BOSTON AREA COMMUNITY HEALTH (BACH) SURVEY

FIRST FOLLOW-UP INTERVIEW

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SECTION A: INTERVIEW SUMMARY

A1. RESPONDENT ID: AFFIX ID LABEL HERE

A2. BACH SURVEY EVENT: F U P 1

A3. FORM COMPLETION DATE: M M / D D / Y Y Y Y

A4. DATA COLLECTOR ID: ____

A5. SEX OF RESPONDENT:
MALE 1
FEMALE 2

A6. LANGUAGE:
ENGLISH 1
SPANISH 2

A7. MODE:
IN-PERSON 1
TELEPHONE 2

A8. START TIME OF INTERVIEW: H H : M M 24 HR CLOCK

SECTION B: SF–12 QUALITY OF LIFE ASSESSMENT

This interview will ask questions about your overall health, some specific health conditions, your lifestyle, and your typical daily activities. Remember, we are interested in how you feel about your health. Most of the questions are similar to what we asked in the first interview about 4-5 years ago. The information you provide today will help us to identify any changes that have occurred since that first interview.

Once again, I would like to remind you that all the information you provide is completely confidential. If you feel uncomfortable answering a question, you should feel free to tell me and we can skip it. Also, there are no right or wrong answers. If you don't know the answer to something, just tell me and we'll move on.

If you need to take a break at any time, just let me know. Are you ready? Let's begin.

B1. In general, would you say your health is:

Excellent 1
Very good 2
Good 3
Fair 4
Poor 5

B2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much….a lot or a little?

IF R DOES NOT DO ACTIVITY, PROBE: Is that because of your health?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, softball, or playing golf [PROBE: These are examples of activities. If you don't do these activities, think of similar activities.]	1	2	3
b. Climbing several flights of stairs	1	2	3

B3. During the past four weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

How much of the time have you…..	All of the time	Most of the time	Some of the time	A little of the time	None of the time
*a. Accomplished less than you would like	1	2	3	4	5
*b. Were limited in the kind of work or other activities?	1	2	3	4	5

B4. During the past four weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

How much of the time have you…..	All of the time	Most of the time	Some of the time	A little of the time	None of the time
*a. Accomplished less than you would like	1	2	3	4	5
*b. Done work or other activities less carefully than usual?	1	2	3	4	5

B5. During the past four weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Would you say:

Not at all 1
A little bit..... 2
Moderately..... 3
Quite a bit..... 4
Extremely 5

These questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

[SHOW RESPONSE CARD 'B6']

B6. *How much of the time during the past four weeks:	All of the time	Most of the time	Some of the time	A little of the time	None of the time
*a. Have you felt calm and peaceful?	1	2	3	4	5
b. Did you have a lot of energy?	1	2	3	4	5
c. Have you felt downhearted and depressed?	1	2	3	4	5
B7. Has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	1	2	3	4	5

[TAKE BACK RESPONSE CARD 'B6']

The next set of questions is about fatigue during your usual daily activities in the past month.

[SHOW RESPONSE CARD 'B8a']

B8a. During everyday activities in the past month, how **weak** did you feel? Using this card, please choose the best category on a scale from 0 to 10 where 0 represents not weak at all and 10 represents very weak?

[TAKE BACK RESPONSE CARD 'B8a']

[SHOW RESPONSE CARD 'B8b']

B8b. During everyday activities in the past month, how **sleepy** did you feel during the day? Using this card, please choose the best category on a scale from 0 to 10 where 0 represents not sleepy at all and 10 represents very sleepy?

[TAKE BACK RESPONSE CARD 'B8b']

[SHOW RESPONSE CARD 'B8c']

B8c. During everyday activities in the past month, how **lively** did you feel? Using this card, please choose the best category on a scale from 0 to 10 where 0 represents not lively at all and 10 represents very lively?

[TAKE BACK RESPONSE CARD 'B8c']

[SHOW RESPONSE CARD 'B8d']

B8d. During everyday activities in the past month, how **tired** did you feel? Using this card, please choose the best category on a scale from 0 to 10 where 0 represents not tired at all and 10 represents very tired?

[TAKE BACK RESPONSE CARD 'B8d']

[SHOW RESPONSE CARD 'B8e']

B8e. During daily activities in the past month, what was your **usual energy level**? Using this card, please choose the best category on a scale from 0 to 10 where 0 represents no energy and 10 represents very energetic?

[TAKE BACK RESPONSE CARD 'B8e']

SECTION C: PAIN INVENTORY

C1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

YES 1
NO 2

GIVE THE RESPONDENT THE BODY MAP AND ASK RESPONDENT:

On the drawings below, shade the areas where you feel pain. Put an X on the area that hurts the most.

PROBE: Can you describe to me approximately where you feel pain today? Anywhere else? Of those places, where does it hurt the most?

[SHOW RESPONSE CARD 'C2']

C2. Thinking of a scale from 0 – 10 where 0 = No pain and 10 = Pain as bad as you can imagine, please give me the number that best describes your pain at its worst in the last 24 hours.

C3. Thinking of a scale from 0 – 10 where 0 = No pain and 10 = Pain as bad as you can imagine, please give me the number that best describes your pain at its least in the last 24 hours.

C4. Thinking of a scale from 0 – 10 where 0 = No pain and 10 = Pain as bad as you can imagine, please give me the number that best describes your pain on the average.

C5. Thinking of a scale from 0 – 10 where 0 = No pain and 10 = Pain as bad as you can imagine, please give me the number that tells how much pain you have right now.

[TAKE BACK RESPONSE CARD 'C2']

[SHOW RESPONSE CARD 'C6']

C6. Thinking of a scale from 0 – 10 where 0 = Does not interfere and 10 = Completely interferes, please give me the number that describes how, during the past 24 hours, pain has interfered with your:

*a.	General activity		
*b.	Mood		
*c.	Walking ability		
d.	Normal Work (includes both work outside the home and housework)		
*e.	Relations with other people		
f.	Sleep		
*g.	Enjoyment of life		

[TAKE BACK RESPONSE CARD 'C6']

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SECTION D: PHYSICAL ACTIVITY (PASE)

Now I am going to ask you about your activities in the last seven days not including today. Your answers should reflect how you actually behaved. There are no right or wrong responses.

D1. **[SHOW RESPONSE CARD 'D1']** *In the last 7 days, how often did you:		**[SHOW RESPONSE CARD 'D1i']** **i. IF EVER**: On average, how many hours per day did you engage in these activities?
*a. Participate in sitting activities such as reading, watching TV or doing handcrafts. Would you say:	Never ..... 0 Seldom (1-2 days) ..... 1 Sometimes (3-4 days) ..... 2 Often (5-7 days) 3	Less than 1 hour..... 1 1 but less than 2 hours ..... 2 2-4 hours ..... 3 More than 4 hours 4
*b. Take a walk outside your home or yard for any reason? For example, for fun or exercise, walking to work, walking the dog, etc. Would you say:	Never ..... 0 Seldom (1-2 days) ..... 1 Sometimes (3-4 days) ..... 2 Often (5-7 days) 3	Less than 1 hour..... 1 1 but less than 2 hours ..... 2 2-4 hours ..... 3 More than 4 hours 4
*c. Engage in light sport or recreational activities such as catch, darts, bocci, golf with a cart, fishing from a boat or pier or other similar activities. Would you say:	Never ..... 0 Seldom (1-2 days) ..... 1 Sometimes (3-4 days) ..... 2 Often (5-7 days) 3	Less than 1 hour..... 1 1 but less than 2 hours ..... 2 2-4 hours ..... 3 More than 4 hours 4
*d. Engage in moderate sport and recreational activities such as doubles tennis, dancing, hunting, ice skating, golf w/o a cart, softball, skating or other similar activities. Would you say:	Never ..... 0 Seldom (1-2 days) ..... 1 Sometimes (3-4 days) ..... 2 Often (5-7 days) 3	Less than 1 hour..... 1 1 but less than 2 hours ..... 2 2-4 hours ..... 3 More than 4 hours 4
*e. Engage in strenuous sport and recreational activities such as jogging, swimming, cycling, singles tennis, basketball, skiing or other activities. Would you say:	Never ..... 0 Seldom (1-2 days) ..... 1 Sometimes (3-4 days) ..... 2 Often (5-7 days) 3	Less than 1 hour..... 1 1 but less than 2 hours ..... 2 2-4 hours ..... 3 More than 4 hours 4
*f. Do any exercises specifically to increase muscle strength and endurance, such as lifting weights or push-ups, etc. Would you say:	Never ..... 0 Seldom (1-2 days) ..... 1 Sometimes (3-4 days) ..... 2 Often (5-7 days) 3	Less than 1 hour..... 1 1 but less than 2 hours ..... 2 2-4 hours ..... 3 More than 4 hours 4

[TAKE BACK RESPONSE CARD FOR 'D1' AND 'D1i']

	*In the last 7 days, have you done any:	YES	NO
D2.	Light housework, such as dusting or washing dishes?	1	2
*D3.	Heavy housework or chores, such as vacuuming, scrubbing floors, washing windows, or carrying wood?	1	2
D4a.	Home repairs like painting, wallpapering, electrical work, etc.	1	2
*b.	Lawn work or yard care, including snow or leaf removal, wood chopping, etc.	1	2
c.	Outdoor gardening	1	2
*d.	Caretaking of another person, such as children, dependent spouse, or an other adult	1	2

D5. In the last 7 days, did you work, including work as a volunteer?

