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?

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

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, 2019 ◯ After June 1, 2019

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

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

6. Since June 2019, have you used prescription female hormones? (Not including oral contraceptives.)

◯ Yes → **a) How many months did you use hormones since June 2019?**
◯ 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 7.**

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

Combined: ◯ Prempro ◯ Combipatch ◯ FemHRT ◯ Climara Pro ◯ Bijuva

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

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

Other hormones:
◯ Compounded bioidentical Estrogen ◯ Testosterone
◯ Compounded bioidentical Progesterone ◯ Other (specify here)

7. 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
Fasting blood sugar?	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 test
◯ Fecal or stool DNA testing (e.g., Cologuard)
◯ Barium enema
◯ Family history of colon cancer
◯ Abdominal pain
◯ Follow-up of (virtual) CT colonoscopy
◯ Prior polyps or prior cancer
◯ Asymptomatic or routine screening

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8. One hears about morning and evening types of people. Which ONE of these types do you consider yourself to be?

◯ Definitely a morning type
◯ More of a morning than an evening type
◯ More of an evening than a morning type
◯ Definitely an evening type
◯ Neither

9. Is your biological MOTHER still living? ◯ Unsure

◯ Yes ◯ No → **At what age did she die?** ◯ less than 70 ◯ 70-79 ◯ 80-89 ◯ 90-99 ◯ 100+ ◯ Unsure

10. Is your biological FATHER still living? ◯ Unsure

◯ Yes ◯ No → **At what age did he die?** ◯ less than 70 ◯ 70-79 ◯ 80-89 ◯ 90-99 ◯ 100+ ◯ Unsure

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11. Since June 2019, have you had any of these clinician-diagnosed illnesses?

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

	YEAR OF DIAGNOSIS: BEFORE JUNE 1 2019	JUNE '19 TO MAY 2021	AFTER JUNE 1 2021	
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
Basal cell skin cancer (Y)	○	○	○	6
Squamous cell skin cancer (Y)	○	○	○	7
Colon or rectal polyp (benign) (Y)	○	○	○	8
Cancer of the colon or rectum (Y)	○	○	○	9
Other cancer (Y)	○	○	○	10
Specify site of other cancer → (e.g., uterus, pancreas, lung, etc.)				
Diabetes mellitus (Y)	○	○	○	11
Elevated cholesterol (Y)	○	○	○	12
High blood pressure (Y)	○	○	○	13
Myocardial infarction (Y)	○	○	○	14
Hospitalized for MI? (N) No (Y) Yes				a
Angina pectoris (Y)	○	○	○	15
Confirmed by angiogram? (N) No (Y) Yes				a
Coronary bypass, angioplasty, or stent (Y)	○	○	○	16
Congestive heart failure (Y)	○	○	○	17
Stroke (CVA) (Y)	○	○	○	18
TIA (Transient ischemic attack) (Y)	○	○	○	19
Peripheral artery disease or claudication of legs (not varicose veins) (Y)	○	○	○	20
Carotid surgery (Endarterectomy) (Y)	○	○	○	21
Pulmonary embolus (Y)	○	○	○	22
Atrial fibrillation (Y)	○	○	○	23
Osteoporosis (Y)	○	○	○	24
Osteoarthritis (Y)	○	○	○	25

Since June 2019, have you had any of these clinician-diagnosed illnesses?

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

	YEAR OF DIAGNOSIS: BEFORE JUNE 1 2019	JUNE '19 TO MAY 2021	AFTER JUNE 1 2021	
Hip fracture (Y)	○	○	○	26
Hip replacement (Y)	○	○	○	27
Knee replacement (Y)	○	○	○	28
Vertebral (spine) fracture (Y)	○	○	○	29
Hyperparathyroidism (Y)	○	○	○	30
Glaucoma (Y)	○	○	○	31
Cataract extraction (Y)	○	○	○	32
Kidney stones (Y)	○	○	○	33
Cholecystectomy (Y)	○	○	○	34
Depression, clinician diagnosed (Y)	○	○	○	35
Alzheimer's or other type of dementia (Y)	○	○	○	36
Parkinson's disease (Y)	○	○	○	37
ALS (Amyotrophic Lat. Sclerosis) (Y)	○	○	○	38
Multiple Sclerosis (Y)	○	○	○	39
Rheumatoid Arthritis or Systemic Lupus (SLE) (Y)	○	○	○	40
Gout (Y)	○	○	○	41
Sarcoidosis (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 2019 (Y)	○	○	○	48

Please specify: Date:

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

11

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12. Have you *ever* had any of these clinician-diagnosed illnesses?

