IOWA WOMEN'S HEALTH STUDY

A Cooperative Study By The

UNIVERSITY OF IOWA
and the
UNIVERSITY OF MINNESOTA

Is the address label on this page correct? If not, please give the correct spelling of your name and your correct address.

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Address Label

Baseline (1986)

MARKING INSTRUCTIONS

Please follow these few simple rules in completing this questionnaire.

- Use only a pencil (Do NOT use pen.)
- Darken completely the circle of the answer you choose.
- Erase cleanly any answer you wish to change.
- Make no stray marks of any kind.
- Written responses must stay within the boxes provided.

EXAMPLES

	CORRECT	INCORRECT	CORRECT	INCORRECT
BRAND	generic	generic	○○●○	⊘⊗⊙◒

WEIGHT HISTORY

TODAY'S DATE: (Please enter numbers in box below.)

[/ /86]
MONTH DAY YEAR

This first section contains questions which will help us get a complete picture of your weight history. For this first question please fill in the circle of the answer which best describes you.

1. Think back to when you were in 6th grade -- or about the age of 12. Would you say at that time, compared to other girls your age, your weight was:
   - ○ BELOW AVERAGE FOR YOUR AGE AND HEIGHT
   - ○ ABOUT AVERAGE FOR YOUR AGE AND HEIGHT
   - ○ ABOVE AVERAGE FOR YOUR AGE AND HEIGHT

Please answer the questions below by writing your answer in the boxes provided.

2. What is your current height? (Without shoes and to the nearest inch)
   [ ] FEET AND [ ] INCHES
3. What is your current weight? (Without clothes and to the nearest pound)
   [ ] POUNDS
4. How much did you weigh one year ago? (Please round to the nearest pound)
   [ ] POUNDS
5. Think back to when you were 18 years old--or about the time you graduated from high school. How much did you weigh when you were 18?
   [ ] POUNDS
6. How much did you weigh when you were 30 years old?
   [ ] POUNDS
7. How much did you weigh when you were 40 years old?
   [ ] POUNDS
8. How much did you weigh when you were 50 years old?
   [ ] POUNDS
9. What is the most you have weighed? (Not including pregnancy weight)
   [ ] POUNDS
10. How old were you when you weighed the most?
    [ ] YEARS OLD

HEALTH HABITS

PHYSICAL ACTIVITY

The next part of your health picture concerns the physical activities that you do in your free time. Please fill in the circle of the answer which best describes you.

11. Aside from any work you do at home or at a job, do you do anything regularly--that is, on a daily basis--that helps you keep physically fit?
    - ○ NO
    - ○ YES
12. How often, in your free time, do you take part in moderate physical activity (such as bowling, golf, light sports or physical exercise, gardening, taking long walks)?
    - ○ MORE THAN 4 TIMES A WEEK
    - ○ 2-4 TIMES A WEEK
    - ○ ABOUT ONCE A WEEK
    - ○ A FEW TIMES A MONTH
    - ○ A FEW TIMES A YEAR
    - ○ RARELY OR NEVER
13. How often, in your free time, do you take part in vigorous physical activity (such as jogging, racket sports, swimming, aerobics, strenuous sports)?
    - ○ MORE THAN 4 TIMES A WEEK
    - ○ 2-4 TIMES A WEEK
    - ○ ABOUT ONCE A WEEK
    - ○ A FEW TIMES A MONTH
    - ○ A FEW TIMES A YEAR
    - ○ RARELY OR NEVER

SMOKING

Some of the following questions may not apply to you. We have used arrows to indicate which questions you should answer. This is for your convenience so you will not have to read questions which do not pertain to you. Please begin with Question 14 by filling in the circle of the answer you choose; then follow the arrows and directions.

14. Have you ever smoked cigarettes on a regular basis, that is, more than 100 cigarettes in your entire life?
    - ○ NO
    - ○ YES → GO TO QUESTION 15

15. How old were you when you first started smoking cigarettes on a regular basis?
    ☐ YEARS OLD

16. On the average, during the entire time you smoked, how many cigarettes did you smoke per day?
    ☐ CIGARETTES PER DAY

17. Do you smoke cigarettes now?
    - ○ NO
    - ○ YES → GO TO QUESTION 19

18. How old were you when you stopped smoking?
    ☐ YEARS OLD → GO TO DIET ASSESSMENT

19. On the average, about how many cigarettes a day do you currently smoke?
    ☐ CIGARETTES PER DAY

DIET ASSESSMENT

Eating habits are also an important part of your health picture. Please continue to fill in the circle of the answer you choose and follow the directional arrows.

PLEASE DO NOT MAKE ANY MARKS IN THE BOXES MARKED "OFFICE USE ONLY"

20. Do you regularly take multiple vitamins?
    - ○ NO
    - ○ YES → IF YES, a) HOW MANY DO YOU TAKE PER WEEK?
      - ○ 2 OR LESS
      - ○ 3-5
      - ○ 6-9
      - ○ 10 OR MORE
    - → b) WHAT SPECIFIC BRAND DO YOU USUALLY USE?
      Please Specify Brand ☐
    - → GO TO QUESTION 21

21. Not counting multiple vitamins, do you take any of the following preparations: (Please answer either "yes" or "no" for each of the following vitamins.)

a) VITAMIN A? ○ NO ○ YES, SEASONAL ONLY ○ YES, MOST MONTHS → IF YES, WHAT DOSE PER DAY?	○ LESS THAN 8,000 IU	○ 8,000 to 12,000 IU	○ 13,000 to 22,000 IU	○ 23,000 IU OR MORE	○ DON'T KNOW	
b) VITAMIN C? ○ NO ○ YES, SEASONAL ONLY ○ YES, MOST MONTHS → IF YES, WHAT DOSE PER DAY?	○ LESS THAN 400 mg.	○ 400 to 700 mg.	○ 750 to 1250 mg.	○ 1300 mg. OR MORE	○ DON'T KNOW	
c) VITAMIN D? ○ NO ○ YES → IF YES, WHAT DOSE PER DAY?	○ LESS THAN 200 IU	○ 200 to 400 mg.	○ 500 to 1000 mg.	○ MORE THAN 1000 IU	○ DON'T KNOW	
d) VITAMIN E? (alpha-tocopherol) ○ NO ○ YES → IF YES, WHAT DOSE PER DAY?	○ LESS THAN 100 IU	○ 100 to 250 IU	○ 300 to 500 IU	○ 600 IU OR MORE	○ DON'T KNOW	
e) SELENIUM? ○ NO ○ YES → IF YES, WHAT DOSE PER DAY?	○ LESS THAN 80 mcg.	○ 80 to 130 mcg.	○ 140 to 250 mcg.	○ 260 mcg. OR MORE	○ DON'T KNOW	
f) IRON? ○ NO ○ YES → IF YES, WHAT DOSE PER DAY?	○ LESS THAN 51 mg.	○ 51 to 200 mg.	○ 201 to 400 mg.	○ 401 mg. OR MORE	○ DON'T KNOW	
g) ZINC? ○ NO ○ YES → IF YES, WHAT DOSE PER DAY?	○ LESS THAN 25 mg.	○ 25 to 74 mg.	○ 75 to 100 mg.	○ 101 mg. OR MORE	○ DON'T KNOW	
h) CALCIUM? (Include Calcium in Dolomite) ○ NO ○ YES → IF YES, WHAT DOSE PER DAY?	○ LESS THAN 400 mg.	○ 400 to 900 mg.	○ 901 to 1300 mg.	○ 1301 mg. OR MORE	○ DON'T KNOW	

