

WOMEN'S SURVEY

INSTRUCTIONS

- Please ask the volunteer for help if you have any questions.
- Print legibly using a blue or black ink pen.
- When entering numbers, enter one per box and stay within the box.
- For the ovals, place a heavy dark mark within the oval or fill in the oval completely.
- If you wish to change an answer, place an "X" through the first mark, and mark the oval for your preferred answer.

Please **PRINT** where applicable.

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1. What is today's date? Month Day Year
□□ □□ □□□□

2. What is your full legal name? (Please print)

First Middle Initial

Last

3. What is your current state of residence? (please use state abbreviation) State
□□

4. What is your social security number? (do not use your spouse's number)

□□□-□□-□□□□

5. What is your date of birth? Month Day Year
□□ □□ □□□□

IMPORTANT!

AFTER YOU HAVE COMPLETED THIS QUESTIONNAIRE, PLEASE GIVE IT TO THE VOLUNTEER, WHO WILL IMMEDIATELY PLACE IT INTO AN ENVELOPE TO PROTECT YOUR PRIVACY AND CONFIDENTIALITY.

For Office Use Only:
CPS ID Number:

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6. What is your current weight?

Pounds

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7. What time did you wake up today? (Round to the nearest hour; mark 12 PM for noon)

		<input type="radio"/> AM
		<input type="radio"/> PM

8. How many hours ago did you have something to eat or drink, other than plain water?

- Less than 2 hours ago
 2-4 hours ago
 5-7 hours ago
 8-11 hours ago
 12 or more hours ago

9. Are you currently on a special diet that is different from your usual diet?

- No → (Go to question 11.)
 Yes

→ If yes, please mark all that apply:

- Low Fat Diet
 Low Sugar Diet
 Low Salt Diet
 High Fiber Diet
 Vegetarian
 Reduced Calorie Diet
 Other _____

10. How long have you been on this special diet?

- I am not on a special diet
 Less than 1 week
 1-4 weeks
 More than 4 weeks, but less than 1 year
 1 or more years

11. Do you currently smoke cigarettes?

- No Yes

12. Do you currently smoke cigars or pipes?

- No Yes

13. Do you currently use smokeless tobacco products, like chewing tobacco or snuff?

- No Yes

14. In the last 24 hours, how many drinks of beer, wine, or liquor have you had?

- zero
 1 drink
 2 drinks
 3 or more drinks

15. Over the last month, on average, how many drinks of beer, wine, or liquor have you had?

- Zero drinks
 1-3 drinks each month
 1 drink each week
 2-4 drinks each week
 5-6 drinks each week
 1 drink each day
 2-3 drinks each day
 4 or more drinks each day

16. How many hours each week do you walk for exercise (for 20 minutes or more without stopping)?

- Zero hours each week
 Less than 1 hour each week
 One hour each week
 2 - 3 hours each week
 4 or more hours each week

17. Over the last month, how many hours each week did you participate in vigorous physical activity (activities that raise your heart rate or make you sweat, such as jogging or running, lap swimming, tennis, bicycling, aerobics, or using an exercise machine). Do not include walking.

- Zero hours each week
- Less than 1 hour each week
- One hour each week
- 2 - 3 hours each week
- 4 or more hours each week

18. When was the last time you participated in 20 minutes or more of vigorous physical activity (activities that raise your heart rate or make you sweat, such as jogging or running, lap swimming, tennis, bicycling, aerobics, or using an exercise machine)? Do not include walking.

- I do not do vigorous physical activity
- Today
- Yesterday
- In the last week
- More than 1 week ago

19. Have your menstrual periods stopped permanently?

- No, my menstrual periods have not stopped → (go to question 20.)
- Not sure → (go to question 20.)

- Yes, I no longer have any bleeding or menstrual periods
- Yes, had menopause, but now I have some bleeding because I am taking hormones

If yes:

a.) How old were you when your periods stopped?

Age

b.) For what reason did your periods stop?

- Natural menopause
- Surgical menopause
- Radiation/chemotherapy

20. Are you currently using any of these medications for osteoporosis or other reason?

- Evista (raloxifene)
- Fosamax (alendronate)
- Miacalcin (calcitonin)
- Didronel
- Not using any of these

21. Are you currently taking female hormones for relief of menopausal symptoms or prevention of diseases, such as bone loss?