YES.....1
NO .....2 **(SECTION E)**

a. How many hours per week did you work, including work as a volunteer, in the last 7 days?

		HOURS

b. Which of the following categories best describes the amount of physical activity required on your job or in your volunteer work?

Mainly sitting with slight arm movements..... 1
Sitting or standing with some walking..... 2
Walking, with some handling of materials weighing less than 50 pounds 3
Walking and heavy manual work often requiring handling of materials weighing over 50 pounds 4

SECTION E: HEALTH AND HEALTH CARE

Now I have some questions about whether a health care provider has ever told you that you have a particular health condition. As you consider your answer, please keep in mind that a health care provider can be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, or anyone else you would see for health care.

E1.	Have you ever been told by a health care provider (that can be a doctor or nurse) that you now have or previously had:	YES	NO	REF	DK	i: **IF YES:** How old were you when you were first told **OR** at the time of the first event **OR** when you had surgery?
a.	A heart attack (myocardial infarction or MI)	1	2	-7	-8	
*b.	Congestive heart failure (CHF) (you may have been short of breath and the doctor may have told you that you had fluid in your lungs or that your heart was not pumping well)	1	2 **(E1c)**	-7	-8	
	b1. **IF YES**: Were you treated for this?	1	2	-7	-8	
*c.	Surgery or angioplasty for arterial disease of the leg (an operation to unclog or bypass arteries in your leg)	1	2	-7	-8	
d.	A TIA or mild stroke (Transient Ischemic Attack, mini stroke)	1	2	-7	-8	
e.	A Stroke (CVA, cerebrovascular accident, blood clot or bleeding in the brain)	1	2 **(E1f)**	-7	-8	
	e1. **IF YES**: Do you have difficulty moving an arm or leg as a result of the stroke or cerebrovascular accident?	1	2	-7	-8	
*f.	Asthma	1	2 **(E1g)**	-7	-8	

f1. **IF YES**: Do you take medication for your asthma?

No 1

Yes, only with flare-ups of my asthma 2

Yes, I take medications regularly, even when I'm not having a flare up 3

	E1 cont.: Have you ever been told by a health care provider that you have or had:	YES	NO	REF	DK	i: **IF YES:** How old were you when you were first told **OR** at the time of the first event **OR** when you had surgery?
g.	Chronic lung disease such as chronic bronchitis, COPD, or emphysema, not including asthma.	1	2 **(E1h)**	-7	-8	
	g1. **IF YES**: Do you take medication for your lung disease? No ..... 1 Yes, only with flare-ups of my lung disease ..... 2 Yes, I take medications regularly, even when I'm not having a flare up.... 3					
*h.	Stomach ulcers or peptic ulcer disease	1	2 **(E1i)**	-7	-8	
	h1. **IF YES**: Has this condition been diagnosed by endoscopy (where a doctor looks into your stomach through a scope) or an upper GI or barium swallow study (where you swallow chalky dye and then x-rays are taken)?	1	2	-7	-8	
i.	Kidney disease or poor kidney function (blood tests show high creatinine)	1	2 **(E1j)**	-7	-8	
	i1. **IF YES**: Have you ever used hemodialysis or peritoneal dialysis?	1	2 **(E1j)**	-7	-8	
	i2. **IF YES**: Have you ever received kidney transplantation?	1	2	-7	-8	

	E1 cont.: Have you ever been told by a health care provider that you have or had:	**YES**	**NO**	**REF**	**DK**	i: **IF YES:** How old were you when you were first told **OR** at the time of the first event **OR** when you had surgery?
j.	Insulin-dependent or juvenile-onset diabetes (Type I)	1	2 **(E1k)**	-7	-8	
	j1. **IF YES**: Are you treating your diabetes by…..					
	i. Modifying your diet	1	2	-7	-8	
	ii. Medications taken by mouth	1	2	-7	-8	
	iii. Insulin injection	1	2	-7	-8	
	iv. No treatment	1	2	-7	-8	
	j2. **IF YES**: Has the diabetes caused:					
	i. Problems with your kidneys	1	2	-7	-8	
	ii. Problems with your eyes treated by an ophthalmologist?	1	2	-7	-8	
*k.	Non-insulin dependent or adult-onset diabetes (Type II)	1	2 **(E1l)**	-7	-8	
	k1 **IF YES**: Are you treating your diabetes by…..					
	i. Modifying your diet	1	2	-7	-8	
	ii. Medications taken by mouth	1	2	-7	-8	
	iii. Insulin injection	1	2	-7	-8	
	iv. No treatment	1	2	-7	-8	
	k2. **IF YES**: Has the diabetes caused:					
	i. Problems with your kidneys	1	2	-7	-8	
	ii. Problems with your eyes treated by an ophthalmologist?	1	2	-7	-8	

	E1 cont.: Have you ever been told by a health care provider that you have or had:	YES	NO	REF	DK	i: **IF YES:** How old were you when you were first told **OR** at the time of the first event **OR** when you had surgery?
l	Arthritis or rheumatism	1	2 **(E1m)**	-7	-8	
	l1. **IF YES**: Is it rheumatoid arthritis	1	2	-7	-8	
	l2. **IF YES**: Do you take medications for it regularly?	1	2	-7	-8	
*m	Lupus (systematic lupus erythematosus)	1	2	-7	-8	
n.	Polymyalgia rheumatica	1	2	-7	-8	
o.	Alzheimer's disease or another form of dementia	1	2	-7	-8	
p.	Cirrhosis or serious liver damage	1	2	-7	-8	
q.	Leukemia or polycythemia vera	1	2	-7	-8	
r.	Lymphoma	1	2	-7	-8	

	E1 cont.: Have you ever been told by a health care provider that you have or had:	YES	NO	REF	DK	i: **IF YES:** How old were you when you were first told **OR** at the time of the first event **OR** when you had surgery?
s.	Cancer s1. SPECIFY:	1	2 **(E1v)**	-7	-8	
	s2. **IF YES:** Has the cancer spread or metastasized to other parts of your body?	1	2	-7	-8	
t.	Any other cancer t1. SPECIFY:	1	2 **(E1v)**	-7	-8	
	t2. **IF YES:** Has the cancer spread or metastasized to other parts of your body?	1	2	-7	-8	
u.	Any other cancer u1. SPECIFY:	1	2 **(E1v)**	-7	-8	
	u2. **IF YES:** Has the cancer spread or metastasized to other parts of your body?	1	2	-7	-8	
*v	AIDS	1	2	-7	-8	
w.	Elevated blood sugar (hyperglycemia) IF FEMALE: excluding when you were pregnant (gestational diabetes)	1	2	-7	-8	
x.	Allergies or eczema (inflamed skin, rashes, sneezing, itchy eyes)	1	2	-7	-8	
*y.	Coronary artery bypass or angioplasty (stent)	1	2	-7	-8	

	E1 cont.: Have you ever been told by a health care provider that you have or had:	**YES**	**NO**	**REF**	**DK**	i: **IF YES:** How old were you when you were first told **OR** at the time of the first event **OR** when you had surgery?
z.	Angina pectoris (chest pain)	1	2	-7	-8	
aa.	An irregular heartbeat or arrhythmia requiring insertion of a pacemaker	1	2	-7	-8	
bb.	Carotid artery surgery (on artery in neck)	1	2	-7	-8	
cc.	Intermittent claudication (leg cramps, usually in calves when walking)	1	2	-7	-8	
dd.	Pulmonary embolus (blood clots in the lungs)	1	2	-7	-8	
ee.	Aortic aneurysm (weakening of the aorta)	1	2	-7	-8	
ff.	Heart-rhythm disturbance	1	2	-7	-8	
gg.	Deep vein thrombosis (blood clot, usually in the leg)	1	2	-7	-8	
hh.	Raynauds disease (poor circulation in toes & fingers)	1	2	-7	-8	
ii	Peripheral vascular disease	1	2	-7	-8	
jj.	High cholesterol	1	2	-7	-8	

	E1 cont.: Have you ever been told by a health care provider that you have or had:	**YES**	**NO**	**REF**	**DK**	i: **IF YES:** How old were you when you were first told **OR** at the time of the first event **OR** when you had surgery?
kk.	High blood pressure (hypertension)	1	2	-7	-8	
ll.	Osteoporosis (thin or brittle bones)	1	2	-7	-8	
mm.	Parkinson's disease	1	2	-7	-8	
nn.	Multiple sclerosis (MS)	1	2	-7	-8	
oo.	Fibromyalgia	1	2	-7	-8	
pp.	Chronic fatigue syndrome	1	2	-7	-8	
qq.	Irritable Bowel Syndrome	1	2	-7	-8	