OFFICE USE ONLY 20b ⓪①②③④⑤⑥⑦⑧⑨ ⓪①②③④⑤⑥⑦⑧⑨ ⓪①②③④⑤⑥⑦⑧⑨ ⓪①②③④⑤⑥⑦⑧⑨

21. (CONTINUED)

i) ARE THERE OTHER SUPPLEMENTS THAT YOU TAKE ON A REGULAR BASIS? PLEASE MARK IF YES:

○ FOLIC ACID	○ B-COMPLEX VITAMINS	○ COPPER	○ IODINE	○ RUTIN
○ VITAMIN B6	○ CHROMIUM	○ MAGNESIUM	○ LECITHIN	○ BETA-CAROTENE

22. For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year. Be sure you fill in a circle for every food item listed.

DAIRY FOODS	AVERAGE USE LAST YEAR: NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
SKIM OR LOW FAT MILK (8 oz. GLASS)	○	○	○	○	○	○	○	○	○
WHOLE MILK (8 oz. GLASS)	○	○	○	○	○	○	○	○	○
CREAM, e.g. COFFEE, WHIPPED (TBS)	○	○	○	○	○	○	○	○	○
SOUR CREAM (TBS)	○	○	○	○	○	○	○	○	○
NON-DAIRY COFFEE WHITENER (tsp.)	○	○	○	○	○	○	○	○	○
SHERBET OR ICE MILK (½ CUP)	○	○	○	○	○	○	○	○	○
ICE CREAM (½ CUP)	○	○	○	○	○	○	○	○	○
YOGURT (1 CUP)	○	○	○	○	○	○	○	○	○
COTTAGE OR RICOTTA CHEESE (½ CUP)	○	○	○	○	○	○	○	○	○
CREAM CHEESE (1 oz.)	○	○	○	○	○	○	○	○	○
OTHER CHEESE, e.g. AMERICAN, CHEDDAR, etc., PLAIN OR AS PART OF A DISH (1 SLICE OR 1 oz. SERVING)	○	○	○	○	○	○	○	○	○
MARGARINE (PAT), ADDED TO FOOD OR BREAD; EXCLUDE USE IN COOKING	○	○	○	○	○	○	○	○	○
BUTTER (PAT), ADDED TO FOOD OR BREAD; EXCLUDE USE IN COOKING	○	○	○	○	○	○	○	○	○

Please try to average your seasonal use of foods over the entire year. For example, if a food such as cantaloupe is eaten 4 times a week during the approximate 3 months that it is in season, then the average use would be once per week.

FRUITS	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
RAISINS (1 oz. OR SMALL PACK) OR GRAPES	○	○	○	○	○	○	○	○	○
PRUNES (½ CUP)	○	○	○	○	○	○	○	○	○
BANANAS (1)	○	○	○	○	○	○	○	○	○
CANTALOUPE (¼ MELON)	○	○	○	○	○	○	○	○	○
WATERMELON (1 SLICE)	○	○	○	○	○	○	○	○	○
FRESH APPLES OR PEARS (1)	○	○	○	○	○	○	○	○	○
APPLE JUICE OR CIDER (SMALL GLASS)	○	○	○	○	○	○	○	○	○
ORANGES (1)	○	○	○	○	○	○	○	○	○
ORANGE JUICE (SMALL GLASS)	○	○	○	○	○	○	○	○	○
GRAPEFRUIT (½)	○	○	○	○	○	○	○	○	○
GRAPEFRUIT JUICE (SMALL GLASS)	○	○	○	○	○	○	○	○	○
OTHER FRUIT JUICES (SMALL GLASS)	○	○	○	○	○	○	○	○	○
STRAWBERRIES, FRESH, FROZEN OR CANNED (½ CUP)	○	○	○	○	○	○	○	○	○
BLUEBERRIES, FRESH, FROZEN OR CANNED (½ CUP)	○	○	○	○	○	○	○	○	○
PEACHES, APRICOTS OR PLUMS (1 FRESH, OR ½ CUP CANNED)	○	○	○	○	○	○	○	○	○

VEGETABLES	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
TOMATOES (1)	○	○	○	○	○	○	○	○	○
TOMATO JUICE (SMALL GLASS)	○	○	○	○	○	○	○	○	○
TOMATO SAUCE (½ CUP) e.g. SPAGHETTI SAUCE	○	○	○	○	○	○	○	○	○
RED CHILI SAUCE (1 TBS)	○	○	○	○	○	○	○	○	○
TOFU OR SOYBEANS (3-4 oz.)	○	○	○	○	○	○	○	○	○
STRING BEANS (½ CUP)	○	○	○	○	○	○	○	○	○
BROCCOLI (½ CUP)	○	○	○	○	○	○	○	○	○

22. (Continued) Please fill in your average use during the past year, of each specified food.

