# The Multiethnic Cohort Study

## *Follow-Up Health Survey*

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If your address shown is incorrect, or if your name has changed, please update the information below:

Correct Marks ■ X
Incorrect Marks ✓ ▬ •

A B 1 2

**Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Please update your telephone numbers for our records:**

**YOUR HOME** ( ) – 

**YOUR CELL** ( ) – 

This survey is to be filled out **ONLY** by the person named on the address label. →

1. **What is your sex?** ☐ Male ☐ Female

2. **What is your date of birth?** Month Day 19 Year

3. **What is your current marital status?** ***(mark only one)***

☐ Married, or living as married with a partner ☐ Separated or divorced
☐ Single, never been married ☐ Widowed

**Email address** (print legibly)

## EXPOSURE TO SMOKE

4. **Were you exposed to smoke from other people's cigarettes or tobacco products on a daily basis during:**

| | No | Yes | *If yes*, for how many hours per day? | For how many years? |
|---|---|---|---|---|
| Childhood at home | ☐ | ☐ → | (enter 00 if less than one) → | (enter 00 if less than one) |
| Adulthood at home | ☐ | ☐ → | → | |
| At work or in social settings such as restaurants, bars, bowling alleys, bingo halls, and friends' homes | ☐ | ☐ → | → | |
| Are you currently exposed to the smoke of others? | ☐ | ☐ → | | |

## TOBACCO

5. **If you ever smoked cigarettes, how soon after waking up did you smoke your first cigarette?** ***(If you never smoked, go to question 8.)***

☐ Within 5 minutes ☐ 31 – 60 minutes
☐ 6 – 30 minutes ☐ After 60 minutes

**Have you ever found it difficult not to be able to smoke in places where it is not allowed?**

☐ No ☐ Yes

**Which cigarette do you or did you hate most to give up?**

☐ First in the morning ☐ Any other

**Do you or did you smoke more frequently during the first hours after awakening than during the rest of the day?**

☐ No ☐ Yes

**Do you or did you smoke even if you were so ill that you were in bed most of the day?**

☐ No ☐ Yes

6. **Did you ever smoke MENTHOL cigarettes regularly** ***(20 or more packs of MENTHOL cigarettes in your lifetime)?***

☐ No ☐ Yes

***If yes,*** **for how many years in total did you smoke MENTHOL cigarettes?**

7. **Are you currently smoking cigarettes of any type?**

☐ No ☐ Yes

***If yes,*** **how many cigarettes per day?**

8. **Have you ever used chewing tobacco?** ☐ No ☐ Yes

***If yes*, number of years of use?** ☐ 1 – 10 years ☐ 11 – 20 years ☐ 21 years or more

***If yes*, are you currently chewing tobacco?** ☐ No ☐ Yes

9. **How much do you currently weigh?** ☐☐☐ **pounds**

10. **What is the most you ever weighed?** ***(women exclude pregnancies)*** ☐☐☐ **pounds →** **At what age?** ☐☐

11. **Has your doctor ever told you that you had any of the following conditions?** ***(mark all that apply)***

| | No | Yes | *If yes*, at what age were you first diagnosed? |
|---|---|---|---|
| High blood pressure | ☐ | ☐ → | ☐☐ |
| Heart attack | ☐ | ☐ → | ☐☐ |
| Angina (chest pain due to exertion) | ☐ | ☐ → | ☐☐ |
| Stroke | ☐ | ☐ → | ☐☐ |
| Diabetes | ☐ | ☐ → | ☐☐ |
| Polyp of intestines | ☐ | ☐ → | ☐☐ |
| Gallbladder removal | ☐ | ☐ → | ☐☐ |
| Gout | ☐ | ☐ → | ☐☐ |
| Rheumatoid arthritis | ☐ | ☐ → | ☐☐ |
| Other arthritis | ☐ | ☐ → | ☐☐ |