ASK WOMEN ONLY; MEN, SKIP TO E2

	E1 cont.: Have you ever been told by a health care provider that you have or previously had:	YES	NO	REF	DK	i: **IF YES:** How old were you when you were first told **OR** at the time of the first event **OR** when you had surgery?
rr.	Gestational diabetes	1	2	-7	-8	
ss.	Endometriosis	1	2	-7	-8	
tt.	Pelvic inflammatory disease or PID	1	2	-7	-8	
uu.	Ovarian cyst(s)	1	2	-7	-8	
vv.	Polycystic ovarian syndrome (PCOS)	1	2	-7	-8	
ww.	Uterine fibroids (fibroids)	1	2	-7	-8	
xx.	Prolapsed uterus	1	2	-7	-8	
yy.	Prolapsed bladder (cystocele)	1	2	-7	-8	
zz.	Prolapsed rectum (rectocele)	1	2	-7	-8	
aaa.	Chronic yeast infections	1	2	-7	-8	
bbb.	Sexual dysfunction	1	2	-7	-8	

ASK MEN ONLY; WOMEN SKIP TO E2e

E2.	Have you ever been told by a health care provider that you have or previously had:	YES	NO	REF	DK	i: IF YES, How old were you when you were first told?
a.	BPH (Benign Prostatic Hyperplasia)	1	2	-7	-8	
b.	Prostatitis	1	2	-7	-8	
c.	Hypogonadism	1	2	-7	-8	
d.	Erectile Dysfunction	1	2	-7	-8	
	ASK ALL RESPONDENTS					
e.	Urinary incontinence?	1	2	-7	-8	
f.	Interstitial cystitis?	1	2	-7	-8	
g.	Painful bladder syndrome?	1	2	-7	-8	
h.	Chronic pelvic pain of bladder origin?	1	2	-7	-8	

E3a. Have you ever been told by a health care provider that you had a problem with your bladder emptying as a result of nerves or muscles that supply the bladder not working well?

YES 1
NO 2

E3b. Has a health care provider ever told you to use a catheter for a bladder condition?

YES 1
NO ..... 2 **(E3c)**

E3b1. Was it an in-dwelling or permanent catheter?

YES 1
NO 2

E3c. Have you ever been told by a health care provider that you had a bladder infection, a urinary tract infection or cystitis, or kidney infection (pyelonephritis)?

YES 1
NO ..... 2 **(E4a)**

c1. How many times were you diagnosed with a bladder infection, urinary tract infection or cystitis in the last 12 months? ☐☐ TIMES

c2. How many times were you diagnosed with a bladder infection, urinary tract infection or cystitis in your lifetime? ☐☐ TIMES

c3. How many times were you diagnosed with a kidney infection (pyelonephritis) in the last 12 months? ☐☐ TIMES

c4. How many times were you diagnosed with a kidney infection (pyelonephritis) in your lifetime? ☐☐ TIMES

E4a. Have you ever been told by a health care provider that you had kidney stones or stones in your urinary tract?

YES.....	1	
NO	2	**(E5a)**

E4b. How many times in your lifetime?

		TIMES

E5a. Has a healthcare provider ever told you that you had gallstones?

YES.....	1	
NO	2	**(E5c)**

E5b. Have you ever had medical treatment to dissolve or remove gallstones? Do not include surgery.

YES.....	1
NO	2

E5c. Have you ever had gallbladder surgery?

YES.....	1	
NO	2	**(E6)**

E5d. How old were you when you had your gallbladder surgery?

		YEARS

Now I have a few questions about your health insurance and use of health care services.

E6.	What is your current health insurance? You might have more than one type of insurance. Do you have…	YES	NO
*a.	Private insurance from your or your partner's employer	1	2
*b.	Private insurance that you purchased (you pay the entire premium)	1	2
c.	Medicare	1	2
d.	Medicaid or Mass Health	1	2
e.	TriCare Military Health (Champus or ChampVA)	1	2
f.	Worker's compensation (a current injury is covered by worker's comp.)	1	2
g.	Some other type of insurance	1 ↓	2
	g1. SPECIFY: _____		
h.	Free care at a particular clinic or hospital	1	2
*i.	IF NO TO ALL: Do you currently have any type of health insurance?	1 ↓	2
	i1. SPECIFY: _____		

E7.	Where do you usually go for health care?	YES	NO
a.	An outpatient clinic or doctor's office	1	2
b.	A hospital emergency room	1	2
c.	A hospital outpatient clinic	1	2
d.	A health center	1	2
e.	A free clinic	1	2

E8. In the last year, how many times did you go to see a health care provider for any reason? (This would include visits for routine health care, emergency, mental health care, dental, physical therapy, etc).

 # VISITS **IF ZERO, GO TO E10.**

E9.	What was (were) the major reason(s) for your visit(s)? Was it (Were they) for:	YES	NO
a.	An urgent (acute) problem	1	2
b.	A routine visit for an ongoing problem	1	2
c.	A flare-up of an ongoing problem	1	2
d.	Pre- or post-surgery/injury care	1	2
e.	Non-illness care (e.g., routine prenatal, general exam)	1	2

E10. When did you last see a health care provider for your own health? Was it…

6 months ago or less 1
More than 6 months ago, but less than a year ago 2
More than 1 year ago, but less than 2 years ago 3
More than 2 years ago, but less than 5 years ago 4
5 years ago or more 5

SECTION F: BIRTH CONTROL

Next, I have some questions about birth control methods that you or your partner may be using now or have used some time during your life. We ask these questions of all people in the health survey, so please be patient if some do not apply to you.

F1. Have you and a partner ever used any of these methods of birth control?				**IF YES:** Are you and your partner currently using this method?		
	YES	**NO**	**DK**	**YES**	**NO**	**DK**
a. Condoms, including female condoms	1	2	-8	1	2	-8
b. Diaphragm	1	2	-8	1	2	-8
c. Some other barrier method, such as cervical cap or sponge	1	2	-8	1	2	-8
d. Foams	1	2	-8	1	2	-8

IF MALE, GO TO SECTION G

F2.	*Are you currently using, or have you ever used for 3 months or more, any of the following: **IF YES, PROBE:** Is this current? **IF YES, GO ACROSS. IF NO, NEXT ITEM**				i. How old were you when you began using?	ii. Not counting any time when you stopped using, for how long altogether have you used?	iii. UNITS
		YES, CURRENT	**YES, PAST**	**NO**	**AGE**	**NUMBER**	
*a.	Birth control pills	1	2	3			MONTHS ..... 1 YEARS 2
*b.	Injections for birth control (Depo Provera, Lunelle)	1	2	3			MONTHS ..... 1 YEARS 2
*c.	Norplant (Implanted under skin)	1	2	3			MONTHS ..... 1 YEARS 2
d.	Patch	1	2	3			MONTHS ..... 1 YEARS 2
e.	Vaginal ring (NuvaRing)	1	2	3			MONTHS ..... 1 YEARS 2
f.	Intrauterine device (IUD): ↓	1	2	3 **(G2)**			
	Mirena	1	2	3			MONTHS ..... 1 YEARS 2
	Other type	1	2	3			MONTHS ..... 1 YEARS 2

SECTION G: REPRODUCTIVE HISTORY

Now I have some more questions about your health history. I know that these may be quite personal, but we ask them of everyone. Please remember that all information you provide is confidential.

FOR MEN; WOMEN GO TO G2

G1.	*Have you ever seen a health care provider for:	YES	NO	REF	DK	i. **IF YES:** How old were you at the time of surgery? **AGE**
*a.	Hernia repair	1	2	-7	-8	
*b.	Vasectomy	1	2 **(G1c)**	-7	-8	
	b1. Reversal of a vasectomy	1	2	-7	-8	
*c.	Bladder surgery	1	2	-7	-8	
d.	Prostate surgery	1	2	-7	-8	
e.	Have you been circumcised?	1	2	-7	-8	If < 1 yr, WRITE 0.
f.	Surgery on the penis (other than circumcision)	1	2	-7	-8	

G2.	*Have you ever been told by a health care provider that you had:	YES	NO	REF	DK
*a.	Chlamydia	1	2	-7	-8
b.	Genital herpes	1	2	-7	-8
c.	HPV or genital warts	1	2	-7	-8
*d.	Syphilis	1	2	-7	-8
e.	Gonorrhea	1	2	-7	-8
*f.	HIV	1	2	-7	-8

FOR WOMEN; MEN GO TO G13

G3. Are you pregnant?

YES 1
NO 2
REFUSED ..... -7
DON'T KNOW ..... -8

G4. Have you taken any female hormones including birth control pills for at least 6 of the last 12 months?