VEGETABLES (CONTINUE)	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
CABBAGE OR COLE SLAW (½ CUP)	○	○	○	○	○	○	○	○	○
CAULIFLOWER (½ CUP)	○	○	○	○	○	○	○	○	○
BRUSSELS SPROUTS (½ CUP)	○	○	○	○	○	○	○	○	○
CARROTS (1 WHOLE OR ½ CUP COOKED)	○	○	○	○	○	○	○	○	○
CORN (1 EAR OR ½ CUP FROZEN OR CANNED)	○	○	○	○	○	○	○	○	○
PEAS, OR LIMA BEANS (½ CUP FRESH, FROZEN, CANNED)	○	○	○	○	○	○	○	○	○
MIXED VEGETABLES (½ CUP)	○	○	○	○	○	○	○	○	○
BEANS OR LENTILS, BAKED OR DRIED (½ CUP)	○	○	○	○	○	○	○	○	○
YELLOW (WINTER) SQUASH (½ CUP)	○	○	○	○	○	○	○	○	○
EGGPLANT, ZUCCHINI, OR OTHER SUMMER SQUASH (½ CUP)	○	○	○	○	○	○	○	○	○
YAMS OR SWEET POTATOES (½ CUP)	○	○	○	○	○	○	○	○	○
SPINACH, COOKED (½ CUP)	○	○	○	○	○	○	○	○	○
SPINACH, RAW AS IN SALAD	○	○	○	○	○	○	○	○	○
KALE, MUSTARD OR CHARD GREENS (½ CUP)	○	○	○	○	○	○	○	○	○
ICEBERG OR HEAD LETTUCE (SERVING)	○	○	○	○	○	○	○	○	○
ROMAINE OR LEAF LETTUCE (SERVING)	○	○	○	○	○	○	○	○	○
CELERY (4" STICK)	○	○	○	○	○	○	○	○	○
MUSHROOMS (ONE) FRESH, COOKED, OR CANNED	○	○	○	○	○	○	○	○	○
BEETS (½ CUP)	○	○	○	○	○	○	○	○	○
ALFALFA SPROUTS (½ CUP)	○	○	○	○	○	○	○	○	○
GARLIC, FRESH OR POWDERED (1 CLOVE OR SHAKE)	○	○	○	○	○	○	○	○	○
GREEN OR CHILI PEPPERS (¼ CUP)	○	○	○	○	○	○	○	○	○

EGGS, MEATS, ETC.	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
EGGS (1)	○	○	○	○	○	○	○	○	○
CHICKEN OR TURKEY, WITH SKIN (4-6 oz.)	○	○	○	○	○	○	○	○	○
CHICKEN OR TURKEY, WITHOUT SKIN (4-6 oz.)	○	○	○	○	○	○	○	○	○
BACON (2 SLICES)	○	○	○	○	○	○	○	○	○
HOT DOGS (1)	○	○	○	○	○	○	○	○	○
PROCESSED MEATS, e.g. SAUSAGE, SALAMI, BOLOGNA, etc. (PIECE OR SLICE)	○	○	○	○	○	○	○	○	○
LIVER (3-4 oz.)	○	○	○	○	○	○	○	○	○
HAMBURGER (1 PATTY)	○	○	○	○	○	○	○	○	○
BEEF, PORK, OR LAMB AS A SANDWICH OR MIXED DISH, e.g. STEW, CASSEROLE, LASAGNE, etc.	○	○	○	○	○	○	○	○	○
BEEF, PORK, OR LAMB AS A MAIN DISH, e.g. STEAK, ROAST, HAM, etc. (4-6 oz.)	○	○	○	○	○	○	○	○	○
CANNED TUNA FISH (3-4 oz.)	○	○	○	○	○	○	○	○	○
DARK MEAT FISH, e.g. MACKEREL, SALMON, SARDINES, BLUEFISH, SWORDFISH (3-5 oz.)	○	○	○	○	○	○	○	○	○
OTHER FISH (3-5 oz.)	○	○	○	○	○	○	○	○	○
SHRIMP, LOBSTER, SCALLOPS AS A MAIN DISH	○	○	○	○	○	○	○	○	○

BREADS, CEREALS, STARCHES	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
COLD BREAKFAST CEREAL (1 CUP)	○	○	○	○	○	○	○	○	○
COOKED OATMEAL (1 CUP)	○	○	○	○	○	○	○	○	○
OTHER COOKED BREAKFAST CEREAL (1 CUP)	○	○	○	○	○	○	○	○	○
WHITE BREAD (SLICE), INCLUDING PITA BREAD	○	○	○	○	○	○	○	○	○
DARK BREAD (SLICE)	○	○	○	○	○	○	○	○	○
ENGLISH MUFFINS, BAGELS, OR ROLLS (1)	○	○	○	○	○	○	○	○	○
MUFFINS OR BISCUITS (1)	○	○	○	○	○	○	○	○	○
BROWN RICE (1 CUP)	○	○	○	○	○	○	○	○	○
WHITE RICE (1 CUP)	○	○	○	○	○	○	○	○	○
PASTA, e.g. SPAGHETTI, NOODLES, etc. (1 CUP)	○	○	○	○	○	○	○	○	○
OTHER GRAINS, e.g. BULGAR, KASHA, COUSCOUS, etc. (1 CUP)	○	○	○	○	○	○	○	○	○

22. (Continued) Please fill in your average use during the past year, of each specified food.

