PLEASE USE PENCIL!

1. Your current weight?

POUNDS

2. Is this your correct date of birth?

○ Yes
○ No → **If No, please write correct date.** MONTH / DAY / YEAR

3. Do you currently smoke cigarettes?

○ No ○ Yes → How many/day? ○ 1–4 ○ 5–14 ○ 15–24 ○ 25–34 ○ 35–44 ○ 45+

4. Have you had your uterus removed (with or without removal of Fallopian tubes)?

○ No
○ Yes, uterus and Fallopian tubes
○ Yes, uterus only

Date of surgery: ○ Before June 1, 2023 ○ After June 1, 2023

5. Have you ever had either of your ovaries surgically removed?

○ No ○ Yes → **a) How many ovaries do you have remaining?** ○ None ○ One

6. During the past two years, have you had any menopausal hot flashes or night sweats?

○ No ○ Yes → **If yes, were they *(mark one)*:** ○ Mild ○ Moderate ○ Severe

7. Since June 2023, have you used prescription female hormones, e.g., estrogen, testosterone? (Not including oral contraceptives.)

○ Yes → **a) How many months did you use hormones since June 2023?**
○ No

○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–25 ○ 26–30 ○ 31–35 ○ 36+ months

b) Are you *currently* using them (within the last month)? ○ Yes ○ No **If No, skip to question 8.**

c) Mark the type(s) of hormones you are *CURRENTLY* using:

Combined: ○ Prempro ○ Combipatch ○ FemHRT ○ Climara Pro ○ Bijuva ○ Duavee

Estrogen: ○ Oral Premarin or conjugated estrogen ○ Oral Estrace or oral estradiol ○ Patch estrogen ○ Estrogen gels, creams, sprays on skin ○ Estrogen + testosterone ○ Other estrogen (specify below)

Vaginal Estrogen: ○ Estring ○ Femring ○ Other vaginal estrogen

Progesterone/ Progestin: ○ Oral Provera/Cycrin/MPA ○ Oral Micronized progesterone or oral Prometrium ○ Vaginal progesterone ○ Other progesterone (specify type)

Other hormones: ○ Testosterone ○ Compounded bioidentical Estrogen ○ Prasterone (Intrarosa) ○ Compounded bioidentical Progesterone ○ Ospemifene (Osphena) ○ Other (specify type)

8. In the past two years, have you used any of these prescription medications or over-the-counter supplements *SPECIFICALLY for menopausal hot flashes or night sweats?* *(mark all that apply)*

○ Female hormones ○ SSRI/SNRI antidepressants ○ Gabapentin
○ Fezolinetant (Veozah) ○ Other prescription or over-the-counter supplements ○ None of these

9. In the past two years have you had . . . *(If yes, mark all that apply)*

	No	Yes, for Screening	Yes, for Symptoms
A physical exam?	(N)	(Y)	(Y)
Exam by eye doctor?	(N)	(Y)	(Y)
Mammogram?	(N)	(Y)	(Y)
Blood sugar and/or HbA1c?	(N)	(Y)	(Y)

Upper endoscopy? (N) No (Y) Yes

Cologuard (fecal DNA)? (N) No (Y) Yes

Fecal occult blood or immunochemical (FIT) test? (N) No (Y) Yes

Colonoscopy or Sigmoidoscopy? (N) No (Y) Yes

Initial reason(s) you had this Colonoscopy or Sigmoidoscopy?

○ Visible blood ○ Diarrhea/constipation
○ Fecal blood (e.g., FIT) ○ Fecal or stool DNA testing (e.g., Cologuard)
○ Abdominal pain ○ Family history of colon cancer
○ Prior polyps or prior cancer ○ Follow-up of (virtual) CT colonoscopy
○ Asymptomatic or routine screening

Blood test for early cancer detection? (N) No (Y) Yes

(Mark all that apply.)

○ Specific for colorectal cancer (e.g., Shield)
○ Specific for lung cancer (e.g., Firstlook)
○ For multiple cancers (e.g., Galleri, Grail)

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10. Since June 2023, have you had any of these clinician-diagnosed illnesses?