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

		YEAR OF FIRST DIAGNOSIS				
		BEFORE 2004	2004–2010	2011–2016	2017–2018	2019 +
Sleep apnea	Y	○	○	○	○	○
Asthma, clinician diagnosed	Y	○	○	○	○	○
COPD/Emphysema/ Chronic bronchitis	Y	○	○	○	○	○
Fatty liver	Y	○	○	○	○	○
Confirmed by liver biopsy? ○ No ○ Yes						
Liver cirrhosis	Y	○	○	○	○	○
Pre-diabetes (Glucose intolerance)	Y	○	○	○	○	○
Gastric bypass, balloon, banding, or sleeve	Y	○	○	○	○	○
Endometriosis (confirmed by laparoscopy)	Y	○	○	○	○	○
Shingles	Y	○	○	○	○	○
Vaccine for shingles	Y	○	○	○	○	○
Wrist or Colles fracture	Y	○	○	○	○	○
Polymyalgia rheumatica	Y	○	○	○	○	○
Splenectomy	Y	○	○	○	○	○

13. During the past 4 years, what is the TOTAL amount of time you used antibiotics? (Exclude skin creams, mouthwash.)

○ None ○ Less than 15 days ○ 15 days to 2 months ○ 2 to 4 months ○ 4 months to 2 years ○ 2 to 3 years ○ 3+ years

a) What was the most common reason that you used an antibiotic?

○ Urinary ○ Dental ○ Tuberculosis ○ Skin ○ Gastrointestinal conditions ○ Other

14. Have you ever been diagnosed by a clinician with a urinary tract infection requiring antibiotics?

○ Yes → **Was at least one episode diagnosed before menopause?** ○ Yes ○ No

○ No

How many episodes have you had in the past year?

○ None ○ 1 ○ 2 ○ 3 or more

15. Have you EVER experienced a blow to the head or neck and at the time experienced any of the following: headache, dizziness, nausea, disorientation, memory problems, visual problems, loss of consciousness, or feeling unsteady on your feet?

○ Yes → **a)** ○ Once ○ Twice ○ 3+ times

○ No

b) At what age(s)? (please mark all that apply)

○ 0–9 ○ 10–19 ○ 20–29 ○ 30–39 ○ 40–49 ○ 50–59 ○ 60–69 ○ 70+

16. In the past 10 years, how many years did you get an influenza vaccination?

○ Every year ○ Most years ○ Occasionally ○ Rarely ○ Not in the last 10 years

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

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

○ Thiazide diuretic ○ Calcium blocker ○ Beta-blocker
○ ACE inhibitors ○ Angiotensin receptor blocker
○ Other anti-hypertensive (e.g., clonidine, doxazosin, Lasix)
○ Coumadin ○ Pradaxa/Xarelto/Eliquis ○ Plavix
○ Prasugrel (Effient) ○ Digoxin ○ Antiarrhythmic
○ "Statin" cholesterol-lowering drug (e.g., Mevacor, Zocor, Lipitor)
○ Other lipid-lowering drug [e.g., Lopid (gemfibrozil), Colestid, Tricor (fenofibrate), Questran (cholestyramine), Zetia]
○ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)

Diabetes drugs: (Mark all that apply)
○ Insulin ○ Non-insulin injections (e.g., Byetta, Victoza, Trulicity)
○ Metformin (Glucophage) ○ Jardiance ○ Invokana
○ Farxiga ○ Januvia ○ Other oral hypoglycemic agent