	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
BREADS (CONTINUED)									
PANCAKES OR WAFFLES (SERVING)	○	○	○	○	○	○	○	○	○
FRENCH FRIED POTATOES (4 oz.)	○	○	○	○	○	○	○	○	○
POTATOES, BAKED, BOILED (1) OR MASHED (1 CUP)	○	○	○	○	○	○	○	○	○
POTATO CHIPS OR CORN CHIPS (SMALL BAG OR 1 oz.)	○	○	○	○	○	○	○	○	○
CRACKERS, TRISKETS, WHEAT THINS (1)	○	○	○	○	○	○	○	○	○
PIZZA (2 SLICES)	○	○	○	○	○	○	○	○	○
Consider the serving size as 1 glass, bottle or can for these carbonated beverages. **CARBONATED BEVERAGES**	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
Low Calorie (sugar-free) types: LOW CALORIE COLA, e.g. TAB WITH CAFFEINE	○	○	○	○	○	○	○	○	○
Low Calorie (sugar-free) types: LOW CALORIE CAFFEINE-FREE COLA, e.g. PEPSI FREE	○	○	○	○	○	○	○	○	○
Low Calorie (sugar-free) types: OTHER LOW CALORIE CARBONATED BEVERAGE, e.g. FRESCA, DIET 7-UP, DIET GINGER ALE	○	○	○	○	○	○	○	○	○
Regular types (not sugar-free): COKE, PEPSI, OR OTHER COLA WITH SUGAR	○	○	○	○	○	○	○	○	○
Regular types (not sugar-free): CAFFEINE FREE COKE, PEPSI, OR OTHER COLA WITH SUGAR	○	○	○	○	○	○	○	○	○
Regular types (not sugar-free): OTHER CARBONATED BEVERAGE WITH SUGAR, e.g. 7-UP, GINGER ALE	○	○	○	○	○	○	○	○	○
OTHER BEVERAGES									
HAWAIIAN PUNCH, LEMONADE, OR OTHER NON-CARBONATED FRUIT DRINKS (1 GLASS, BOTTLE, CAN)	○	○	○	○	○	○	○	○	○
DECAFFEINATED COFFEE (1 CUP)	○	○	○	○	○	○	○	○	○
COFFEE (1 CUP)	○	○	○	○	○	○	○	○	○
TEA (1 CUP), NOT HERBAL TEAS	○	○	○	○	○	○	○	○	○
BEER (1 GLASS, BOTTLE, CAN)	○	○	○	○	○	○	○	○	○
RED WINE (4 oz. GLASS)	○	○	○	○	○	○	○	○	○
WHITE WINE (4 oz. GLASS)	○	○	○	○	○	○	○	○	○
LIQUOR, e.g. WHISKEY, GIN, etc. (1 DRINK OR SHOT)	○	○	○	○	○	○	○	○	○
SWEETS, BAKED GOODS, MISCELLANEOUS	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MO.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
CHOCOLATE (BARS OR PIECES) e.g. HERSHEY'S, M & M'S	○	○	○	○	○	○	○	○	○
CANDY BARS, e.g. SNICKERS, MILKY WAY, REESES	○	○	○	○	○	○	○	○	○
CANDY WITHOUT CHOCOLATE (1 oz.)	○	○	○	○	○	○	○	○	○
COOKIES, HOME BAKED (1)	○	○	○	○	○	○	○	○	○
COOKIES, READY MADE (1)	○	○	○	○	○	○	○	○	○
BROWNIES (1)	○	○	○	○	○	○	○	○	○
DOUGHNUTS (1)	○	○	○	○	○	○	○	○	○
CAKE, HOME BAKED (SLICE)	○	○	○	○	○	○	○	○	○
CAKE READY MADE (SLICE)	○	○	○	○	○	○	○	○	○
SWEET ROLL, COFFEE CAKE OR OTHER PASTRY, HOME BAKED (SERVING)	○	○	○	○	○	○	○	○	○
SWEET ROLL, COFFEE CAKE OR OTHER PASTRY, READY MADE (SERVING)	○	○	○	○	○	○	○	○	○
PIE, HOMEMADE (SLICE)	○	○	○	○	○	○	○	○	○
PIE, READY MADE (SLICE)	○	○	○	○	○	○	○	○	○
JAMS, JELLIES, PRESERVES, SYRUP, OR HONEY (1 TBS)	○	○	○	○	○	○	○	○	○
PEANUT BUTTER (TBS)	○	○	○	○	○	○	○	○	○
POPCORN (1 CUP)	○	○	○	○	○	○	○	○	○
NUTS (SMALL PACKET OR 1 oz.)	○	○	○	○	○	○	○	○	○
BRAN, ADDED TO FOOD (1 TBS)	○	○	○	○	○	○	○	○	○
WHEAT GERM (1 TBS)	○	○	○	○	○	○	○	○	○
CHOWDER OR CREAM SOUP (1 CUP)	○	○	○	○	○	○	○	○	○
OIL AND VINEGAR DRESSING, e.g. ITALIAN (1 TBS)	○	○	○	○	○	○	○	○	○
MAYONNAISE OR OTHER CREAMY SALAD DRESSING (1 TBS)	○	○	○	○	○	○	○	○	○
MUSTARD, DRY OR PREPARED (1 tsp)	○	○	○	○	○	○	○	○	○
SALT (1 SHAKE)	○	○	○	○	○	○	○	○	○
PEPPER (1 SHAKE)	○	○	○	○	○	○	○	○	○

23. What do you do with the visible fat on your meat?

- ◯ EAT MOST OF THE FAT
- ◯ EAT SOME OF THE FAT
- ◯ EAT AS LITTLE AS POSSIBLE
- ◯ (DON'T EAT MEAT)

24. What kind of fat do you usually use for frying and sautéing? (exclude "Pam"-type spray)

- ◯ REAL BUTTER
- ◯ MARGARINE
- ◯ VEGETABLE OIL
- ◯ VEGETABLE SHORTENING
- ◯ LARD

25. What kind of fat do you usually use for baking?

- ◯ REAL BUTTER
- ◯ MARGARINE
- ◯ VEGETABLE OIL
- ◯ VEGETABLE SHORTENING
- ◯ LARD

26. What form of margarine do you usually use?

- ◯ NONE
- ◯ STICK FORM
- ◯ TUB FORM
- ◯ DIET FORM (LOW CALORIE)

27. How often do you eat food that is fried at home? (exclude the use of "Pam"-type spray)

- ◯ DAILY
- ◯ 1-3 TIMES PER WEEK
- ◯ 4-6 TIMES PER WEEK
- ◯ LESS THAN ONCE A WEEK

28. How often do you eat fried food away from home? (e.g. french fries, fried chicken, fried fish)

- ◯ DAILY
- ◯ 1-3 TIMES PER WEEK
- ◯ 4-6 TIMES PER WEEK
- ◯ LESS THAN ONCE A WEEK

GO TO QUESTION 29

29. How many teaspoons of sugar do you add to your food each day? (Enter "0" if none.)

[ ] TEASPOONS

30. What type of cooking oil do you usually use?

[ ] TYPE AND BRAND

31. What kind of cold breakfast cereal do you usually use?

[ ] TYPE AND BRAND

32. What is the type of salt that you predominately use?

- ◯ NON-IODIZED SALT
- ◯ IODIZED SALT
- ◯ DON'T KNOW
- ◯ NEVER USE SALT

33. Are there any other important foods that you usually eat at least once per week?

Include for example: Paté, tortillas, yeast, cream sauce, custard, horseradish, parsnips, rhubarb, radishes, fava beans, carrot juice, coconut, avocado, mango, papaya, dried apricots, dates, figs.

(Do not include dry spices and do not list something that has been listed in the previous sections.)