MARK HERE FOR "YES," LEAVE BLANK FOR "NO"

		YEAR OF DIAGNOSIS: BEFORE JUNE 1 2023	JUNE '23 TO MAY 2025	AFTER JUNE 1 2025	
Fibrocystic/other benign breast disease	(Y)	○	○	○	1
Confirmed by biopsy? (N) No (Y) Yes					a
Breast cancer	(Y)	○	○	○	2
Cancer of the ovary	(Y)	○	○	○	3
Leukemia or Lymphoma	(Y)	○	○	○	4
Melanoma	(Y)	○	○	○	5
Skin cancer (non melanoma)	(Y)	○	○	○	6
Cancer of the colon or rectum	(Y)	○	○	○	7
Colon or rectal polyp (benign)	(Y)	○	○	○	8
Other cancer	(Y)	○	○	○	9
Specify site of other cancer (e.g., uterus, pancreas, lung, etc.)					
Diabetes mellitus	(Y)	○	○	○	10
Elevated cholesterol	(Y)	○	○	○	11
High blood pressure	(Y)	○	○	○	12
Myocardial infarction	(Y)	○	○	○	13
Hospitalized for MI? (N) No (Y) Yes					a
Angina pectoris	(Y)	○	○	○	14
Confirmed by angiogram? (N) No (Y) Yes					a
Coronary bypass, angioplasty, or stent	(Y)	○	○	○	15
Heart failure	(Y)	○	○	○	16
Stroke (CVA)	(Y)	○	○	○	17
TIA (Transient ischemic attack)	(Y)	○	○	○	18
Carotid surgery (Endarterectomy)	(Y)	○	○	○	19
Pulmonary embolus	(Y)	○	○	○	20
Atrial fibrillation	(Y)	○	○	○	21
Osteoporosis	(Y)	○	○	○	22
Osteoarthritis	(Y)	○	○	○	23
Asthma, clinician diagnosed	(Y)	○	○	○	24
COPD/Emphysema/ Chronic bronchitis	(Y)	○	○	○	25

Since June 2023, have you had any of these clinician-diagnosed illnesses?

MARK HERE FOR "YES," LEAVE BLANK FOR "NO"

		YEAR OF DIAGNOSIS: BEFORE JUNE 1 2023	JUNE '23 TO MAY 2025	AFTER JUNE 1 2025	
Hip fracture	(Y)	○	○	○	26
Hip replacement	(Y)	○	○	○	27
Wrist or Colles fracture	(Y)	○	○	○	28
Vertebral (spine) fracture	(Y)	○	○	○	29
Knee replacement	(Y)	○	○	○	30
Glaucoma	(Y)	○	○	○	31
Cataract extraction	(Y)	○	○	○	32
Endometriosis (confirmed by laparoscopy)	(Y)	○	○	○	33
Kidney stones	(Y)	○	○	○	34
Cholecystectomy	(Y)	○	○	○	35
Depression, clinician diagnosed	(Y)	○	○	○	36
Alzheimer's or other type of dementia	(Y)	○	○	○	37
Parkinson's disease	(Y)	○	○	○	38
ALS (Amyotrophic Lat. Sclerosis)	(Y)	○	○	○	39
Multiple Sclerosis	(Y)	○	○	○	40
Rheumatoid Arthritis or Systemic Lupus (SLE)	(Y)	○	○	○	41
Sleep Apnea	(Y)	○	○	○	42
Chronic viral hepatitis (B or C)	(Y)	○	○	○	43
Gastric/duodenal ulcer	(Y)	○	○	○	44
Barrett's esophagus	(Y)	○	○	○	45
Celiac disease	(Y)	○	○	○	46
Crohn's/ Ulcerative colitis/ Microscopic colitis	(Y)	○	○	○	47
Other major illness or surgery since June 2023	(Y)	○	○	○	48

Please specify: Date:

(e.g., deep vein thrombosis, GERD, etc.)