○ Thyroid hormone (e.g., Synthroid, Levothroid, Levoxyl)
○ Triptans (e.g., Imitrex, Maxalt, Zomig, Amerge, Replax)
○ Bisphosphonates (e.g., Fosamax, Boniva, Actonel)
○ Evista (raloxifene) ○ Tamoxifen (Nolvadex)
○ Anticholinergics (e.g., Detrol, Ditropan, Vesicare)
○ Antidepressant medications (e.g., SSRIs, SNRIs, Tricyclics)
○ Minor tranquilizers (e.g., Valium, alprazolam, lorazepam)
○ ß-agonist inhaler (e.g., albuterol [Ventolin], Maxair)
○ Prescription sleep medications (e.g., Ambien, Sonata, Lunesta)
○ Over-the-counter sleep medications
○ Prilosec, Nexium, Prevacid, Protonix, Aciphex, Dexilant
○ H2 blocker (e.g., Pepcid, Tagamet, Zantac, Axid)
○ Other regular medications (no need to specify)

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

○ Yes → **What was the site of the bleeding?**
○ Esophagus ○ Stomach ○ Duodenum ○ Colon/rectum ○ Other ○ Site unknown

○ No

19. In the past two years, have you had an episode of:

a) Diverticulitis (NOT diverticulosis) diagnosed by a clinician or that required antibiotics?

○ Yes → **If Yes, did you...**
○ **Have more than one episode?**
○ **Require surgery?** ○ **Have an abscess?**
○ **Require hospitalization?**

○ No

b) Diverticular bleeding that required blood transfusion and/or hospitalization?

○ No ○ Yes

c) Diverticulosis of the colon WITHOUT diverticulitis or diverticular bleeding?

○ No ○ Yes

20. What is your usual walking pace outdoors? ◯ 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)

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

	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	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
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	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

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

	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)	◯	◯	◯	◯	◯	◯	◯	◯	◯

23. Over the past 4 weeks...

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

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

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

	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 Citracel, etc.)	◯	◯	◯	◯

25. How often do you use a laxative (such as softeners, bulking agents, or suppositories)?
◯ Never ◯ <Once/month ◯ 1–3 times/month ◯ Once/week ◯ 2–3 times/wk ◯ 4–5 times/wk ◯ Daily ◯ 2+ times/day

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

27. 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

28. 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

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

30. 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

31. 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

32. During the last 12 months, how often have you leaked or lost control of your urine?
○ Never ○ Less than once/month ○ Once/month ○ 2–3 times/month ○ About once/week ○ Almost every day

i) When you lose your urine, how much usually leaks?
○ A few drops ○ Enough to wet your underwear ○ Enough to wet your outerclothing ○ Enough to wet the floor

ii) When you lose urine, what is the usual cause?
(a) ○ Coughing, sneezing, laughing, or doing physical activity
(b) ○ A sudden and urgent need to go to the bathroom
(c) ○ Both a) and b) equally
(d) ○ In other circumstances

33. How frequently do you have a bowel movement?
○ More than twice a day ○ Twice a day ○ Daily ○ Every other day ○ Every 3–4 days ○ Every 5 days or less often

34. Which best describes your hearing:
○ Excellent ○ Good ○ A little hearing trouble ○ Moderate hearing trouble ○ A lot of trouble ○ Deaf

35. Do you wear a hearing aid?
○ Yes, All the time ○ Yes, Most the time ○ Yes, Occasionally ○ No, Never

36. 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

37. Please rate your ability to do the following activities. *(Mark one answer for each row.)*

Are you able to . . .	Without Help	With Some Help	Unable
a. Get to places out of walking distance	○ Drive car, or travel alone on bus, train, or taxi	○ Need someone to help you or go with you	○ Unable to travel except by ambulance, etc.
b. Go shopping for groceries or clothes (assuming you had transportation)	○ Can shop by yourself, assuming you had transportation	○ Need someone to help you on all shopping trips	○ Completely unable to do any shopping
c. Prepare your own meals	○ Plan and cook full meals yourself	○ Can prepare some things. Unable to cook full meals	○ Completely unable to prepare any meals
d. Do your own housework	○ Can clean floors, bathroom, etc.	○ Need help with heavy housework & cleaning	○ Completely unable to do any housework
e. Handle your own money	○ Write checks, pay bills, etc., by yourself	○ Can manage day-to-day buying. Need help with checkbook & paying bills	○ Completely unable to handle money
f. Handle your medications	○ Able to keep track of and take meds yourself	○ Need someone to help manage medications	○ Completely unable to manage medications