- No → (Go to question 24.)
- Yes

22. When did you last take female hormones?

- I am not taking hormones
- Today
- yesterday
- two days ago
- 3-6 days ago
- one week or more ago

23. What type of female hormones do you use now?

- Estrogen Pills (such as Premarin) alone
- Estrogen and Progesterone together in one pill (such as Prempro or Premphase)
- Both Estrogen (such as Premarin) and Progesterone (such as Provera)

If you use both estrogen pills and progesterone pills, when did you last take a progesterone pill (such as Provera)?

- Today
- yesterday
- two days ago
- 3-6 days ago
- one week or more ago

- Estrogen Patch
- Estrogen Cream
- Not sure what type
- Other (Please Specify:)

27. Have you taken any other vitamins or supplements in the last 24 hours?

- No
- Yes

If yes, please list what other vitamins, dietary, or herbal supplements you have taken in the last 24 hours:

28. Are you currently taking any of the following medications?

	No	Yes
a. Cholesterol-lowering (such as Mevacor, Zocor, Pravachol, Lipid, Lescol, Questran, (lovastatin), etc.)	<input type="radio"/>	<input type="radio"/>
b. Medications for Heart or Blood Pressure (such as Procardia, Cardizem, Lasix, Lopressor, Tenormin, Vasotec, Zestril, etc.)	<input type="radio"/>	<input type="radio"/>
c. Tamoxifen (such as Nolvadex)	<input type="radio"/>	<input type="radio"/>
d. Insulin injections for diabetes	<input type="radio"/>	<input type="radio"/>
e. Oral diabetes medications	<input type="radio"/>	<input type="radio"/>
f. Oral Steroids (such as Prednisone) or steroid injections?	<input type="radio"/>	<input type="radio"/>
g. Thyroid Medications (such as Synthroid, or Levo-thyroxine)	<input type="radio"/>	<input type="radio"/>
h. Anti-depressant medications (such as Prozac, Zoloft, Paxil, Effexor, Serzone, Elavil, (amitriptyline, nortriptyline), etc.)	<input type="radio"/>	<input type="radio"/>
i. Blood anticoagulants (such as warfarin, Coumadin)	<input type="radio"/>	<input type="radio"/>
j. Antibiotics (such as penicillins, sulfa drugs, cyclosporins, tetracycline, etc.)	<input type="radio"/>	<input type="radio"/>

29. Have you taken any other medications in the last week?

- No
- Yes

If yes, please list any other medications that you have taken in the last week:

30. Have you ever been diagnosed with any of the following conditions? If so, when were you first diagnosed?

Condition	Never	Yes, in the last year	Yes, over a year ago
a. Heart attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Liver disease or failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Renal (kidney) disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Breast cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Ovarian cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Colon or rectal cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Skin cancer, other than melanoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Melanoma skin cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If other cancer, please specify which type:

31. In the last ten years, have you had any medical treatment for cancer, such as surgery, radiation therapy, or chemotherapy? (Do not include screening or detection tests)

- No
- Yes

If yes, what was the last year that you had any such treatment?

Year

32. During the last three months, have you been hospitalized for at least 24 hours?

- No
- Yes

If yes, what was the reason (were the reasons) that you were hospitalized?

33. What time is it right now? (Round to the nearest hour; mark 12 PM for noon)

AM
 PM

It is important for us to know the time that your blood sample is collected.

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- When marking answers, draw one dot for yes and two dots for no.
- For the oval, draw a very dark mark after the oval or in the middle of the oval.
- If you wish to change an answer, place an "X" through the mark and mark the

1. What is today's date?

Month: Day: Year:

2. What is your full legal name? (Please print)

First: _____ Middle Initial: _____

Last: _____

3. What is your current state of residence? (Please use state abbreviation)

State:

Thank you for completing this questionnaire. Please give the questionnaire to the volunteer.

4. Please check the correct answer(s).

I K 2 5 CORRECT

a 2 x t INCORRECT

4. What is your zip code?

- -

5. What is your date of birth?

Month: Day: Year:

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