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11. Have you *ever* had any of these clinician-diagnosed illnesses? (11)

MARK HERE FOR "YES," LEAVE BLANK FOR "NO"

		YEAR OF FIRST DIAGNOSIS					
		BEFORE 2008	2008–2014	2015–2020	2021–2022	2023 +	
Gastric bypass, balloon, banding, or sleeve	Y	○	○	○	○	○	
Fatty liver disease/MASLD	Y	○	○	○	○	○	
Confirmed by liver biopsy? ○ No ○ Yes							a
Liver cirrhosis	Y	○	○	○	○	○	
Pre-diabetes (Glucose intolerance)	Y	○	○	○	○	○	
Gout	Y	○	○	○	○	○	
Pseudogout	Y	○	○	○	○	○	
Shingles	Y	○	○	○	○	○	
Vaccine for shingles	Y	○	○	○	○	○	
Macular degeneration of retina	Y	○	○	○	○	○	
Retinal detachment	Y	○	○	○	○	○	

12. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a transfusion? (12)

○ Yes → **What was the site of the bleeding?**
○ No ○ Esophagus ○ Stomach ○ Duodenum (a)
○ Colon/rectum ○ Other ○ Site unknown

13. In the past two years, have you had an episode of: (13)

a) Diverticulitis (NOT diverticulosis) diagnosed by a clinician?

○ Yes → **If Yes, did you...** ○ Require hospitalization? (a)
○ No ○ Require surgery? ○ Have an abscess?
○ Require antibiotics? ○ Have a CT scan?
○ Have more than one episode?

b) Diverticular bleeding that required blood transfusion and/or hospitalization? ○ No ○ Yes (b)

c) Diverticulosis of the colon WITHOUT diverticulitis or diverticular bleeding? ○ No ○ Yes (c)

14. In the last year, how often have you had heartburn or acid-reflux? (14)

○ None in the past year ○ Less than once/month ○ About once/month
○ About once/week ○ Several times/week ○ Daily

15. In the past year, have you been bothered by constipation or diarrhea for at least 12 weeks (not necessarily consecutive)? (15)

○ Yes, diarrhea
○ Yes, constipation → **If Yes, were your bowel movements associated with abdominal pain?**
○ No ○ No ○ Yes (a)

16. How often do you use a laxative (such as softeners, bulking agents, or suppositories)? (16)

○ Never ○ < Once/month ○ 1–3 times/month
○ Once/week ○ 2–3 times/wk ○ 4–5 times/wk
○ Daily ○ 2–3 times/day

17. How frequently do you have a bowel movement? (17)

○ More than twice/day ○ Twice/day ○ Daily
○ Every other day ○ Every 3–4 days
○ Every 5 days or less often

18. Regular Medication *(Mark if used regularly in past 2 years.)* (18)

○ Acetaminophen (e.g., Tylenol)
Days/week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
Tablets/wk: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets

○ Low dose aspirin (100 mg or less/tablet)
Days/week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
Tablets/wk: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets

○ Aspirin or aspirin-containing products (325 mg or more/tablet)
Days/week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
Tablets/wk: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets

○ Ibuprofen (e.g., Advil, Motrin, Nuprin)
Days/week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
Tablets/wk: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets

○ Other anti-inflammatory (e.g., Aleve, Clinoril, Relafen, Celebrex)
Days/week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days