38. This question asks about how well you sleep. In the past four weeks:

	No	Less than once/week	1–2 times per week	3–4 times per week	5+ times per week
Did you have trouble falling asleep?	○	○	○	○	○
Did you wake up several times at night?	○	○	○	○	○
Did you wake up earlier than you planned to?	○	○	○	○	○
Did you have trouble getting back to sleep after you woke up too early?	○	○	○	○	○

a. If you do have any sleep problems, how long have you been experiencing them?
○ Less than 3 months ○ 3 months or more ○ Not applicable

39. On average, over a 24-hour period, do you sleep:
○ <5 hours ○ 5 hrs. ○ 6 hrs. ○ 7 hrs. ○ 8 hrs. ○ 9 hrs. ○ 10+ hours

40. Overall, was your typical night's sleep during the past 4 weeks:
○ Very sound or restful ○ Sound or restful ○ Average quality ○ Restless ○ Very restless

41. 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? 41

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

42. 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? 42

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

43. In the last year, how often have you had heartburn or acid-reflux? 43

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

44. How likely are you to select low calorie foods for yourself? 44

○ Unlikely ○ Slightly unlikely ○ Slightly likely ○ Very likely

45. Do these apply to you:

a) "I eat anything I want, anytime I want." ○ Yes ○ No 45

b) "I pay a great deal of attention to changes in my figure." ○ Yes ○ No a

46. In the past year, have you been bothered by constipation or diarrhea for at least 12 weeks (not necessarily consecutive)? 46

○ No

○ Yes, diarrhea

○ Yes, constipation → **If Yes, were your bowel movements associated with abdominal pain?** a

○ No ○ Yes

47. 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.)* 47

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All	
Vigorous activities, such as running, lifting heavy objects, participating in 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 a mile*	○	○	○	
Walking *several blocks*	○	○	○	
Walking *one* block	○	○	○	
Bathing or dressing yourself	○	○	○	

48. Have you received a COVID-19 vaccine? 48

○ Yes → If yes: What type? ○ Pfizer ○ Moderna ○ Johnson & Johnson/Janssen ○ Other a

○ No, but I plan to get it

○ No, I do not plan to get it

49. Have you ever been diagnosed with COVID-19 or tested positive for COVID-19? 49

○ **No**, and I have never been tested by PCR swab or antigen test →

○ **No**, and I have only ever tested NEGATIVE by PCR swab or antigen test → **Continue on NEXT page**

○ **Yes**, I was diagnosed by a clinician as probably having COVID-19, but never had a PCR or antigen test → **When?** **Month:** ○ Jan ○ Feb ○ Mar ○ Apr ○ May ○ June ○ July ○ Aug ○ Sep ○ Oct ○ Nov ○ Dec

○ **Yes**, I had a positive PCR swab or antigen test → **Year:** ○ 2020 ○ 2021 ○ 2022

IF YES TO EITHER, CONTINUE....

a) Did you experience any symptoms when you had COVID-19?

○ Yes, I had symptoms → **How long did your COVID symptoms last?** a

○ No, I was asymptomatic ○ Less than 1 month ○ 1–2 months ○ 3–4 months ○ 5–6 months ○ 6+ months

b) At any point, did you require hospitalization due to COVID-19?

○ No ○ Yes, without a ventilator ○ Yes, with a ventilator → How many days on a ventilator? _____ b

c) Have you experienced any long-term COVID-19 symptoms (lasting for more than 4 weeks)?

○ Yes → **Which of the following long-term COVID-19 symptoms have you experienced?** c

○ No

○ Fatigue	○ Confusion, disorientation, "brain fog"	○ Headache
○ Shortness of breath or difficulty breathing	○ Memory issues	○ Intermittent fever
○ Persistent cough	○ Depression, anxiety, changes in mood	○ Mouth or tongue ulcers
○ Muscle, joint or chest pain	○ Heart palpitations	○ Tinnitus
○ Smell and taste problems	○ Rash, blisters or welts anywhere on body	○ Other symptoms

50. **These questions are about how you feel and how things have been with you *during the past 4 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 4 weeks...* *(Mark one response on each line.)*** 50

	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?	◯	◯	◯	◯	◯	◯
Have you felt hopeless about the future?	◯	◯	◯	◯	◯	◯
Have you felt no interest in things?	◯	◯	◯	◯	◯	◯