YES 1
NO 2
REFUSED ..... -7
DON'T KNOW ..... -8

G5.	*Have you ever had:	YES	NO	DK	i. **IF YES:** How old were you at the time of surgery? **AGE**
*a.	A hysterectomy, an operation to remove your uterus or womb?	1	2 **(G5b)**	-8	
a1.	Was this surgery done through the abdomen or vagina (birth canal)?	ABDOMINALLY.....1 VAGINALLY 2		-8	
a2.	Did you have a menstrual period in the 3 months prior to surgery?	1 **(G5a3)**	2	-8	
a2a.	Did you have a menstrual period in the 12 months prior to surgery?	1	2	-8	
a3.	What was the reason for surgery? CIRCLE ALL THAT APPLY.	CANCER .....1 UTERINE FIBROIDS.....2 ABNORMAL UTERINE BLEEDING .....3 ENDOMETRIOSIS .....4 CHRONIC PAIN .....5 UTERINE PROLAPSE.....6 BENIGN CYSTS.....7 OTHER……8			SPECIFY:_____

G5.	*Have you ever had:	**YES**	**NO**	**DK**	i. **IF YES:** How old were you at the time of surgery? **AGE**
*b.	An ovary removed?	1	2 **(G5c)**	-8	
b1.	Were one or two ovaries removed?	ONE..... 1 TWO 2		-8	
b2.	Did you have a menstrual period in the 3 months prior to surgery?	1 **(G5b3)**	2	-8	
b2a.	Did you have a menstrual period in the 12 months prior to surgery?	1	2	-8	
b3.	What was the reason for surgery? CIRCLE ALL THAT APPLY	CANCER ..... 1 ENDOMETRIOSIS..... 2 CHRONIC PAIN..... 3 BENIGN CYSTS ..... 4 TO PREVENT CANCER .... 5 OTHER 6			SPECIFY:_____
*c.	Surgery for incontinence (urine leakage)?	1	2	-8	
d.	Bladder surgery?	1	2	-8	
e.	Surgery for repair of pelvic prolapse (pelvic floor disorder)?	1	2	-8	
f.	Tubal ligation?	1	2	-8	
					i. **IF YES:** How old were you at the first surgery?
g.	A D and C (dilation and curettage)?	1	2 **(G5h)**	-8	
	g1. **IF YES**: How many D and Cs?				
					i. **IF YES:** How old were you at the first surgery?
h.	An endometrial biopsy?	1	2 **(G6)**	-8	
	h1. **IF YES**: How many biopsies?				

G6. Have you ever been pregnant?

YES 1
NO ..... 2 **(G8)**

[NOTE: ASK G6c, d, and e UNTIL TOTAL = G6b.]

a. How many times have you been pregnant? Please include a current pregnancy, miscarriages, stillbirths, tubal or ectopic pregnancies, abortions and live births.

		# PREGNANCIES

b. How many of your pregnancies resulted in a live birth?
[NOTE: COUNT A PREGNANCY RESULTING IN TWINS, TRIPLETS, ETC AS ONE BIRTH]

		# BIRTHS	**IF ZERO, GO TO G8**

c. How many of these live birth pregnancies resulted in a vaginal delivery?

		# DELIVERIES

d. **IF b ≠ c** How many of these live births were by cesarean (c-section) delivery?

		# C-SECTIONS

e. **IF b ≠ c + d** How many of these live births were by both a vaginal and cesarean (c-section) delivery?

		# VAGINAL AND C-SECTION DELIVERIES

f. What was the birth weight of the heaviest baby? (Pounds and ounces or grams?)

		AND			OR				
POUNDS			OUNCES			GRAMS			

G7a. How old were you at the time of your first live birth?

YEARS | | |

G7b. **IF >1 LIVE BIRTH**: How old were you at the time of your last live birth?

YEARS | | |

NOTE: THIS CAN BE SAME AGE.

		YES	NO	REF	DK
G8.	Have you had a menstrual period in the last 12 months?	1 **(G9)**	2	-7 **(G9)**	-8 **(G9)**
a.	Did your periods stop because of:				
	1. Menopause	1	2	-7	-8
	2. Pregnancy or breastfeeding	1	2	-7	-8
	3. Medication, chemotherapy or radiation treatment	1	2	-7	-8
	4. Severe weight loss or another reason	1	2	-7	-8
b.	Can you tell me approximately what year your periods stopped?				

				REF…… -7
				DK…….. -8
Y	Y	Y	Y	

GO TO G12

G9. Compared to a year ago, has the number of days between the start of one menstrual period and the start of your next menstrual period become less predictable?

YES 1
NO 2

G10. Have you had a menstrual period in the past 3 months?

YES 1
NO 2

			YES	NO	REF	DK
G11.	a.	In the last 12 months, have you had pelvic pain related in any way with your menstrual cycle?	1	2 **(G12)**	-7 **(G12)**	-8 **(G12)**
	b.	In the last 12 months, have you had this pain …….				
		i. Shortly before a period	1	2	-7	-8
		ii. Shortly after a period	1	2	-7	-8
		iii. At mid-cycle	1	2	-7	-8
		iv. During a period	1	2	-7	-8
		v. Not at the same time in your cycle	1	2	-7	-8
	c.	Is this pain in the area of your bladder?	1	2	-7	-8

G12. Have you had pain at the vulva, the opening to the vagina, either with intercourse or spontaneously?

YES 1
NO ..... 2 **(G13)**

G12a. Where was the pain located?

Deep inside the vagina 1
At the opening of the vagina 2
Both deep inside and at the opening 3
DON'T KNOW ..... -8
Other 99
SPECIFY: _____

G12b. Did you ever have pain at the opening of the vagina (vulva) that lasted for at least three months?

YES 1
NO 2

G12c. Did you feel that your vulvar pain has been cured or resolved?

YES 1
NO 2

ASK OF MEN AND WOMEN

G13. *In the last 12 months, have you had:		YES	NO	REF	DK
*a.	Pelvic pain during or in the 24 hours after sexual intercourse?	1	2	-7	-8
*b.	**WOMEN**: Pelvic pain not with periods or intercourse?	1	2	-7	-8
c.	**MEN**: Pelvic pain not with intercourse?	1	2	-7	-8

IF NO PELVIC PAIN (G11 AND G13) , GO TO SECTION H

G14. On average, how many days of pelvic pain do you have a month? Would you say:

1 - 2 1
3 - 5 2
6 - 10 3
More than 10 4

G15. For how long have you been experiencing your pelvic pain? Would you say….

Less than 3 months 1
More than 3, but less than 6 months 2
More than 6 months, but less than a year 3
A year or longer 4

G16. To what extent does this pain prevent you from doing the things you want to do? Would you say…..

Not at all 1
Some 2
A lot 3

G17. In the last four weeks, how much has this been a problem for you?

No problem 1
Very small problem 2
Small problem 3
Medium problem 4
Big problem 5

SECTION H: PSYCHOSOCIAL FACTORS

Next, I'm going to read you several statements describing how people sometimes feel. Think about the last week and the feelings you may have experienced. Please answer Yes or No to each statement that I read, keeping in mind that the "I" in each statement refers to you. Please tell me whether or not these statements apply to you and how you have been feeling over the last week.

*Much of the time during the last week…	YES	NO
*H1. I felt depressed.	1	2
*H2. I felt that everything I did was an effort.	1	2
*H3. My sleep was restless.	1	2
H4. I was happy.	1	2
H5. I felt lonely.	1	2
*H6. I enjoyed life.	1	2
H7. I felt sad.	1	2
*H8. I could not "get going".	1	2

H9. Now I have a few questions about people who may be close to you.	YES	NO
a. In the last six months, has anyone close to you caused you special worry or been especially demanding?	1	2 **(H10)**
b. In the last 6 months, has [ITEM b1-b6] caused you special worry or been especially demanding?		
*b1. A spouse or partner?	1	2
*b2. A parent?	1	2
b3. A child?	1	2
b4. A sibling?	1	2
*b5. Another relative or friend?	1	2
b6. Someone at work?	1	2

These next questions ask about your feelings and thoughts during the last month. For each one, please indicate how often you felt or thought a certain way. **[SHOW RESPONSE CARD 'H10']**

	Never	Almost Never	Sometimes	Fairly Often	Very Often
H10. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
H11. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
H12. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
H13. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

[TAKE BACK RESPONSE CARD 'H10']

H14. Please tell me how strongly you agree or disagree with the following statement:

"I often have the feeling that I am being treated unfairly"

Would you say…

Strongly disagree..... 1
Moderately disagree..... 2
Slightly disagree..... 3
Slightly agree..... 4
Moderately agree..... 5
Strongly agree..... 6

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.

[SHOW RESPONSE CARD 'H15']

H15.	Thinking about the past month…	Almost never or never	A few times	Sometimes	Most times	Almost always or always
*a.	Do you have difficulties falling asleep?	1	2	3	4	5
*b.	After getting up in the morning, can you fall asleep again?	1	2	3	4	5
*c.	Do you use sleeping pills?	1	2	3	4	5
d.	Are you tired during wake time?	1	2	3	4	5
e.	Are you tired after sleeping?	1	2	3	4	5
f.	Are you restless during the night (moving your legs and arms)?	1	2	3	4	5
g.	Do you get up during the night?	1	2	3	4	5
*h.	Do you suffer from headaches first thing in the morning?	1	2	3	4	5
i.	Do you feel exhausted for no obvious reasons?	1	2	3	4	5
*j.	How often have you been told that you quit breathing during your sleep?	1	2	3	4	5
k.	How often have you nodded off or fallen asleep while driving a vehicle?	1	2	3	4	5
*l.	How frequently have you been told that you snore?	1 (H17a)	2	3	4	5

[TAKE BACK RESPONSE CARD 'H15']

H16a. Has your snoring bothered other people?

YES 1
NO ..... 2 **(H17a)**

H16b. Has your snoring been described as:

Slightly louder than breathing 1
As loud as talking 2
Louder than talking 3
Very loud, can be heard in next room 4
DK ..... -8

H17a. How many hours of actual sleep do you usually get during the night?
(This may be different than the number of hours you spend in bed)

[ ][ ] . [ ] HOURS

H17b. How long does it usually take you to fall asleep at bedtime?