○ Thiazide diuretic ○ Calcium blocker ○ Beta-blocker
○ ACE inhibitors (e.g., lisinopril, enalapril, benazepril)
○ Angiotensin receptor blocker (e.g., losartan, valsartan, irbesartan)
○ Spironolactone ○ Eplerenone ○ Finerenone
○ Other anti-hypertensive (e.g., clonidine, doxazosin, Lasix)
○ Warfarin/Coumadin/Heparin
○ Pradaxa/Xarelto/Eliquis/Savaysa
○ Antiplatelet medication (e.g., Plavix, Effient, Brilinta)
○ Antiarrhythmic
○ Statin (e.g., atorvastatin, rosuvastatin, simvastatin)
○ PCSK9 inhibitor (Praluent, Repatha, Leqvio) ○ Ezetimibe (Zetia)
○ Other lipid-lowering drugs (e.g., fenofibrate, cholestyramine)
○ Steroids taken orally (e.g., prednisone, Decadron, Medrol)
○ Immune modulating medications (other than steroids) (e.g., Humira, Dupixent, methotrexate, Remicade)
○ Insulin ○ Metformin (e.g., glucophage)
○ SGLT2 inhibitors (e.g., Jardiance, Farxiga, Invokana)
○ DPP4 inhibitors (e.g., Januvia, Onglyza, Tradjenta, Nesina)
○ GLP1 agonists (e.g., semaglutide, Rybelsus, Ozempic, Wegovy, Victoza, Trulicity)
○ GLP1/GIP dual agonists (e.g., tirzepatide, Mounjaro, Zepbound)
○ Other oral hypoglycemic agent
○ Thyroid hormone (e.g., Synthroid, levothyroxine, Levoxyl)
○ Triptans (e.g., Imitrex, Maxalt, Zomig, Amerge, Relpax)
○ IV anti-amyloid drug for Alzheimer's (e.g., lecanemab)
○ Prescription memory loss medications (e.g., Aricept, donepezil, Exelon, rivastigmine, Namenda, memantine, galantamine)
○ Over-the-counter memory products (e.g., Prevagen, Neuriva)
○ Bisphosphonates (e.g., Fosamax, Boniva, Actonel)
○ Other bone building medications (e.g., Prolia, Tymlos, Forteo)
○ Aromatase inhibitors (e.g., anastrozole, exemestane)
○ Evista (raloxifene) ○ Tamoxifen (Nolvadex)
○ Anticholinergics (e.g., Detrol, Ditropan, Vesicare)
○ Antidepressant medications (e.g., SSRIs, SNRIs, Tricyclics)
○ Benzodiazepines (e.g., Valium, alprazolam, lorazepam)
○ ß-agonist inhaler (e.g., albuterol [Ventolin], Maxair)
○ Prescription sleep medications (e.g., Ambien, Sonata, Lunesta)
○ Melatonin
Dose? ○ 1 mg or less ○ 2–5 mg ○ 6–10 mg ○ over 10 mg
○ Other over-the-counter sleep medications
○ Prilosec, Nexium, Prevacid, Protonix, Aciphex, Dexilant
○ Potassium-competitive channel blockers (e.g., vonoprazen)
○ H2 blocker (e.g., Pepcid, Tagamet, Zantac, Axid)
○ Other regular medications (no need to specify)

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19. Which best describes your eyesight using both eyes (with glasses or contact lenses, if you wear them)?

○ Excellent ○ Good ○ Fair ○ Poor ○ Very Poor ○ Completely blind

20. What is your best visual acuity (corrected by glasses or contacts if you wear them) for each eye?

LEFT EYE:	○ 20/25 or better	○ 20/30 to 20/65	○ 20/70 to 20/180	○ 20/200 or worse
RIGHT EYE:	○ 20/25 or better	○ 20/30 to 20/65	○ 20/70 to 20/180	○ 20/200 or worse

21. Which best describes your hearing (without a hearing aid or hearing assist device)?

○ Excellent ○ Good ○ A little hearing trouble ○ Moderate hearing trouble ○ A lot of trouble hearing ○ Deaf

22. Do you wear a prescription or over-the-counter hearing aid(s)?

○ Yes, All the time ○ Yes, Most the time ○ Yes, Occasionally ○ No, Never

23. In the past 12 months, have you had ringing, roaring, or buzzing in your ears or head?

○ Never ○ <Once/week ○ About once/week ○ Several times/week ○ Almost every day ○ Every day

a) On the days you hear the sound, how long does it last?

○ A few seconds ○ Less than 5 minutes ○ 5 minutes to an hour ○ Several hours ○ All the time

b) Does the sound affect your ability to: ○ Sleep ○ Work ○ Concentrate ○ Perform other activities ○ None of these

24. Do you snore?

○ Every night ○ Most nights ○ A few nights a week ○ Occasionally ○ Almost never ○ Don't know

25. On average, how often are your daily activities affected because you are sleepy during the day?

○ Almost every day ○ 4–6 days/wk ○ 1–3 days/wk ○ Rarely ○ Never

26. On average, over a 24-hour period, do you sleep:

○ <5 hours ○ 5 hours ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10+ hours

27. Has your spouse (or sleep partner) ever told you that you appear to "act out your dreams" while sleeping (punched or flailed arms in the air, shouted or screamed), on three or more occasions?

○ No ○ Yes ○ I do not have a sleep partner

28. In the past 2 years, have you had migraine headaches?

○ Yes ➡ Did you sometimes have an aura? ○ No ○ Yes

○ No

On average, on *how many days per month* do you get migraine headaches?

○ <1 day ○ 1–7 days ○ 8–14 days ○ 15–29 days ○ Daily

29. Do you have any problems with your sense of smell, such as not being able to smell things or things not smelling the way they are supposed to for at least 3 months? (Do not include COVID-related changes to sense of smell.)