51. **During the *past 4 weeks*, how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?** 51

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

52. **Please choose the answer that best describes how true or false each of the following statements is for you. *(Mark one response on each line.)*** 52

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
Over the past 4 weeks, I have felt about the same as I have felt during the past year	◯	◯	◯	◯	◯
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	◯	◯	◯	◯	◯

53. **During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your *physical health*? *(Mark one response on each line.)*** 53

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

54. **During the *past 4 weeks*, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?** 54

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

55. **How much *bodily* pain have you had during the *past 4 weeks*?** 55

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

56. **During the *past 4 weeks*, how much did *bodily pain* interfere with your normal work (including both work outside the home and housework)?** 56

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

57. **In general, would you say your health is:** 57

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

58. **During the *past 4 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.)*** 58

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

59. **Over the *last 2 weeks*, how often have you been bothered by the following problems?** 59

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	◯	◯	◯	◯
Not being able to stop or control worrying	◯	◯	◯	◯
Feeling down, depressed, or hopeless	◯	◯	◯	◯
Little interest or pleasure in doing things	◯	◯	◯	◯

60. **On average, during the past year, on how many days did you consume an alcoholic beverage of any type?** 60

◯ No days ◯ Less than one/month ◯ 1 day/mo ◯ 2–4 days/mo ◯ 1–2 days/wk ◯ 3–4 days/wk ◯ 5–6 days/wk ◯ 7 days/wk

61. **In a typical month, what is the largest number of drinks of beer, wine, and/or liquor you have in one day?** 61

◯ None ◯ 1 drink/day ◯ 2 ◯ 3 ◯ 4 ◯ 5–6 ◯ 7–9 ◯ 10–14 ◯ 15 or more drinks/day

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

Have you recently experienced any change in your ability to remember things?	◯ Yes	◯ No
Do you have more trouble than usual remembering recent events?	◯ Yes	◯ No
Do you have more 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 any difficulty in understanding or following spoken instructions?	◯ Yes	◯ No
Do you have more 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

63. Please respond to the following questions on a scale from 0 to 10:

Overall, how satisfied are you with life as a whole these days?	Not satisfied at all	Completely Satisfied
In general, how happy or unhappy do you usually feel?	Extremely Unhappy	Extremely Happy
In general, how would you rate your physical health?	Poor	Excellent
How would you rate your overall mental health?	Poor	Excellent
Overall, to what extent do you feel the things you do in your life are worthwhile?	Not at All Worthwhile	Completely Worthwhile
I understand my purpose in life.	Strongly Disagree	Strongly Agree
I always act to promote good in all circumstances, even in difficult and challenging situations.	Not True of Me	Completely True of Me
I am always able to give up some happiness now for greater happiness later.	Not True of Me	Completely True of Me
I am content with my friendships and relationships.	Strongly Disagree	Strongly Agree
My relationships are as satisfying as I would want them to be.	Strongly Disagree	Strongly Agree
How often do you worry about being able to meet normal monthly living expenses?	Worry all of the time	Do not ever worry
How often do you worry about safety, food, or housing?	Worry all of the time	Do not ever worry

For each: ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

64. In the PAST 12 MONTHS, have you used any cannabis product for medicinal or recreational purposes? (smoke, vape, edibles, creams/lotions, etc.) *(Mark all that apply.)*

- ◯ No
- ◯ Yes, containing CBD only →
- ◯ Yes, containing THC →
- ◯ Prefer not to answer

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

◯ Once a month or less ◯ 2–3 times/month ◯ 1–2 times/week
◯ 3–5 times/week ◯ Daily ◯ More than once per day

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

- ◯ Smoking such as in a joint, bong, pipe, blunt, or vaping
- ◯ Eating it in food such as brownies, cakes, cookies, candy, or pills
- ◯ Applying topically such as in a lotion, cream, or patch
- ◯ Other

c) How long have you regularly used cannabis?

◯ Not regular user
◯ Less than 1 year ◯ 1 to 2 years ◯ 2 to 5 years ◯ 5 to 10 years
◯ 10 to 15 years ◯ 15 to 20 years ◯ 20+ years

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