OTHER FOODS THAT YOU USUALLY EAT AT LEAST ONCE PER WEEK	USUAL SERVING SIZE	SERVINGS PER WEEK
(a)		
(b)		
(c)		

DO NOT WRITE IN THIS AREA

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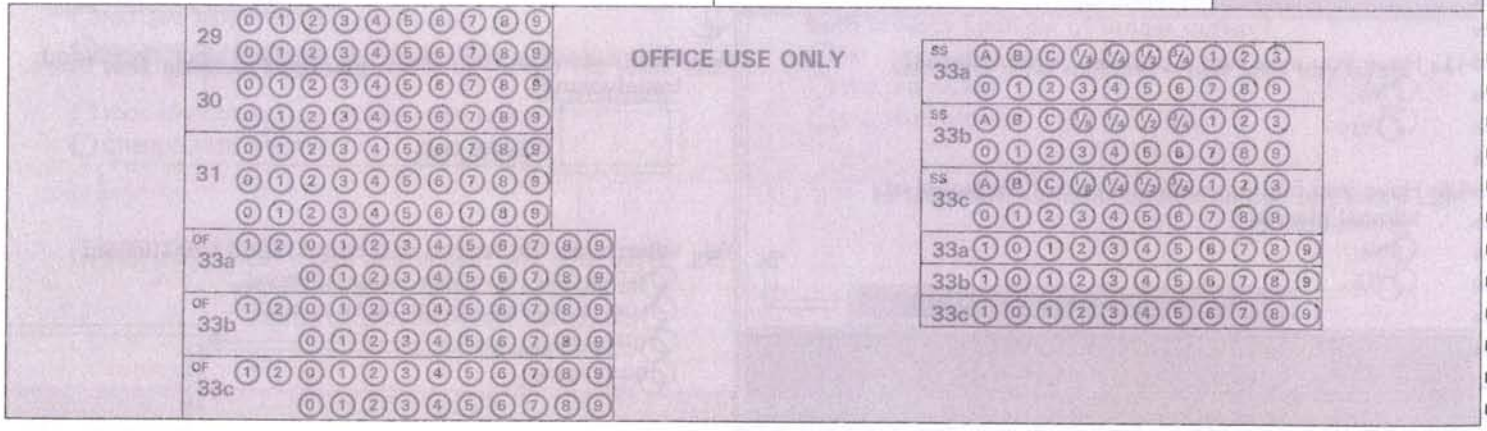

MEDICAL HISTORY

MEDICAL CONDITIONS

Please indicate, by filling in the circle, (either "no", "yes", or "not sure") if a physician has told you that you have any of the following conditions. In addition, please give your approximate age of diagnosis. It is very important that you mark an answer for each of the following questions, even if you have never had that condition.

HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE. . .

NO	YES	NOT SURE	IF "YES" AGE AT FIRST DIAGNOSIS	
○	○	○	☐ years old	34. SUGAR DIABETES (DIABETES MELLITUS)?
○	○	○	☐ years old	35. ADRENAL GLAND CONDITIONS (SUCH AS CUSHING'S DISEASE)?
○	○	○	☐ years old	36. BENIGN (NON-CANCEROUS) LUMPS OR CYSTS IN BREAST?
○	○	○	☐ years old	37. ENDOMETRIOSIS?
○	○	○	☐ years old	38. FIBROID (NON-CANCEROUS) TUMORS OF THE UTERUS (WOMB)?
○	○	○	☐ years old	39. POLYCYSTIC OVARIES (STEIN-LEVENTHAL SYNDROME)?
○	○	○	☐ years old	40. OTHER NON-CANCEROUS CYSTS OR TUMORS OF THE OVARY?

41. Have you ever had a problem with arthritis?
- ○ NO
- ○ YES

42. Have you had an adrenalectomy? (Removal of adrenal glands)
- ○ NO
- ○ YES

GO TO TOP OF NEXT COLUMN

OFFICE USE ONLY 49 ⓪①②③④⑤⑥⑦⑧⑨ ⓪①②③④⑤⑥⑦⑧⑨ 53 ①⓪①②③④⑤⑥⑦⑧⑨

Again, please indicate, by filling in the circle, (either "no", "yes", or "not sure") whether a physician has ever told you that you have any of the following conditions. It is very important that you mark an answer for each of the following questions even if you have never had that condition.

HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE. . .

NO	YES	NOT SURE	
○	○	○	43. HEART DISEASE OR ANGINA?
○	○	○	44. HEART ATTACK?
○	○	○	45. HIGH BLOOD PRESSURE (HYPERTENSION)?
○	○	○	46. RECTAL/COLON POLYPS?
○	○	○	47. CHRONIC COLITIS?
○	○	○	48. LIVER CIRRHOSIS OR OTHER CHRONIC LIVER DISEASE?

49. Have you ever been diagnosed by a physician as having any form of cancer, other than skin cancer?
- ○ NO
- ○ YES (Please Specify:) ☐

50. Since the age of 35, have you suffered a fracture (broken bone) of your upper arm, forearm, wrist, ribs, or hip which required treatment by a physician?
- ○ NO
- ○ YES

51. Have you ever received blood or had a blood transfusion?
- ○ NO → GO TO NEXT PAGE
- ○ YES
- ○ DONT KNOW → GO TO NEXT PAGE

52. How old were you when you received your first blood transfusion?

☐ YEARS OLD

53. What was the reason you had a blood transfusion?
- ○ BLOOD LOSS (for example, surgery or bleeding)
- ○ LOW BLOOD PRODUCTION DUE TO ILLNESS
- ○ OTHER (Please Specify:) → ☐
- ○ DONT KNOW

GYNECOLOGICAL HISTORY

Another important part of your health picture is your reproductive history. Although some of these questions may seem personal, each of the questions gives us information vital to constructing a statewide picture of Iowa women.

54. Have you ever had a menstrual cycle or period?
- ○ NO → GO TO QUESTION 63
- ○ YES

55. How old were you when you menstruated for the first time (had your first period)?

[ ] YEARS OLD

56. During your menstruating years, would you describe the occurence of your menstrual cycle as always regular, usually regular, or never regular? (By regular, we mean that the start of your period was predictable within 5 days.)
- ○ MY PERIODS WERE ALWAYS REGULAR.
- ○ MY PERIODS WERE USUALLY REGULAR.
- ○ MY PERIODS WERE NEVER REGULAR.