○ No ○ Yes ➡ Which problem do you have? ○ Loss of smell ○ Things don't smell right ○ Don't know

30. How many vaccinations for COVID-19 have you received (best estimate)?

○ Zero ○ One ○ Two ○ Three ○ Four ○ Five or more ○ Unsure

31. Have you ever been diagnosed with COVID-19 or tested positive for COVID-19?

○ No ○ Yes ➡

a) Number of times you have had COVID? ○ One ○ Two ○ Three ○ Four or more

b) Were you ever hospitalized for COVID? ○ Yes ○ No

c) Have you experienced any long-term COVID-19 symptoms (lasting for more than THREE months)?

○ No ○ Yes ➡ Which of the following long-term COVID-19 symptoms have you experienced?

○ Fatigue	○ Confusion, disorientation, "brain fog"	○ Headache
○ Shortness of breath or difficulty breathing	○ Memory issues	○ Intermittent fever
○ Persistent cough	○ Depression, anxiety, changes in mood	○ Mouth ulcers
○ Muscle or joint pain	○ Heart palpitations	○ Mouth pain
○ Chest pain	○ Skin rash	○ Thirst
○ Smell and taste problems	○ Ringing in ear or hearing loss	○ GI Symptoms
○ Sleep problems or sleep apnea	○ Post-exertional malaise	○ Other symptoms

32. In the PAST 12 MONTHS, have you used any cannabis product for medicinal or recreational purposes?

○ Yes, containing THC ➡

○ Yes, containing CBD only ➡

○ No

a) In the PAST 12 MONTHS, how often did you use any cannabis product?

○ Monthly or less ○ Weekly ○ Daily ○ More than once per day

b) In the PAST 12 MONTHS, what was the usual way you used cannabis?

○ Smoking/vaping ○ Edibles ○ Other

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33. Do you have difficulty with your balance? 33

○ No ○ Occasionally ○ Often

34. Do you usually use a cane, walker, or wheelchair/scooter? *(Mark all that apply)* 34

○ No ○ Cane ○ Walker ○ Wheelchair/scooter ○ Unable to walk

35. What is your usual walking pace outdoors? 35

○ Unable to walk ○ Easy, casual (less than 2 mph)
○ Normal, average (2-2.9 mph) ○ Brisk pace (3-3.9 mph) ○ Very brisk/striding (4 mph or faster)

36. DURING THE PAST YEAR, what was your average time PER WEEK spent at each of the following recreational activities? 36

	TIME PER WEEK									
	Zero	1–4 Min.	5–19 Min.	20–59 Min.	One Hour	1–1.5 Hrs.	2–3 Hrs.	4–6 Hrs.	7–10 Hrs.	11+ Hrs.
Walking for exercise or walking for transportation/errands	○	○	○	○	○	○	○	○	○	○
Running or jogging	○	○	○	○	○	○	○	○	○	○
Bicycling (include stationary machine) Intensity: ○ Low ○ Medium ○ High	○	○	○	○	○	○	○	○	○	○
Pickleball, tennis, squash, racquetball	○	○	○	○	○	○	○	○	○	○
Lap swimming Intensity: ○ Low ○ Medium ○ High	○	○	○	○	○	○	○	○	○	○
Other aerobic exercise (aerobic dance, ski or stair machine, etc.)	○	○	○	○	○	○	○	○	○	○
Lower intensity exercise (stretching, toning)	○	○	○	○	○	○	○	○	○	○
Other vigorous activities (e.g., lawn mowing)	○	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises **Arm Weights**	○	○	○	○	○	○	○	○	○	○
(Include free weights or resistance machines) **Leg Weights**	○	○	○	○	○	○	○	○	○	○
Yoga	○	○	○	○	○	○	○	○	○	○
Meditation	○	○	○	○	○	○	○	○	○	○
Prayer	○	○	○	○	○	○	○	○	○	○
Other Mind Body practices	○	○	○	○	○	○	○	○	○	○

37. DURING THE PAST YEAR, on average, how many <u>HOURS PER WEEK</u> did you spend: 37

	TIME PER WEEK								
	Zero	One Hour	2–5 Hrs.	6–10 Hrs.	11–20 Hrs.	21–40 Hrs.	41–60 Hrs.	61–90 Hrs.	Over 90 Hrs.
Standing or walking around at work or away from home? (hrs./week)	○	○	○	○	○	○	○	○	○
Standing or walking around at home? (hrs./week)	○	○	○	○	○	○	○	○	○
Sitting at work or away from home or while driving? (hrs./week)	○	○	○	○	○	○	○	○	○
Sitting at home while watching TV/DVD/Streaming? (hrs./week)	○	○	○	○	○	○	○	○	○
Other sitting at home (e.g., reading, meal times, at desk)? (hrs./week)	○	○	○	○	○	○	○	○	○