[ ][ ][ ] MINUTES

Now I'm going to read you a list of symptoms you may or may not be experiencing.
[SHOW RESPONSE CARD 'H18']

H18.	Which of the following symptoms apply to you at this time?	None	Mild	Moderate	Severe	Extremely severe
a.	Decline in your feeling of general well-being (general state of health, subjective feeling)	1	2	3	4	5
b.	Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	1	2	3	4	5
c.	Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	1	2	3	4	5
d.	Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	1	2	3	4	5
e.	Increased need for sleep, often feeling tired	1	2	3	4	5
f.	Irritability (feeling aggressive, easily upset about little things, moody)	1	2	3	4	5
g.	Nervousness (inner tension, restlessness, feeling fidgety)	1	2	3	4	5
h.	Anxiety (feeling panicky)	1	2	3	4	5
i.	Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	1	2	3	4	5
j.	Decrease in muscular strength (feeling of weakness)	1	2	3	4	5
k.	Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	1	2	3	4	5
l.	Feeling that you have passed your peak	1	2	3	4	5
m.	Feeling burnt out, having hit rock-bottom	1	2	3	4	5
n.	Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	1	2	3	4	5
o.	Decrease in ability/frequency to perform sexually	1	2	3	4	5
p.	**MEN ONLY:** Decrease in the number of morning erections	1	2	3	4	5
q.	**MEN ONLY:** Decrease in beard growth	1	2	3	4	5

[TAKE BACK RESPONSE CARD 'H18'] **WOMEN, GO TO SECTION I.**

H19. Erectile dysfunction (ED) (sometimes called impotence) means being unable to get and keep an erection that is rigid enough for satisfactory sexual activity. In general, how would you describe yourself? **[SHOW RESPONSE CARD 'H19']**

No ED/Not impotent: always able to get and keep an erection good enough for sexual intercourse	1	**➔ Go to Section I**
Minimal ED/Minimally impotent: usually able to get and keep an erection good enough for sexual intercourse	2	
Moderate ED/Moderately impotent: sometimes able to get and keep an erection good enough for sexual intercourse	3	
Complete ED/Completely impotent: never able to get and keep an erection good enough for sexual intercourse	4	

[TAKE BACK RESPONSE CARD 'H19']

H20. When did you start having trouble getting and keep an erection that's rigid enough for satisfactory sexual activity?

6 months or less	1
More than 6 months, less than a year	2
More than 1 year, less than 2 years	3
More than 2 years, less than 5 years	4
5 years or more	5

H21. During the past 4 weeks, how much of a problem has this been?

No problem	1
Very small problem	2
Small problem	3
Medium problem	4
Big problem	5

SECTION I: TOBACCO, ALCOHOL AND BEVERAGE CONSUMPTION

Now I'd like to ask you about your tobacco use and exposure to second hand smoke.

I1. Have you smoked at least 100 cigarettes (about 5 packs) during your entire life?

YES 1
NO ..... 2 **(I5)**

I1a. How old were you when you first started smoking cigarettes?

[ ][ ] YEARS OLD

I2. Do you smoke cigarettes now?

YES ..... 1 **(I3)**
NO 2

I2a. How old were you when you quit smoking cigarettes?

[ ][ ] YEARS OLD

I3. On average, about how many cigarettes do (did) you smoke?
IF R ANSWERS IN PACKS, PROBE FOR NUMBER OF CIGARETTES

a. [ ][ ][ ] # CIGARETTES

b. DAY 1
WEEK 2
MONTH 3
YEAR 4

I4. For approximately how many years have you smoked (did you smoke) this amount?

[ ][ ] YEARS

IF < 1 YEAR, RECORD 01.

I5. Have you ever smoked at least 20 cigars in your entire life?

YES 1
NO ..... 2 **(I6)**

a. Do you smoke cigars now?

YES 1
NO ..... 2 **(I6)**

b1. How many cigars do you smoke?

CIGARS

b2. DAY 1
WEEK 2
MONTH 3
YEAR 4

I6. Do you live with someone who smokes tobacco at home regularly?

YES 1
NO 2

I7. Currently do you spend time on a daily basis, at work or in other activities outside your home, with people who are smoking?

YES 1
NO 2

Now I would like to ask you a few questions about drinking alcoholic beverages.

I8. Have you ever had an alcoholic drink?

YES 1
NO ..... 2 **(I14)**

I9. Have you had an alcoholic drink in the last 30 days?

YES 1
NO ..... 2 **(I13)**

I10. *In the last 30 days, did you drink any:	i. **IF YES:** About how often do you drink _____? Would you say:	ii. **IF YES:** About how much do you drink on a typical day when you drink _____? Would you say:	iii. IF YES: How often are you having a meal when you drink _____? Would you say:
*a. Beer or lite beer? YES.....1 NO ..... 2 **(I10b)**	Every day .....1 5-6 days a week .....2 3-4 days a week .....3 1-2 days a week .....4 Or, less often than weekly 5	1-2 12oz serving(s) ..... 1 3-5 12oz servings ..... 2 1-2 six packs (12oz bottles/cans) 3 2-3 six packs (12oz bottles/cans) 4 3+ six packs (12oz bottles/cans) . 5	Less than ½ the time..... 1 ½ the time or more..... 2
*b. Wine, wine coolers, sangria or champagne? YES.....1 NO ..... 2 **(I10c)**	Every day .....1 5-6 days a week .....2 3-4 days a week .....3 1-2 days a week .....4 Or, less often than weekly 5	1-2 glasses (5oz) ..... 1 1/2 carafe (12.5oz)..... 2 1 bottle..... 3 2-4 bottles..... 4 5 or more bottles of wine or champagne (125oz each) 5	Less than ½ the time..... 1 ½ the time or more..... 2
*c. Hard liquor such as tequila, gin, vodka, scotch, rum, whiskey, or liqueurs, either alone or mixed? YES..... 1 NO .....2 **(I11)**	Every day .....1 5-6 days a week .....2 3-4 days a week .....3 1-2 days a week .....4 Or, less often than weekly 5	1 shot (1.5oz)..... 1 2-3 shots..... 2 4-6 shots or a 1/2pint ..... 3 7-11 shots or a pint ..... 4 2 pints (32 oz) or more..... 5	Less than ½ the time..... 1 ½ the time or more..... 2

I11. Considering all the types of alcoholic beverages, how many times during the last 30 days did you have 5 or more drinks within a 24-hour period?

		# TIMES

I12. Now, thinking about the occasions or days that you drink, how many drinks on average do you have during those occasions (at one sitting or session)?

		# DRINKS

I13. In the past 10 years, has your use of alcoholic beverages…….

Increased 1

Decreased 2

Not changed 3

Now I would like to ask you a few questions about other, non-alcoholic beverages that you drink every day. Think about the past 7 days.

I14. *How many servings of _[ITEM]_ did you drink each day? A serving is one 8 oz glass or cup.

	# SERVINGS	
*a. Water		
*b. Juice		
*c. Milk		
*d. Soda or carbonated beverages with caffeine		
e. Soda or carbonated beverages without caffeine		
f. Herbal tea or decaffeinated tea		
g. Tea with caffeine, including green tea		
h. Coffee with caffeine		
*i. Decaffeinated coffee		
j. Other caffeinated beverage, other than soda or coffee		
k. Other non-caffeinated, non-carbonated beverage		

I15. What time of the day did you drink the most beverages? Would you say

Before noon 1
Noon to 5 PM 2
After 5 PM 3

SECTION J: BLADDER HEALTH

I am going to ask you a series of questions about specific types of experiences that you may or may not have had during the last month, related to your bladder and pelvic area health. IF RESPONDENT DOES NOT HAVE SYMPTOM, PROCEED TO NEXT ITEM
[SHOW RESPONSE CARD 'J1, J2 and J3'].

J1. *During the last month, how often have you had:	i. Would you say…						ii. About how long have you had this experience? Would you say…					iii. In the past 4 weeks, how much has _____ been a problem for you? Would you say…					iv. Have you ever seen a healthcare provider for this symptom?		v. **IF YES:** Did you receive treatment?	
	I do not have the symptom	**Rarely**	**A few times**	**Fairly often**	**Usually**	**Almost always**	**< 3 months**	**3 - 6 months**	**7 - 12 months**	**1 - 5 years**	**6+ years**	**No problem**	**Very small**	**Small**	**Medium**	**Big**	**Yes**	**No**	**Sought and received**	**Sought, but did not receive**
*a. A sensation of not emptying your bladder completely after you have finished urinating?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
*b. To urinate again less than 2 hours after you finished urinating?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
*c. To stop and start again several times while you urinate?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
d. Difficulty postponing urination?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
e. A weak urinary stream?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
f. To push or strain to begin urination?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2

IF RESPONDENT DOES NOT HAVE SYMPTOM, PROCEED TO NEXT ITEM
[SHOW RESPONSE CARD 'J1, J2 and J3'].