| | No | Yes | *If yes*, at what age were you first diagnosed? |
|---|---|---|---|
| Osteoporosis (brittle bones) | ☐ | ☐ → | ☐☐ |
| Ulcer (stomach or duodenal) | ☐ | ☐ → | ☐☐ |
| Kidney stones | ☐ | ☐ → | ☐☐ |
| Asthma | ☐ | ☐ → | ☐☐ |
| Glaucoma | ☐ | ☐ → | ☐☐ |
| Cataract surgery | ☐ | ☐ → | ☐☐ |
| Parkinson's disease | ☐ | ☐ → | ☐☐ |
| Skin cancer (not Melanoma) | ☐ | ☐ → | ☐☐ |
| Enlarged prostate *(men only)* | ☐ | ☐ → | ☐☐ |
| Benign disease (not cancer) of the breast *(women only)* | ☐ | ☐ → | ☐☐ |

12. **Have you had any of the following tests?** ***(mark all that apply)***

**IF YES, MARK EVERY YEAR YOU HAD THE TEST.**

| | No | Yes | Before 2005 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gastroscopy of the stomach | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colonoscopy or sigmoidoscopy of the colon | ☐ | ☐ → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| PSA blood test for prostate *(men only)* | ☐ | ☐ → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mammogram *(women only)* | ☐ | ☐ → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pap smear *(women only)* | ☐ | ☐ → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## ALCOHOL

13. **Do you currently drink alcoholic beverages?**

☐ No ☐ Yes

***If yes*, how many days in a week on average do you drink alcohol?**

☐ Less than one ☐ 4 – 6 days
☐ 1 – 3 days ☐ Daily

***If yes*, how many cans / bottles / glasses do you consume on days that you drink alcohol?**

☐☐ **cans / bottles / glasses**

## PHYSICAL ACTIVITY

14. On average during the last year, how many hours *at night* did you sleep? Hours ☐☐

15. On average during the last year, how many hours *in the daytime* did you sleep *(include naps)*? Hours ☐☐

16. On average during the last year, how many hours *per day* did you spend in the following sitting activities?

MARK ONLY ONE

| | None | Less than 1 hr. | 1 to 2 hrs. | 3 to 4 hrs. | 5 to 6 hrs. | 7 to 10 hrs. | 11 hrs. or more |
|---|---|---|---|---|---|---|---|
| Sitting in car, bus, truck or train | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sitting at work | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Watching TV | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sitting at meals | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other sitting activities (such as reading, playing cards, sewing, using a personal computer) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

17. On average during the last year, how many hours *per week* did you spend in the following activities?

MARK ONLY ONE

| | None | 1/2 to 1 hr. | 2 to 3 hrs. | 4 to 6 hrs. | 7 to 10 hrs. | 11 to 20 hrs. | 21 to 30 hrs. | 31 hrs. or more |
|---|---|---|---|---|---|---|---|---|
| Strenuous Recreational Activities (such as running, jogging, bicycling on hills, soccer, tennis, swimming laps, aerobics, weightlifting) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Strenuous Work (such as moving heavy furniture, loading or unloading trucks, construction work, shoveling or equivalent labor) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Moderate Recreational Activities (such as brisk walking, golfing, bicycling on level ground, gardening, dancing, softball) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Moderate Work (such as housework, yard work, restaurant work, sales work or equivalent moderate physical activity) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

18. About how many hours *per day*, on average, do you spend *outdoors* on weekdays and weekends?

| | None | less than 1 | 1 to 2 | 3 to 4 | 5 to 6 | 7 to 8 | more than 8 |
|---|---|---|---|---|---|---|---|
| Weekdays: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weekends: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## VITAMINS

19. Did you take any of the following vitamins during the past year, *at least once a week*?

HOW OFTEN? → FOR HOW MANY YEARS?

| | No | Yes | | 1 to 3 times a week | 4 to 6 times a week | Once a day | 1 year or less | 2 to 4 years | 5 to 9 years | 10 years or more |
|---|---|---|---|---|---|---|---|---|---|---|
| **MULTIPLE VITAMINS** Regular type such as One-a-Day, Centrum, Thera-type or other | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| B-complex or Stress-tab type | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **SINGLE VITAMINS** Folic acid or folate | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vitamin D, alone or combined with something else | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## HEALTH-RELATED