57. Did your menstrual bleeding usually last the same number of days for each period?
- ○ NO
- ○ YES

58. Do you currently have menstrual periods? That is, have you had a menstrual period within the last year?
- ○ NO
- ○ YES → GO TO QUESTION 62

59. How old were you when your periods stopped completely?

[ ] YEARS OLD

60. What was the reason your periods stopped? (SELECT ONLY ONE ANSWER)
- ○ NATURAL MENOPAUSE (CHANGE OF LIFE)
- ○ BECAUSE OF HYSTERECTOMY (EITHER UTERUS AND/OR OVARIES WERE SURGICALLY REMOVED)
- ○ TOOK MEDICATION THAT STOPPED YOUR PERIOD
- ○ OTHER (PLEASE SPECIFY:)

[ ]

61. Since your periods stopped, have you ever had any vaginal or uterine bleeding?
- ○ NO
- ○ YES

62. Do you think you are now going through menopause (the change of life)?
- ○ NO
- ○ YES

63. Have you ever had a D & C or any other endometrial biopsy of your womb, that is, a "scraping" or "cleaning out" of your womb?
- ○ NO → GO TO QUESTION 65
- ○ YES
- ○ DON'T KNOW → GO TO QUESTION 65

64. How many times have you had a D & C done?

[ ] TIMES

65. Has your uterus (womb) been surgically removed?
- ○ NO
- ○ YES
- ○ DON'T KNOW

66. Have your ovaries been surgically removed?
- ○ NO
- ○ YES - ONE OVARY
- ○ YES - BOTH OVARIES
- ○ DON'T KNOW

67. Have you ever had a breast biopsy, (including a needle biopsy or aspiration) to remove a small piece of breast tissue to see if cancer is present?
- ○ NO
- ○ YES

68. Have you had a mastectomy (surgical removal of a breast)?
- ○ NO
- ○ YES, ONE BREAST
- ○ YES, BOTH BREASTS

69. Have you ever had partial removal of either one or both breasts because of breast cancer?
- ○ NO
- ○ YES, ONE BREAST
- ○ YES, BOTH BREASTS

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PREGNANCY HISTORY

Now, a few questions about your pregnancy history.

70. Have you ever been pregnant? (Count live births, stillbirths, miscarriages, ectopic pregnancies, and induced abortions)

○ NO → GO TO QUESTION 78

○ YES

71. How many times have you been pregnant? (Include live births, stillbirths, miscarriages, ectopic pregnancies and induced abortions)

[ ] TIMES PREGNANT

72. Please fill in the following information for each time you were pregnant, regardless of its outcome.

A. First, record your age at the beginning of each pregnancy.
B. Then, record the number of months you were pregnant (to the nearest month).
C. Finally, record the pregnancy outcome, that is, if the pregnancy resulted in a:

- LIVE BIRTH OF ONE OR MORE CHILDREN
- STILLBIRTH (child born dead after five months or more of pregnancy)
- MISCARRIAGE (spontaneous loss of child before five months)
- ECTOPIC PREGNANCY
- INDUCED ABORTION

D. NOTE: Count multiple births (for example, twins or triplets) as one pregnancy.

Repeat steps A, B, and C for each time pregnant; as recorded in Question 71.

Pregnancy #1

A. Your Age at Beginning of Pregnancy #1 [ ] YEARS OLD

B. Number of Months Pregnant [ ] MONTHS

C. Pregnancy Outcome (Fill in only one circle)
○ LIVE BIRTH ○ MISCARRIAGE
○ STILLBIRTH ○ ECTOPIC
○ INDUCED ABORTION

Pregnancy #2

A. Your Age at Beginning of Pregnancy #2 [ ] YEARS OLD

B. Number of Months Pregnant [ ] MONTHS

C. Pregnancy Outcome (Fill in only one circle)
○ LIVE BIRTH ○ MISCARRIAGE
○ STILLBIRTH ○ ECTOPIC
○ INDUCED ABORTION

Pregnancy #3

A. Your Age at Beginning of Pregnancy #3 [ ] YEARS OLD

B. Number of Months Pregnant [ ] MONTHS

C. Pregnancy Outcome (Fill in only one circle)
○ LIVE BIRTH ○ MISCARRIAGE
○ STILLBIRTH ○ ECTOPIC
○ INDUCED ABORTION

Pregnancy #4

A. Your Age at Beginning of Pregnancy #4 [ ] YEARS OLD

B. Number of Months Pregnant [ ] MONTHS

C. Pregnancy Outcome (Fill in only one circle)
○ LIVE BIRTH ○ MISCARRIAGE
○ STILLBIRTH ○ ECTOPIC
○ INDUCED ABORTION

Pregnancy #5

A. Your Age at Beginning of Pregnancy #5 [ ] YEARS OLD

B. Number of Months Pregnant [ ] MONTHS

C. Pregnancy Outcome (Fill in only one circle)
○ LIVE BIRTH ○ MISCARRIAGE
○ STILLBIRTH ○ ECTOPIC
○ INDUCED ABORTION

Pregnancy #6

A. Your Age at Beginning of Pregnancy #6 [ ] YEARS OLD

B. Number of Months Pregnant [ ] MONTHS

C. Pregnancy Outcome (Fill in only one circle)
○ LIVE BIRTH ○ MISCARRIAGE
○ STILLBIRTH ○ ECTOPIC
○ INDUCED ABORTION

Pregnancy #7

A. Your Age at Beginning of Pregnancy #7 [ ] YEARS OLD

B. Number of Months Pregnant [ ] MONTHS

C. Pregnancy Outcome (Fill in only one circle)
○ LIVE BIRTH ○ MISCARRIAGE
○ STILLBIRTH ○ ECTOPIC
○ INDUCED ABORTION

Pregnancy #8

A. Your Age at Beginning of Pregnancy #8 ☐ YEARS OLD

B. Number of Months Pregnant ☐ MONTHS

C. Pregnancy Outcome (Fill in only one circle)

- ○ LIVE BIRTH
- ○ STILLBIRTH
- ○ MISCARRIAGE
- ○ ECTOPIC
- ○ INDUCED ABORTION

Pregnancy #9

A. Your Age at Beginning of Pregnancy #9 ☐ YEARS OLD

B. Number of Months Pregnant ☐ MONTHS

C. Pregnancy Outcome (Fill in only one circle)

- ○ LIVE BIRTH
- ○ STILLBIRTH
- ○ MISCARRIAGE
- ○ ECTOPIC
- ○ INDUCED ABORTION

Pregnancy #10

A. Your Age at Beginning of Pregnancy #10 ☐ YEARS OLD

B. Number of Months Pregnant ☐ MONTHS

C. Pregnancy Outcome (Fill in only one circle)

- ○ LIVE BIRTH
- ○ STILLBIRTH
- ○ MISCARRIAGE
- ○ ECTOPIC
- ○ INDUCED ABORTION

○ FILL IN HERE IF YOU HAVE BEEN PREGNANT MORE THAN 10 TIMES.