J1. *During the last month, how often have you had:	i. Would you say…						ii. About how long have you had this experience? Would you say…					iii. In the past 4 weeks, how much has _____ been a problem for you? Would you say…					iv. Have you ever seen a healthcare provider for this symptom?		v. **IF YES:** Did you receive treatment?	
	I do not have the symptom	**Rarely**	**A few times**	**Fairly often**	**Usually**	**Almost always**	**< 3 months**	**3 - 6 months**	**7 - 12 months**	**1 - 5 years**	**6+ years**	**No problem**	**Very small**	**Small**	**Medium**	**Big**	**Yes**	**No**	**Sought and received**	**Sought, but did not receive**
*g. To get up to urinate more than once during the night?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
h. A prolonged trickle or dribble at the end of your urine flow?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
i. Urine leakage almost immediately after you have finished urinating and walked away from the toilet?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
PROBE: ↓ This refers to leakage not in connection with a sudden compelling urge, nor in connection with sneezing, coughing or other physical activity																				
j. Difficulty starting to urinate?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
k. Pain or burning during urination?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2

J1. *During the last month, how often have you had:	i. Would you say…						ii. About how long have you had this experience? Would you say…					iii. In the past 4 weeks, how much has _____ been a problem for you? Would you say…					iv. Have you ever seen a healthcare provider for this symptom?		v. **IF YES:** Did you receive treatment?	
	I do not have the symptom	**Rarely**	**A few times**	**Fairly often**	**Usually**	**Almost always**	**< 3 months**	**3 - 6 months**	**7 - 12 months**	**1 - 5 years**	**6+ years**	**No problem**	**Very small**	**Small**	**Medium**	**Big**	**Yes**	**No**	**Sought and received**	**Sought, but did not receive**
l. **IF MALE**: Pain or discomfort in the area between the rectum and testicles	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
m. **IF MALE**: Pain in your testicles?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
n. **IF MALE**: Pain or discomfort at the tip of the penis, not related to urination?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
o. **IF MALE**: Pain or discomfort during or after sexual climax (ejaculation)?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
*p. A strong urge or pressure to urinate immediately, with no, or little warning?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
q. Frequent urination during the day?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2

J1.	*During the last month, how often have you had:	i. Would you say…						ii. About how long have you had this experience? Would you say…					iii. In the past 4 weeks, how much has _____ been a problem for you? Would you say…					iv. Have you ever seen a healthcare provider for this symptom?		v. **IF YES:** Did you receive treatment?	
		I do not have the symptom	**Rarely**	**A few times**	**Fairly often**	**Usually**	**Almost always**	**< 3 months**	**3 - 6 months**	**7 - 12 months**	**1 - 5 years**	**6+ years**	**No problem**	**Very small**	**Small**	**Medium**	**Big**	**Yes**	**No**	**Sought and received**	**Sought, but did not receive**
*r.	Burning, discomfort, pain or pressure in your pelvic or bladder area?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
s.	Pain or discomfort in your urethra?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
t.	Visible blood in your urine?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
u.	Pain increasing when your bladder fills?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
*v.	Pain relieved by urination?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
w.	Pain or discomfort in your lower back?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
x.	Pain or discomfort in your rectum?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2
y.	**IF FEMALE:** Pain or discomfort at the entrance to the vagina?	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	5	1	2	1	2

[TAKE BACK RESPONSE CARD 'J1, J2 and J3']

J2. Some people experience a strong urge or pressure to urinate that signals the need to urinate. In the last 7 days, how many times did you feel a strong urge or pressure that signaled the need to urinate immediately, whether or not you urinated or leaked urine? Would you say…

Not at all	1	**(J3a/b)**
Once	2	**(J2b)**
A few times (2 -3)	3	**(J2b)**
Several times (4 -6)	4	**(J2b)**
Many times (7 or more) but not everyday	5	**(J2b)**
Everyday	6	

↓

a. IF EVERYDAY: How many times per day? [ ][ ] TIMES

J2b. About how long have you had this experience? Would you say…

< 3 months	1
3 - 6 months	2
7 - 12 months	3
1 - 5 years	4
6+ years	5

J2c. In the past 4 weeks, how much has this been a problem for you? Would you say…

No problem	1
Very small	2
Small	3
Medium	4
Big	5

J2d. Have you ever seen a healthcare provider for this symptom?

YES	1	
NO	2	**(J3a/b)**

J2e. Did you receive treatment?

Sought, and received	1
Sought, and not received	2

FOR MALES:

J3a. Think about any pain or discomfort associated with your bladder and pelvic area. This includes your genitals (penis, testicles, and perineum). On a scale of 0 – 10, with 0 being no pain or discomfort and 10 being pain as bad as you can imagine, how would you rate your usual pain or discomfort over the last month?

FOR FEMALES:

J3b. Think about any pain or discomfort associated with your bladder and pelvic area. Include your genitals (vagina and perineum). On a scale of 0 – 10, with 0 being no pain or discomfort and 10 being pain as bad as you can imagine, how would you rate your usual pain or discomfort over the last month?

J4. Over the last month, how much have urinary symptoms, pain or discomfort in your pelvic or bladder area kept you from doing the kinds of things that you would usually do? Would you say:

Not at all	1
Slightly	2
Moderately	3
Greatly	4

[SHOW RESPONSE CARD 'J5'].

J5. *During the last month, how often have urinary symptoms, pain, or discomfort in your pelvic or bladder area interfered with [ITEM a-g]. Would you say…..	None of the time	A little of the time	Some of the time	Most of the time	All of the time
*a. Drinking fluids before you travel?	1	2	3	4	5
*b. Drinking fluids before you go to bed?	1	2	3	4	5
*c. Driving for 2 hours without stopping?	1	2	3	4	5
d. Getting enough sleep at night?	1	2	3	4	5
e. Going to places that may not have a toilet?	1	2	3	4	5
f. Playing sports outdoors such as golf	1	2	3	4	5
g. Going to movies, shows, church, etc.?	1	2	3	4	5

[TAKE BACK RESPONSE CARD 'J5']

J6. In the last 7 days, on average, how many times have you had to go to the bathroom to empty your bladder during the day meaning from the time you woke up in the morning until you fell asleep at night? | | | TIMES

a. In the last 7 days, how much has this been a problem for you?

No problem 1
Very small problem 2
Small problem 3
Medium problem 4
Big problem 5

b. In your opinion, do you feel that you urinate too often during the day?

YES 1
NO 2

J7. In the last 7 days, on average, how many times have you had to go to the bathroom to empty your bladder during the night after falling asleep? | | | TIMES

a. In the last 7 days, how much has this been a problem for you?

No problem 1
Very small problem 2
Small problem 3
Medium problem 4
Big problem 5

b. In your opinion, do you feel that you get up too often during the night to urinate?

YES 1
NO 2

The next set of questions asks about symptoms you may or may not have related to urine leakage or accidents with urination.

J8. Many people complain that they leak urine (wet themselves) or have accidents. In the last 12 months, have you leaked <u>even a small amount</u> of urine?

YES 1
NO ..... 2 **(J15)**

a. In the last 12 months, how often did you experience urinary leakage (wet yourself)?

Less than once per month 1
One or more times per month 2
One or more times per week 3
Everyday 4

b. Does this leaking happen…

After you finish urinating but <u>before</u> you leave the toilet 1
When you are not using the toilet at all 2
At both times (after urinating as well as when you are not using the toilet) 3

J9. When you leak urine, about how much is it?
Would you say….

Drops or a little more 1
Small splashes 2
Or more 3

J10. a. Have you ever accidentally leaked urine when you were coughing, sneezing, or performing some physical activity such as lifting or exercise?

YES 1
NO ..... 2 **(J10b)**

a1. How many times has this happened in the last 7 days?

		TIMES

a2. In the last 7 days, how much has this been a problem for you?

No problem 1
Very small problem 2
Small problem 3
Medium problem 4
Big problem 5

b. Have you accidentally leaked urine when you had the strong feeling that you needed to empty your bladder, but couldn't get to the toilet fast enough?

YES 1
NO ..... 2 **(J10c)**

b1. How many times has this happened in the last 7 days?

		TIMES

b2. In the last 7 days, how much has this been a problem for you?

No problem 1
Very small problem 2
Small problem 3
Medium problem 4
Big problem 5

c. Have you accidentally leaked urine without any particular physical activity or warning?

YES 1
NO ..... 2 **(J11)**

c1. How many times has this happened in the last 7 days?

		TIMES

c2. In the last 7 days, how much has this been a problem for you?

No problem..... 1
Very small problem..... 2
Small problem 3
Medium problem..... 4
Big problem 5

J11. What type of protection or products do you use most often?

None (no protection)..... 1 **(J13)**
Tissue, toilet paper, or paper towel..... 2 **(J13)**
Minipad or pantiliner 3
Menstrual pad..... 4
Incontinence pad (Poise, Serenity or other)..... 5
Incontinence diaper (Attends, Depends)..... 6
Something else..... 7 **(J13)**

J12. During a typical 24-hour period, on average, how many pads or adult diapers do you use because they get wet or damp?

Zero..... 1
One 2
Two or three 3
Four or more..... 4

J13. About how long have you had urine leakage? Would you say:

Less than 3 months 1
3 but less than 6 months..... 2
6 or more but less than 12 months..... 3
1 year or more but less than 5 years..... 4
5 years or more 5

J14. Have you ever seen a health care provider for your urine leakage?

YES 1
NO ..... 2 **(J14b)**

a. Did you receive treatment?