20. In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

21. Current health insurance coverage: *(mark all that apply)*

☐ None ☐ Medicaid ☐ Medicare ☐ Private insurance ☐ VA (Military) ☐ Other type



PLEASE GO TO THE NEXT PAGE →

## MEDICATIONS

**22. Have you ever taken any of the following medications at least two times per week *(for one month or longer)*?**

| | | *If yes*, how many years have you taken them? |
|---|---|---|
| **ASPIRIN** (Anacin, Bufferin, Bayer, Excedrin, Ecotrin or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **ACETAMINOPHEN** (Aspirin-Free Anacin, Tylenol or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **CELEBREX** (Celecoxib), **VIOXX** (Rofecoxib), **OR BEXTRA** (Valdecoxib) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **OTHER PAIN RELIEF MEDICATION** (Motrin, Ibuprofen, Advil, Aleve, Naprosyn, Indocin or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **WATER PILLS FOR HIGH BLOOD PRESSURE OR OTHER REASONS** (Hydrochlorthiazide, Maxzide, Furosemide, Lasix or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **OTHER HIGH BLOOD PRESSURE MEDICATION** (Verapamil, Norvasc, Prinivil, Cozaar, Procardia, Atenolol, Metaprolol, Lotensin, Vasotec or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **HIGH CHOLESTEROL MEDICATION** (Lipitor, Mevacor, Zocor, Pravachol, Lopid or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **PEPTIC ULCER MEDICATION** (Tagamet, Zantac, Pepcid, Prevacid, Prilosec or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **PILLS FOR DIABETES** (Glucophage, Glyburide, Glucotrol, Avandia, Actos or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **INSULIN SHOTS FOR DIABETES** | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **ALLERGY PILLS OR SHOTS** (Antihistamines such as Claritin, Allegra, Zyrtec, Benadryl or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **ASTHMA MEDICATION PILLS OR INHALERS** (Albuterol, Azmacort, Proventil, Theophylline or other) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **EVISTA** (Raloxifene) | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |
| **FOSAMAX** (Alendronate), **ACTONEL** (Risedronate), **OR BONIVA** (Ibandronate) for brittle bones | ☐ No<br>☐ Yes, but not now<br>☐ Yes, currently | |

## WOMEN ONLY

**23. Did you ever take estrogen *(female hormones)* by pill, injection, or patch for menopause or other reasons?**

- ☐ No (go to question 24)
- ☐ Yes, and I am currently taking it
- ☐ Yes, but I no longer take it

***If yes*, for how many years did you take estrogen?**

- ☐ Less than one year
- ☐ 1 – 2 years
- ☐ 3 – 5 years
- ☐ 6 – 9 years
- ☐ 10 – 14 years
- ☐ 15 – 19 years
- ☐ 20 years or more

**If you stopped taking estrogen, when did you stop?**

- ☐ Less than one year ago
- ☐ 1 – 2 years ago
- ☐ 3 – 4 years ago
- ☐ 5 – 6 years ago
- ☐ 7 – 8 years ago
- ☐ 9 or more years ago

**24. Did you ever take progesterone *(such as provera)* for menopause?**

- ☐ No
- ☐ Yes, and I am currently taking it
- ☐ Yes, but I no longer take it

***If yes*, at what age did you start?**

***If yes*, for how many years did you take progesterone?**

- ☐ Less than one year
- ☐ 1 – 2 years
- ☐ 3 – 5 years
- ☐ 6 – 9 years
- ☐ 10 – 14 years
- ☐ 15 – 19 years
- ☐ 20 years or more

**If you stopped taking progesterone, when did you stop?**

- ☐ Less than one year ago
- ☐ 1 – 2 years ago
- ☐ 3 – 4 years ago
- ☐ 5 – 6 years ago
- ☐ 7 – 8 years ago
- ☐ 9 or more years ago

**THANK YOU SO MUCH FOR YOUR TIME AND COOPERATION!**