73. Please record the number of children to which you have given birth (live births only, enter "0" if none)

☐ BOYS ☐ GIRLS

IF NO LIVE BIRTHS, GO TO QUESTION 77

74. Of all the live births, how many occurred after your 30th birthday? (Enter "0" if none)

☐ BOYS ☐ GIRLS

75. Did you breast feed any of your children for more than one month?

- ○ NO → GO TO QUESTION 77
- ○ YES

76. How many of your children did you breast feed for more than one month?

☐ CHILDREN

77. Did you ever receive any drugs to prevent the secretion of milk, or lactation?

- ○ NO
- ○ YES

78. Did you ever try for one straight year or more to become pregnant and, during that time, not become pregnant?

- ○ NO → GO TO MEDICATIONS
- ○ YES

79. Did you or your husband ever visit a doctor, clinic, or hospital because you had a problem getting pregnant?

- ○ NO → GO TO MEDICATIONS
- ○ YES

80. What was the reason you had a problem getting pregnant?

- ○ PROBLEM WITH OVARIES
- ○ PROBLEM FALLOPIAN TUBES
- ○ PROBLEM WITH UTERUS/CERVIX
- ○ HUSBAND HAD FERTILITY PROBLEM
- ○ OTHER FERTILITY PROBLEM
- ○ NO PROBLEM WAS FOUND

MEDICATIONS

We can gain valuable information by knowing the medications you have taken and are now taking. Please fill in the appropriate circle.

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS. . .

NO	YES BUT NOT CURRENTLY	YES CURRENTLY	DON'T KNOW	
○	○	○	○	81. INSULIN?
○	○	○	○	82. Pills for SUGAR DIABETES (OR TO LOWER BLOOD SUGAR)?
○	○	○	○	83. Medication for an OVERACTIVE THYROID GLAND?
○	○	○	○	84. Medication for an UNDERACTIVE THYROID GLAND?
○	○	○	○	85. Medication to control EPILEPSY (CONVULSIONS OR SEIZURES)?

MEDICATIONS (continued)

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS. . .

NO	YES BUT NOT CURRENTLY	YES CURRENTLY	DON'T KNOW	
○	○	○	○	86. STIMULANTS (for example, Dexedrine, amphetamines, "uppers")?
○	○	○	○	87. TRANQUILIZERS (PILLS FOR NERVES) (for example, Valium or Librium)?
○	○	○	○	88. DIURETICS (WATER PILLS) (for example, thiazides, hydrochlorthiazides)?
○	○	○	○	89. BLOOD PRESSURE MEDICATION - other than diuretics?
○	○	○	○	90. SKIN CREAMS OR SKIN LOTIONS CONTAINING ESTROGEN or other female hormones?
○	○	○	○	91. Pills or shots containing STEROID HORMONES OTHER THAN ESTROGEN?
○	○	○	○	92. CANCER CHEMOTHERAPY - either intravenously, injections or pills?
○	○	○	○	93. WEIGHT LOSS PILLS or appetite suppressants prescribed by a doctor?
○	○	○	○	94. NON-PRESCRIPTION WEIGHT LOSS PILLS or appetite suppressants?

95. Have you ever taken BIRTH CONTROL PILLS (for either birth control or any other reason)?

- ○ NO, HAVE NEVER TAKEN → GO TO QUESTION 101
- ○ YES, CURRENTLY TAKING
- ○ YES, BUT NOT CURRENTLY TAKING

96. For how long did you take BIRTH CONTROL PILLS?

- ○ ONE MONTH OR LESS
- ○ 2-6 MONTHS
- ○ 7-12 MONTHS
- ○ 13 MONTHS-2 YEARS
- ○ 3-5 YEARS
- ○ MORE THAN 5 YEARS

97. How old were you when you first took BIRTH CONTROL PILLS?

[ ] YEARS OLD

98. Have you ever taken the SEQUENTIAL-TYPE OF BIRTH CONTROL PILL? (one color pill for about two weeks followed by another color for five or six days, for example, Norquen, C-Quen or Oracon)

- ○ NO → GO TO QUESTION 101
- ○ YES
- ○ DON'T KNOW → GO TO QUESTION 101

GO TO QUESTION 99

99. How old were you when you first started taking the SEQUENTIAL-TYPE OF BIRTH CONTROL PILL?

[ ] YEARS OLD

100. How long were you on the SEQUENTIAL-TYPE OF BIRTH CONTROL PILL?

- ○ ONE MONTH OR LESS
- ○ 2-6 MONTHS
- ○ 7-12 MONTHS
- ○ 13 MONTHS-2 YEARS
- ○ 3-5 YEARS
- ○ MORE THAN 5 YEARS

101. Have you ever used pills other than birth control pills which contain ESTROGEN OR OTHER FEMALE HORMONES (for example, at the change of life or menopause, after surgery, or at any other time)?

- ○ NO, HAVE NEVER TAKEN → GO TO FAMILY MEDICAL HISTORY
- ○ YES, CURRENTLY
- ○ YES, BUT NOT CURRENTLY

102. For how long did you take ESTROGENS OR OTHER FEMALE HORMONE PILLS (other than birth control pills)?

- ○ ONE MONTH OR LESS
- ○ 2-6 MONTHS
- ○ 7-12 MONTHS
- ○ 13 MONTHS-2 YEARS
- ○ 3-5 YEARS
- ○ MORE THAN 5 YEARS

FAMILY MEDICAL HISTORY

Now we are almost finished with your health picture. In this section, we wish to obtain medical information about living and deceased female members of your family. For this study we are interested only in your blood relatives -- that is, those who are your natural daughters, sisters, mother, and so-forth.