YES 1
NO 2

b. *To help with your incontinence, are you currently [ITEM b1-b5] ?		YES	NO
*b1.	Doing exercises to strengthen the muscles near the bladder?	1	2
*b2.	Timing your urination (bladder training)	1	2
*b3.	Taking a prescription medication	1	2
b4.	Using some other medical treatment (pessary, biofeedback, electric stimulation, acupuncture, homeopathy or herbs)?	1	2
*b5.	Doing nothing	1	2

The next questions refer to the experiences with urinary symptoms and pain/discomfort in your pelvic or bladder area and how much it may affect different aspects of your life.

[SHOW RESPONSE CARD 'J15']

J15. *How much do urinary symptoms, pain or discomfort in your pelvic or bladder area affect [ITEM]?		Not at all	Slightly	Moderately	Greatly
*a.	Your ability to do household chores, such as cooking, housecleaning, laundry, or yard work?	1	2	3	4
*b.	Physical recreational activities, such as walking, swimming, or other exercise?	1	2	3	4
*c.	Entertainment activities such as going to a film or concert?	1	2	3	4
d.	Your ability to travel by car or bus for distances greater than 30 minutes away from home?	1	2	3	4

		Not at all	Slightly	Moderately	Greatly
J15.	*How much do urinary symptoms, pain or discomfort in your pelvic or bladder area affect [ITEM]?				
e.	Your participation in social activities outside your home?	1	2	3	4
*f.	Your emotional health?	1	2	3	4
J16.	In addition, do urinary symptoms, pain or discomfort in your pelvic or bladder area cause you to experience frustration? Would you say...	1	2	3	4

[TAKE BACK RESPONSE CARD 'J15']

J17. How much did you think about your urinary symptoms and/or pelvic pain during the last month?

None 1
Only a little 2
Some 3
A lot..... 4

J18. If you were to spend the rest of your life with your urinary and/or pelvic pain condition the way it has been over the last month, how would you feel about that?

Delighted..... 1
Pleased..... 2
Mostly satisfied..... 3
Mixed, about equally satisfied and dissatisfied 4
Mostly dissatisfied 5
Unhappy..... 6
Terrible..... 7

J19. Which of the following statements best describes your bladder condition best at the moment? My bladder condition …….

Does not cause me any problems at all..... 1
Causes me some very minor problems 2
Causes me some minor problems..... 3
Causes me (some) moderate problems..... 4
Causes me severe problems..... 5
Causes many severe problems 6

SECTION K: SOCIO-DEMOGRAPHIC INFORMATION

Now I am going to ask you some questions about your background.

K1. What is your current marital status?

Married	1
Living with a partner	2
Divorced/separated	3
Widowed	4
Single, never married	5
OTHER	99

K2. What is the highest grade/degree you have completed?

Less than 8th grade	1
8th grade	2
9th through 11th grade	3
High school diploma/GED	4
Technical training	5
Associates degree	6
Bachelors degree	7
Masters degree	8
Doctorate degree (e.g. MD, PhD, JD)	9

K3. How many years of school have you <u>completed</u> altogether?

		YEARS

Now I would like to ask you a few questions about your current work situation.

K4. Which of the following categories best describes your current work situation?

Working for pay	1	
Unemployed and looking for work	2	**(K6)**
Temporarily laid off; On sick or other leave	3	**(K6)**
Disabled	4	**(K6)**
Retired	5	**(K6)**
Homemaker	6	**(K6)**
Full-Time Student	7	**(K6)**
Other (INCLUDING VOLUNTEER)	99	

a. SPECIFY: _____

K5. Are you currently working 35 hours or more each week (full time) or less than 35 hours?

35 HRS OR MORE/WK	1
LESS THAN 35 HRS/WK	2

K6. What is (was) your usual occupation? SPECIFY: _____

K7. How many people, including yourself, are supported on your household's income? [ ][ ] # PEOPLE

K8.	*Are you having trouble paying for…….	YES	NO
*a.	Transportation	1	2
*b.	Housing	1	2
c.	Health or medical care, medications	1	2
*d.	Food	1	2

K9. **[SHOW RESPONSE CARD 'K9']**

Income is important in analyzing the health information we collect. Including income from wages, salaries, Social Security or retirement benefits, help from relatives, veteran's benefits, real estate, investments, and other sources, about how much was your total household income in the last 12 months? Please look at this card and tell me which category best describes the amount.

Less than $5,000	1
$5,000 - $9,999	2
$10,000 - $19,999	3
$20,000 - $29,999	4
$30,000 - $39,999	5
$40,000 - $49,999	6
$50,000 - $59,999	7
$60,000 - $69,999	8
$70,000 - $79,999	9
$80,000 - $89,999	10
$90,000 - $99,999	11
$100,000 - $109,999	12
$110,000 - $119,999	13
$120,000 or more	14
REFUSED	-7
DON'T KNOW	-8

[TAKE BACK RESPONSE CARD 'K9']

K10. Do you (or any family member) have a computer at home or use a computer located somewhere else?

Yes, computer at home	1	
No computer at home, but access to a computer	2	**(K12)**
No computer at home and no access to a computer	3	**(Section L)**

K10a. How many computers? [ ][ ]

K11. Do you have an internet connection?

YES	1	
NO	2	**(K12)**

K11a. How are you connected to the Internet?

Dial-up	1
Fiber Optic	2
DSL	3
Cable	4
Satellite Wireless	5
Other	6

K12. Other than home, where do you use the computer?	YES	NO
a. Work	1	2
b. Local Library	1	2
c. Friends	1	2
d. Family outside household	1	2
e. Other	1	2

K13. How many hours per week do you use a computer (do not include work related time)? [ ][ ] HOURS

K14. Do you ever search for health-related information on the internet?

YES..... 1
NO ..... 2 **(Section L)**

K14a. How often?

About once a week..... 1
About once a month 2
Several times a year..... 3

K14b.	Do you search on the internet by …….	YES	NO
a.	Using search engines (includes banner ads)	1	2
b.	Using general health portals (e.g. WebMd)	1	2
c.	Using disease specific websites	1	2

K14c. Have you ever used the internet to obtain information concerning a urological problem (e.g., urinary problem, pelvic pain, sexual functioning, etc.)?

YES..... 1
NO ..... 2 **(Section L)**

K14d. What was the problem?

SPECIFY: _____

_____

_____

_____

SECTION L: MEDICATIONS

IF MEDICATION AND VITAMIN BOTTLES ARE NOT AVAILABLE, PROCEED TO L2.

IF RESPONDENT COLLECTED MEDICATIONS AT THE BEGINNING OF THE INTERVIEW:
Now I'd like to collect some information about any medications you have taken over the past 4 weeks. First I'd like to write down the information from the medications you have collected. This should only take a moment. Then, I will ask you some questions about vitamins or supplements.

L1.	i. **MEDICATION NAME**	ii. **AMOUNT PER DOSE**	iii. **DOSES PER DAY**	iv. **How long have you been on this medication?**
a.				☐☐ MONTHS ..... 1 YEARS 2
b.				☐☐ MONTHS ..... 1 YEARS 2
c.				☐☐ MONTHS ..... 1 YEARS 2
d.				☐☐ MONTHS ..... 1 YEARS 2
e.				☐☐ MONTHS ..... 1 YEARS 2
f.				☐☐ MONTHS ..... 1 YEARS 2
g.				☐☐ MONTHS ..... 1 YEARS 2

L1.	i. **MEDICATION NAME**	ii. **AMOUNT PER DOSE**	iii. **DOSES PER DAY**	iv. **How long have you been on this medication?**
h.				MONTHS.....1 YEARS 2
i.				MONTHS.....1 YEARS 2
j.				MONTHS.....1 YEARS 2
k.				MONTHS.....1 YEARS 2
l.				MONTHS.....1 YEARS 2
m.				MONTHS.....1 YEARS 2
n.				MONTHS.....1 YEARS 2
o.				MONTHS.....1 YEARS 2
p.				MONTHS.....1 YEARS 2

L1. **i. MEDICATION NAME**	ii. **AMOUNT PER DOSE**	iii. **DOSES PER DAY**	iv. **How long have you been on this medication?**
q.			☐☐ MONTHS ..... 1 YEARS 2
r.			☐☐ MONTHS ..... 1 YEARS 2
s.			☐☐ MONTHS ..... 1 YEARS 2
t.			☐☐ MONTHS ..... 1 YEARS 2

IF RESPONDENT COLLECTED VITAMINS OR SUPPLEMENTS AT THE BEGINNING OF THE INTERVIEW:
Now I'd like to collect some information about any vitamins or supplements you have taken over the past 4 weeks. First I'd like to write down the information from the vitamins or supplements you have collected. This should only take a moment. Then, I will ask you some questions about the medications.

