="radio"/>	<input type="text"/>
6. Multiple myeloma	<input type="radio"/>	<input type="text"/>
7. Ovarian cancer	<input type="radio"/>	<input type="text"/>
8. Other cancer	<input type="radio"/>	<input type="text"/>
Type: <input type="text"/>		
9. Cancer recurrence or metastasis	<input type="radio"/>	<input type="text"/>
Location: <input type="text"/>		
10. Diabetes (sugar, sugar diabetes)	<input type="radio"/>	<input type="text"/>
11. Heart attack	<input type="radio"/>	<input type="text"/>
12. Stroke	<input type="radio"/>	<input type="text"/>
13. Coronary bypass surgery	<input type="radio"/>	<input type="text"/>
14. Angioplasty or stent for artery repair	<input type="radio"/>	<input type="text"/>
15. Congestive heart failure (CHF)	<input type="radio"/>	<input type="text"/>
16. Atrial fibrillation	<input type="radio"/>	<input type="text"/>
17. Blood clot in lung or leg	<input type="radio"/>	<input type="text"/>
18. End stage renal disease	<input type="radio"/>	<input type="text"/>
19. Chronic kidney disease	<input type="radio"/>	<input type="text"/>
20. Hypertension (high blood pressure)	<input type="radio"/>	<input type="text"/>
21. High cholesterol	<input type="radio"/>	<input type="text"/>
22. Colon or rectal polyp (benign)	<input type="radio"/>	<input type="text"/>
23. Alzheimer's disease/dementia	<input type="radio"/>	<input type="text"/>
24. Lupus	<input type="radio"/>	<input type="text"/>
25. Depression treated with medication	<input type="radio"/>	<input type="text"/>
26. Sarcoidosis	<input type="radio"/>	<input type="text"/>
27. Hip fracture (broken hip)	<input type="radio"/>	<input type="text"/>
28. Multiple sclerosis	<input type="radio"/>	<input type="text"/>
29. COPD (chronic obstructive pulmonary disease)	<input type="radio"/>	<input type="text"/>

	Yes	Year
30. Crohn's disease or ulcerative colitis	<input type="radio"/>	<input type="text"/>
31. Pancreatitis	<input type="radio"/>	<input type="text"/>
32. Hay fever most years (allergy involving nose/eyes)	<input type="radio"/>	<input type="text"/>
33. HIV/AIDS	<input type="radio"/>	<input type="text"/>
34. Peripheral neuropathy	<input type="radio"/>	<input type="text"/>
35. Other serious illness:		
<input type="text"/>	<input type="radio"/>	<input type="text"/>
<input type="text"/>	<input type="radio"/>	<input type="text"/>

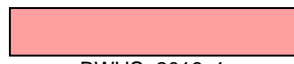
12. Have you ever developed a keloid scar? A keloid is a scar that grew much larger than the wound that caused the scar and is thicker than usual.
 No Yes Don't know

13. As an adult, how many teeth have you lost due to tooth decay or gum disease?

14. 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 # tablets per day # days per week
- Tylenol (Acetaminophen)
- Ibuprofen, Naproxen, Aleve, or Motrin
- Pills to lower cholesterol Name:
- Insulin pump or injection 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:
- Inhalers or pills for asthma 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, or as weekly injections:



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15. 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 Worst imaginable pain
○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

16. In the past 7 days, how would you rate your fatigue on average?

○ None ○ Mild ○ Moderate ○ Severe ○ Very severe

17. Since March 2017, have you used female hormone pills or used patches or injections (e.g., estrogen) for menopause?

○ No ○ Yes → How many months? [][] → Type:
○ Premarin or other estrogen pills ○ Patch estrogen
○ Estrogen with progestin pills ○ Patch estrogen with progestin
○ Estrogen injection

18. Since March 2017, have you taken birth control pills, patches, implants (rod), or injections?

○ No ○ Yes → How many months? [][]

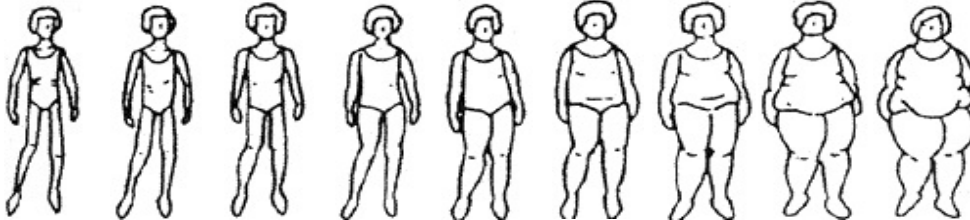
19. Have your periods stopped permanently?

○ No ○ Yes → Did they stop in the last 2 years? → ○ No ○ Yes, due to → {
○ Natural menopause
○ Surgery
○ Other: []

20. Have you had surgery to remove your ovaries or uterus?

○ No ○ Yes → ○ Both ovaries removed ○ One ovary removed ○ Uterus removed

21. Which drawing looks most like your shape at age 5 and age 10?



Age 5 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9
Age 10 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9

22. On average during the past year, how many hours each week did you spend:

Vigorous exercise (e.g., jogging, aerobics) [][] hours each week

Walking for exercise [][] hours each week

23. What is your usual pace of walking?

○ Casual/strolling (less than 2 MPH)
○ Average/normal (2-3 MPH)
○ Brisk (more than 3 MPH)

24. On average during the past year, how many hours each day did you spend:

Sitting watching TV or videos [][] hrs each day

Sitting at work or during the day [][] hrs each day

25. During the past year, did you have health insurance?

○ No ○ Yes, part of the time ○ Yes, all the time

26. Financial well-being may affect health. How would you rate your consumer credit?

○ Poor ○ Fair ○ Good ○ Very good ○ Excellent
○ Don't know/Don't have any consumer credit
○ Prefer not to respond

27. Do you consider yourself to be:

○ Heterosexual/straight ○ Bisexual
○ Gay/lesbian ○ Other, specify: []
○ Prefer not to respond []

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28. Please indicate which best describes how often you felt or behaved this way during the past week.

Rarely or none of the time Some or a little of the time Moderate amount of time Most or all of the time

I was bothered by things that usually do not bother me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I did not feel like eating; my appetite was poor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that I could not shake off the blues even for family/friends.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that I was just as good as other people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had trouble keeping my mind on what I was doing.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that everything I did was an effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt hopeful about the future.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I thought my life had been a failure.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt fearful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My sleep was restless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was happy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I talked less than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt lonely.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People were unfriendly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I enjoyed life.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had crying spells.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt sad.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that people disliked me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not get going.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. How often:

Hardly ever Some of the time Often

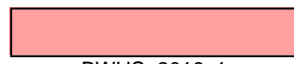
Do you feel a lack of companionship?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel left out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you feel isolated from others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. For each question below, please indicate how each situation describes you AND indicate whether that situation bothers you.

Not true True rarely True sometimes True all the time This bothers me Very much Somewhat Not at all

I accomplish my goals with limited resources.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is very important for me to be the best at the things that I do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No matter how hard I work, I feel like I should do more.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I put pressure on myself to achieve a certain level of accomplishment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The only way for me to be successful is to work hard.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am a perfectionist.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

31. Have you ever used a commercial genetic testing kit (e.g., Ancestry.com, 23andMe)? No Yes



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