38. Over the past 4 weeks... 38

How would you rate your level (degree) of sexual desire or interest?
○ Very high ○ High ○ Moderate ○ Low ○ Very low or none at all

How frequent was your sexual activity or intercourse?
○ No sexual activity ○ 1–2 times ○ 3–4 times ○ 5–6 times ○ 7 or more times

How would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?
○ No sexual activity ○ Very high ○ High ○ Moderate ○ Low ○ Very low or none at all

How often did you become lubricated ("wet") during sexual activity or intercourse?
○ No sexual activity ○ Almost always or always ○ Most times ○ Sometimes ○ A few times ○ Almost never or never

When you had sexual stimulation or intercourse, how often did you reach orgasm?
○ No sexual activity ○ Almost always or always ○ Most times ○ Sometimes ○ A few times ○ Almost never or never

How satisfied have you been with your overall sexual life?
○ Very satisfied ○ Moderately satisfied ○ About equally satisfied and dissatisfied ○ Moderately dissatisfied ○ Very dissatisfied

How often did you experience discomfort or pain during vaginal penetration?
○ Did not attempt intercourse ○ Almost never or never ○ A few times ○ Sometimes ○ Most times ○ Almost always or always

39. Please answer Yes or No for each of the following questions about your memory: 39

Have you recently experienced any change in your ability to remember things?	○ Yes	○ No
Do you have <u>more</u> trouble than usual remembering recent events?	○ Yes	○ No
Do you have <u>more</u> trouble than usual remembering a short list of items, such as a shopping list?	○ Yes	○ No
Do you have trouble remembering things from one second to the next?	○ Yes	○ No
Do you have difficulty in understanding or following spoken instructions?	○ Yes	○ No
Do you have <u>more</u> trouble than usual following a group conversation or a plot in a TV program due to your memory?	○ Yes	○ No
Do you have trouble finding your way around familiar streets?	○ Yes	○ No

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40. How often do you feel isolated, that you lack companionship, or that you are left out? 40

○ Hardly ever ○ Some of the time ○ Often

41. Please rate your agreement with the following statement.
Overall, I have been feeling that the things I am doing are worthwhile. 41

○ Strongly disagree ○ Disagree ○ Somewhat disagree ○ Neither agree or disagree ○ Somewhat agree ○ Agree ○ Strongly agree

42. For each item below, please indicate how often <u>on average</u> you have used that item <u>during the past year</u>. 42

	HOW OFTEN DID YOU USE EACH PRODUCT DURING THE PAST YEAR?			
	Never	Once per week or less	2 to 5 times per week	Daily
Prebiotic supplements (inulin, FOS, GOS, etc.)	○	○	○	○
Probiotic supplements (Lactobacillus, Bifidobacterium, etc.)	○	○	○	○
Fiber supplement (Metamucil, Konsyl or Citrucel, etc.)	○	○	○	○

43. Regarding your eating habits during the past year. . . 43

	Never/ Rarely	Sometimes	Often	Usually/ Always
While I eat, I'm fully aware of the smells and taste of my food (e.g., temperature, texture, etc.).	○	○	○	○
I stop eating when I'm full, even if my plate is not empty yet.	○	○	○	○
I eat anything I want, whenever I want.	○	○	○	○
When I eat, I do something else on the side (e.g., read, watch TV, drive, work, be on the phone).	○	○	○	○
I try to make food and beverage choices that are good for the environment.	○	○	○	○
When I start eating, I just can't seem to stop.	○	○	○	○