L2. **i. VITAMIN OR SUPPLEMENT NAME**	ii. **AMOUNT PER DOSE**	iii. **DOSES PER DAY**	iv. **How long have you been on this vitamin or supplement?**
a.			☐☐ MONTHS ..... 1 YEARS 2
b.			☐☐ MONTHS ..... 1 YEARS 2
c.			☐☐ MONTHS ..... 1 YEARS 2
d.			☐☐ MONTHS ..... 1 YEARS 2
e.			☐☐ MONTHS ..... 1 YEARS 2
f.			☐☐ MONTHS ..... 1 YEARS 2
g.			☐☐ MONTHS ..... 1 YEARS 2

L2.	i. VITAMIN OR SUPPLEMENT NAME	ii. AMOUNT PER DOSE	iii. DOSES PER DAY	iv. How long have you been on this vitamin or supplement?
h.				☐☐ MONTHS ..... 1 YEARS 2
i.				☐☐ MONTHS ..... 1 YEARS 2
j.				☐☐ MONTHS ..... 1 YEARS 2
k.				☐☐ MONTHS ..... 1 YEARS 2
l.				☐☐ MONTHS ..... 1 YEARS 2
m.				☐☐ MONTHS ..... 1 YEARS 2
n.				☐☐ MONTHS ..... 1 YEARS 2
o.				☐☐ MONTHS ..... 1 YEARS 2
p.				☐☐ MONTHS ..... 1 YEARS 2

L2. **i. VITAMIN OR SUPPLEMENT NAME**	ii. **AMOUNT PER DOSE**	iii. **DOSES PER DAY**	iv. **How long have you been on this vitamin or supplement?**
q.			☐☐ MONTHS ..... 1 YEARS 2
r.			☐☐ MONTHS ..... 1 YEARS 2
s.			☐☐ MONTHS ..... 1 YEARS 2
t.			☐☐ MONTHS ..... 1 YEARS 2

PROCEED TO L3.

Now I am going to ask you questions about your medications. Let's start with pills or medicines you are currently taking or have taken within the last 4 weeks, which are prescribed by your health care provider. I will read off a list of medications, please let me know if you are taking any in the groups I mention. **IF YES, GO ACROSS. IF NO, GO TO NEXT ITEM**

L3.	**i.** *In the last four weeks have you taken: **IF YES, ASK NAME**	YES	NO	REF	DK	ii. What is the name of that medication? Any others?	iii. How long have you been on this medicine? MONTHS	YEARS
*a.	Any medication, pills, or injection medicines to thin your blood? (Lovenox, Heparin, Coumadin)	1	2	-7	-8			1 2
								1 2
*b.	Anything for your heart or heart beat including pills, paste or patches? (Digoxin, Nitrodur, Nitroglycerin, Inderal)	1	2	-7	-8			1 2
								1 2
*c.	Anything for stomach ulcers, reflux or heartburn? (Nexium, Axid)	1	2	-7	-8			1 2
								1 2
d.	Any medications for cholesterol or fats in your blood? (Lipitor, Zocor, Mevacor, Pravachol)	1	2	-7	-8			1 2
								1 2
*e.	Blood pressure or fluid pills (Norvasc, Vasotec, Aldomet, Nifedipine, Captopril, Atenolol, Lasix, HCTZ, Spironolactone)?	1	2	-7	-8			1 2
								1 2

L3. continued **IF YES, GO ACROSS. IF NO, GO TO NEXT ITEM**

L3.	**i.** *In the last four weeks have you taken: **IF YES, ASK NAME**	YES	NO	REF	DK	ii. What is the name of that medication? Any others?	iii. How long have you been on this medicine? MONTHS	YEARS
f.	Thyroid pills? (Synthroid, Levoxyl, Tapazole)	1	2	-7	-8			1 2
								1 2
g.	Insulin or pills for sugar in your blood? (NPH, regular insulin, Glucophage, Micronase, Glucotrol, Avandia)	1	2	-7	-8			1 2
								1 2
*h.	Medications for anxiety, such as tranquilizers, sedatives, or sleeping pills? (Ativan, Halcion, Valium, Xanax)	1	2	-7	-8			1 2
								1 2
i.	Anti-depression medication? (Prozac, Zoloft, Paxil, Elavil)	1	2	-7	-8			1 2
								1 2
*j.	**IF MALE:** Hormones, including pills, patches, creams, and injectables? (Testosterone injections/patches)	1	2	-7	-8			1 2
								1 2

L3. continued **IF YES, GO ACROSS. IF NO, GO TO NEXT ITEM**

L3.	**i.** *In the last four weeks have you taken: **IF YES, ASK NAME**	YES	NO	REF	DK	ii. What is the name of that medication? Any others?	iii. How long have you been on this medicine? MONTHS	YEARS
k.	**IF MALE:** Medication for erectile dysfunction? (Viagra, Alprostadil, Caverject)	1	2	-7	-8			1 2
								1 2
l.	**IF FEMALE:** Medications for endometriosis? (Birth control pills, Indocin, Naprosyn)	1	2	-7	-8			1 2
								1 2
*m.	Medications for pelvic pain (Codeine, Aspirin, Oxycodone, Demerol, Morphine, Dilantin, Tegretol, Elavil, Pamelor, Tofranil)?	1	2	-7	-8			1 2
								1 2
n.	Medications for urinary incontinence and/or urgency? (Detrol, Ditropan, Urispas, Probanthine)	1	2	-7	-8			1 2
								1 2
*o.	Any non-steroid anti-inflammatories? (Celebrex, Ibuprofen, Naprosyn)	1	2	-7	-8			1 2
								1 2

L3. continued **IF YES, GO ACROSS. IF NO, GO TO NEXT ITEM**

L3.	**i.** *In the last four weeks have you taken: **IF YES, ASK NAME**	YES	NO	REF	DK	ii. What is the name of that medication? Any others?	iii. How long have you been on this medicine? MONTHS	YEARS
p.	Any steroid anti-inflammatories? (Prednisone, Decadron)	1	2	-7	-8			1 2
								1 2
q.	**IF FEMALE:** Any female hormones including for birth control, including pills, creams, patches, implants or injectables? (Premarin, Provera, Prempro, Estrace)	1	2	-7	-8			1 2
								1 2
r.	Any medications for your urinary symptoms? (including BPH IF MALE)	1	2	-7	-8			1 2
								1 2
*s.	Any inhalers?(Albuterol, Advair)	1	2	-7	-8			1 2
								1 2
t.	Any medications for allergies, either pills or sprays) (Allegra, Zyrtec, Flonase)	1	2	-7	-8			1 2
								1 2
*u.	Any other prescription pills or medications?	1	2	-7	-8			1 2
								1 2

Now I'm going to ask you about over-the-counter medicines (non-prescription) that you are currently taking or have taken within the last 4 weeks.

IF YES, GO ACROSS. IF NO, GO TO NEXT ITEM

L4.	**i.** *In the last four weeks have you taken: **IF YES, ASK NAME**	YES	NO	REF	DK	ii. What is the name of that medicine? Any others?	iii. What are you taking it for?
*a.	Any over the-counter medications for pain?	1	2	-7	-8		
*b.	Anything for problems sleeping (Nytol, Benadryl)?	1	2	-7	-8		
*c.	Any cold medications (Sudafed, Nyquil, Coricidin)?	1	2	-7	-8		
d.	Any non-steroidal anti-inflammatories (Motrin, Advil, Aleve)?	1	2	-7	-8		
*e.	Any steroidal anti-inflammatories (Hydrocortisone)?	1	2	-7	-8		
f.	**IF FEMALE:** Anything for PMS (premenstrual syndrome) (Pamprin, Advil or Midol)?	1	2	-7	-8		

L4. continued

IF YES, GO ACROSS. IF NO, GO TO NEXT ITEM

L4.	**i.** *In the last four weeks have you taken: **IF YES, ASK NAME**	YES	NO	REF	DK	ii. What is the name of that medicine? Any others?	iii. What are you taking it for?
g.	Omega-3, fish oil or flax seed oil?	1	2	-7	-8		
*h.	Any herbal or natural medications?	1	2	-7	-8		
i.	Any other non-prescription medications?	1	2	-7	-8		

SECTION M: CONTACT INFORMATION

In the event that we need to contact you at some point in the future, it would be helpful for us to verify your contact information.

M1. What is your home telephone number? _____

M2. What is your work telephone number? _____

M3. What is your cell phone number? _____

M4. Do you have an email address where we could contact you? _____

M5. **IF MARRIED/PARTNERED**: What is your spouse/partner's first and last name?

a. FIRST NAME: _____

b. LAST NAME: _____

It would also be helpful to have the name and phone number of a contact person for you. This would be someone who does not live in your household but who would know how to contact you. We will only contact this person if we cannot contact you. This information, as with all of the other information that you have provided, will remain strictly confidential.

M6. What is the name of a reliable contact person for you? Can you spell the first and last name?

a. FIRST NAME: _____

b. LAST NAME: _____

c. What is (his/her) address?

c1. ADDRESS _____

c2. CITY _____

c3. STATE _____

c4. ZIP _____

d. What is (his/her) home, work, and cell phone numbers?

d1. HOME: _____

d2. WORK: _____

d3. CELL: _____

M7. What is the name of a second reliable contact person for you? Can you spell the first and last name?

a. FIRST NAME: _____

b. LAST NAME: _____

c. What is (his/her) address?

c1. ADDRESS _____

c2. CITY _____

c3. STATE _____

c4. ZIP _____

d. What is (his/her) home, work, and cell phone numbers?

d1. HOME: _____

d2. WORK: _____

d3. CELL: _____

M8. **FEMALES ONLY:** Sometimes it is helpful to have a maiden name when we try to re-contact people. What is your maiden name?

MAIDEN NAME: _____

M9. END TIME OF INTERVIEW: | | | : | | | 24 HR CLOCK

H H M M