44. How do the following statements describe you? 44

	Never or Very Rarely True	Rarely True	Sometimes True	Often True	Very Often or Always True
When I take a shower or a bath, I stay alert to the sensations of water on my body.	○	○	○	○	○
I'm good at finding words to describe my feelings.	○	○	○	○	○
I don't pay attention to what I'm doing because I'm daydreaming, worrying or otherwise distracted.	○	○	○	○	○
I believe some of my thoughts are abnormal or bad and I shouldn't think that way.	○	○	○	○	○
When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.	○	○	○	○	○
I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.	○	○	○	○	○
I have trouble thinking of the right words to express how I feel about things.	○	○	○	○	○
I do jobs or tasks automatically without being aware of what I'm doing.	○	○	○	○	○
I do think my emotions are bad or inappropriate and I shouldn't feel them.	○	○	○	○	○
When I have distressing thoughts or images, I am able to just notice them without reacting.	○	○	○	○	○
I pay attention to sensations, such as the wind in my hair or sun on my face.	○	○	○	○	○
Even when I'm feeling terribly upset, I can find a way to put it into words.	○	○	○	○	○
I find myself doing things without paying attention.	○	○	○	○	○
I tell myself I shouldn't be feeling the way I'm feeling.	○	○	○	○	○
When I have distressing thoughts or images, I just notice them and let them go.	○	○	○	○	○

45. Your current partner status: ○ Married ○ Domestic partnership ○ Divorced/separated ○ Widowed ○ Never married 45

46. Your current living arrangement: *(Mark all that apply)* 46

○ Alone ○ With spouse/partner ○ With other family ○ With pet(s) ○ Other
○ Assisted living ○ Nursing home ○ Senior/retirement housing or community for people age 55+

47. Thinking about people close to you, how many have died over your lifetime? 47

○ None ○ 1 ○ 2 ○ 3 ○ 4 or more

If 1 OR MORE: please answer the following questions with respect to the <u>ONE PERSON</u> whose death was the MOST DISTRESSING to you:

a) What was this person's relationship to you? Please choose one response only. a

○ Spouse/partner ○ Child ○ Sibling ○ Close Friend or relative ○ Parent ○ Other (specify) _____

b) Approximately when did this person die? Please choose one response only. b

○ Before 2010 ○ 2010–2015 ○ 2016–2019 ○ 2020 ○ 2021 ○ 2022 ○ 2023 ○ 2024+

c) Have you continued to have strong feelings that won't go away of wanting the person back even though you know it's not possible? ○ Yes ○ Sometimes ○ No c

d) Have thoughts of your deceased loved one continued to be on your mind so much that it makes it hard to think about or care about other things? ○ Yes ○ Sometimes ○ No d

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48. **In general, would you say your health is:** 48

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

49. **Compared to one year ago, how would you rate your health in general now?** 49

◯ Much better now than one year ago ◯ Somewhat better now than one year ago ◯ About the same
◯ Somewhat worse than one year ago ◯ Much worse than one year ago

50. **The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?** *(Mark one response on each line.)* 50

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
Vigorous activities, such as running, lifting heavy objects, strenuous sports	◯	◯	◯
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	◯	◯	◯
Lifting or carrying groceries	◯	◯	◯
Climbing *several* flights of stairs	◯	◯	◯
Climbing *one* flight of stairs	◯	◯	◯
Bending, kneeling, or stooping	◯	◯	◯
Walking *more than one mile*	◯	◯	◯
Walking *several blocks*	◯	◯	◯
Walking *one block*	◯	◯	◯
Bathing or dressing yourself	◯	◯	◯
Getting in and out of a bed or chair	◯	◯	◯

51. **During the *past four weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your *physical health*?** 51

a) Cut down the amount of time you spent on work or other activities ◯ Yes ◯ No
b) Accomplished less than you would like ◯ Yes ◯ No
c) Were limited in the kind of work or other activities ◯ Yes ◯ No
d) Had difficulty performing the work or other activities (for example, it took extra effort) ◯ Yes ◯ No

52. **During the *past four weeks*, 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)?** ***(Mark one response on each line.)*** 52

a) Cut down the amount of time you spent on work or other activities ◯ Yes ◯ No
b) Accomplished less than you would like ◯ Yes ◯ No
c) Didn't do work or other activities as carefully as usual ◯ Yes ◯ No

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53. **During the *past four weeks*, to what extent have *your physical or emotional problems* interfered with your normal social activities with family, friends, neighbors, or groups?** 53

◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

54. **How much *bodily pain* have you had during the *past four weeks*?** 54

◯ None ◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very severe

55. **During the *past four weeks*, how much did *bodily pain* interfere with your normal work (including both work outside the home and housework)?** 55

◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

56. **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. How much of the time during the *past four weeks...*** 56

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
Did you feel full of pep?	◯	◯	◯	◯	◯	◯
Have you been a very nervous person?	◯	◯	◯	◯	◯	◯
Have you felt so down in the dumps nothing could cheer you up?	◯	◯	◯	◯	◯	◯
Have you felt calm and peaceful?	◯	◯	◯	◯	◯	◯
Did you have a lot of energy?	◯	◯	◯	◯	◯	◯
Have you felt downhearted and blue?	◯	◯	◯	◯	◯	◯
Did you feel worn out?	◯	◯	◯	◯	◯	◯
Have you been a happy person?	◯	◯	◯	◯	◯	◯
Did you feel tired?	◯	◯	◯	◯	◯	◯

57. **During the *past four weeks*, how much of the time have your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?** 57

◯ All of the time ◯ Most of the time ◯ Some of the time ◯ A little of the time ◯ None of the time

58. **Please choose the answer that best describes how true or false each of the following statements is for you.** 58

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
I seem to get sick a little easier than other people.	◯	◯	◯	◯	◯
I am as healthy as anybody I know.	◯	◯	◯	◯	◯
I expect my health to get worse.	◯	◯	◯	◯	◯
My health is excellent.	◯	◯	◯	◯	◯

59. Choose the best answer for how you felt during the *past month*:

Are you basically satisfied with your life?	◯ Yes	◯ No
Have you dropped many of your activities and interests?	◯ Yes	◯ No
Do you feel that your life is empty?	◯ Yes	◯ No
Do you often get bored?	◯ Yes	◯ No
Are you in good spirits most of the time?	◯ Yes	◯ No
Are you afraid that something bad is going to happen to you?	◯ Yes	◯ No
Do you feel happy most of the time?	◯ Yes	◯ No
Do you often feel helpless?	◯ Yes	◯ No
Do you feel you have more problems with memory than most?	◯ Yes	◯ No
Do you prefer to stay at home, rather than going out and doing new things?	◯ Yes	◯ No
Do you think it is wonderful to be alive now?	◯ Yes	◯ No
Do you feel pretty worthless the way you are now?	◯ Yes	◯ No
Do you feel full of energy?	◯ Yes	◯ No
Do you feel that your situation is hopeless?	◯ Yes	◯ No
Do you think that most people are better off than you are?	◯ Yes	◯ No

60. Outside of your employment, do you provide regular care to any of the following? *(Mark one response on each line. For people to whom you do not provide regular care, mark "Zero hours")*

	HOURS PER WEEK					
	Zero Hrs.	1-8 Hrs.	9-20 Hrs.	21-35 Hrs.	36-72 Hrs.	73+ Hrs.
Your grandchildren	◯	◯	◯	◯	◯	◯
Disabled or ill spouse/partner	◯	◯	◯	◯	◯	◯
Disabled or ill adult child	◯	◯	◯	◯	◯	◯
Disabled or ill other person	◯	◯	◯	◯	◯	◯

61. How often do you go to religious meetings or services?
◯ More than once a week ◯ Once a week ◯ 1 to 3 times per month ◯ Less than once per month ◯ Never or almost never

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

63. How many living children (include stepchildren) do you have?
Daughters ◯ None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more
Sons ◯ None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more

64. How many of your children do you see at least once a month? ◯ None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 or more

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

66. Apart from your children, how many close relatives do you see at least once a month?
◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

67. How many close friends do you have?
◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

68. How many of these friends do you see at least once a month?
◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

69. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with?
◯ Yes → **a) How often do you see or talk to this person?**
◯ No ◯ Daily ◯ Weekly ◯ Monthly ◯ Several times/year ◯ Once/year or less

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

71. Did you (the participant) have help with filling out this questionnaire?
◯ I filled it out alone ◯ Someone helped me

72. Only if a tape measure is available, carefully measure your waist and hips. Use instructions on the back of the cover letter.

	Inches	Fraction
WAIST		0 ¼ ½ ¾
HIP		0 ¼ ½ ¾

73. Please indicate the name of someone at a DIFFERENT PERMANENT ADDRESS to whom we might write in the event we are unable to contact you:

Name: _____ Address: _____

Phone or E-mail: _____ _____

For Office Only

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Thank you! Please return completed form to: Nurses' Health Study, 181 Longwood Ave., Boston, MA 02115

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