103. Was your mother ever diagnosed as having cancer?

- ○ NO → GO TO QUESTION 105
- ○ YES
- ○ DON'T KNOW → GO TO QUESTION 105

104. Which, if any, of these cancers did your mother ever have? (Fill in all that apply, even if she has died.)

- ○ BREAST CANCER
- ○ OVARIAN CANCER
- ○ CANCER OF THE UTERUS OR ENDOMETRIUM (LINING OF THE WOMB)
- ○ CANCER OF THE CERVIX
- ○ CANCER OF FEMALE REPRODUCTIVE ORGANS, BUT SPECIFIC SITE OF THE CANCER IS UNKNOWN
- ○ CANCER OF ANOTHER SITE

SITE IF KNOWN [ ]

- ○ CANCER, SITE UNKNOWN

105. Was your maternal grandmother (your mother's mother) ever diagnosed as having cancer?

- ○ NO → GO TO QUESTION 107
- ○ YES
- ○ DON'T KNOW → GO TO QUESTION 107

106. Which, if any, of these cancers did your maternal grandmother ever have? (Fill in all that apply, even if she has died.)

- ○ BREAST CANCER
- ○ OVARIAN CANCER
- ○ CANCER OF THE UTERUS OR ENDOMETRIUM (LINING OF THE WOMB)
- ○ CANCER OF THE CERVIX
- ○ CANCER OF FEMALE REPRODUCTIVE ORGANS, BUT SPECIFIC SITE OF THE CANCER IS UNKNOWN
- ○ CANCER OF ANOTHER SITE

SITE IF KNOWN [ ]

- ○ CANCER, SITE UNKNOWN

107. Was your paternal grandmother (your father's mother) ever diagnosed as having cancer?

- ○ NO → GO TO QUESTION 109
- ○ YES
- ○ DON'T KNOW → GO TO QUESTION 109

108. Which, if any of these cancers did your paternal grandmother ever have? (Fill in all that apply, even if she has died.)

- ○ BREAST CANCER
- ○ OVARIAN CANCER
- ○ CANCER OF THE UTERUS OR ENDOMETRIUM (LINING OF THE WOMB)
- ○ CANCER OF THE CERVIX
- ○ CANCER OF FEMALE REPRODUCTIVE ORGANS, BUT SPECIFIC SITE OF THE CANCER IS UNKNOWN
- ○ CANCER OF ANOTHER SITE

SITE IF KNOWN [ ]

- ○ CANCER, SITE UNKNOWN

109. Were any of your aunts (blood relatives only, that is your mother's or father's sisters) ever diagnosed as having cancer?

- ○ HAVE NO AUNTS → GO TO QUESTION 111
- ○ NO → GO TO QUESTION 111
- ○ YES
- ○ DON'T KNOW → GO TO QUESTION 111

GO TO QUESTION 110

110. Which of these cancers did any of your aunts (blood relatives only) ever have? Fill in all that apply.

- ○ BREAST CANCER
- ○ OVARIAN CANCER
- ○ CANCER OF THE UTERUS OR ENDOMETRIUM (LINING OF THE WOMB)
- ○ CANCER OF THE CERVIX
- ○ CANCER OF FEMALE REPRODUCTIVE ORGANS, BUT SPECIFIC SITE OF THE CANCER IS UNKNOWN
- ○ CANCER OF ANOTHER SITE
- ○ CANCER, SITE UNKNOWN

111. Were any of your natural sisters ever diagnosed as having cancer?

- ○ HAVE NO NATURAL SISTERS → GO TO QUESTION 113
- ○ NO → GO TO QUESTION 113
- ○ YES
- ○ DON'T KNOW → GO TO QUESTION 113

112. Which of these cancers did any of your natural sisters ever have? Fill in all that apply.

- ○ BREAST CANCER
- ○ OVARIAN CANCER
- ○ CANCER OF THE UTERUS OR ENDOMETRIUM (LINING OF THE WOMB)
- ○ CANCER OF THE CERVIX
- ○ CANCER OF FEMALE REPRODUCTIVE ORGANS, BUT SPECIFIC SITE OF THE CANCER IS UNKNOWN
- ○ CANCER OF ANOTHER SITE
- ○ CANCER, SITE UNKNOWN

113. Were any of your daughters ever diagnosed as having cancer?

- ○ HAVE NO DAUGHTERS → GO TO QUESTION 115
- ○ NO → GO TO QUESTION 115
- ○ YES
- ○ DON'T KNOW → GO TO QUESTION 115

114. Which of these cancers did any of your daughters ever have?

- ○ BREAST CANCER
- ○ OVARIAN CANCER
- ○ CANCER OF THE UTERUS OR ENDOMETRIUM (LINING OF THE WOMB)
- ○ CANCER OF THE CERVIX
- ○ CANCER OF FEMALE REPRODUCTIVE ORGANS, BUT SPECIFIC SITE OF CANCER IS UNKNOWN
- ○ CANCER, SITE UNKNOWN
- ○ CANCER OF ANOTHER SITE

Please specify other sites:

1. _____
2. _____
3. _____
4. _____

OFFICE USE ONLY 114 [0 0 0 0 / 1 1 1 1 / 2 2 2 2 / 3 3 3 3 / 4 4 4 4 / 5 5 5 5 / 6 6 6 6 / 7 7 7 7 / 8 8 8 8 / 9 9 9 9]

OFFICE USE ONLY 104 [0 1 2 3 4 5 6 7 8 9] [0 1 2 3 4 5 6 7 8 9]
106 [0 1 2 3 4 5 6 7 8 9] [0 1 2 3 4 5 6 7 8 9]
108 [0 1 2 3 4 5 6 7 8 9] [0 1 2 3 4 5 6 7 8 9]

To complete your health picture, the following section asks about your background characteristics.

115. Which of the following groups best describes your racial or ethnic background?

- ○ WHITE, NOT OF HISPANIC ORIGIN
- ○ BLACK, NOT OF HISPANIC ORIGIN
- ○ HISPANIC
- ○ AMERICAN INDIAN OR ALASKAN NATIVE
- ○ ASIAN OR PACIFIC ISLANDER

116. What is your birth date?

(Enter numbers please) ___ / ___ / ___

MONTH DAY YEAR

117. How many years of school have you completed? (Fill in only one)

- ○ 1-8 YEARS (GRADE SCHOOL)
- ○ 9-12 YEARS (HIGH SCHOOL), BUT DID NOT GRADUATE
- ○ HIGH SCHOOL GRADUATE
- ○ VOCATIONAL EDUCATION BEYOND HIGH SCHOOL
- ○ SOME COLLEGE, BUT NOT COLLEGE GRADUATE
- ○ COLLEGE GRADUATE
- ○ GRADUATE SCHOOL

118. What is your current religious preference?

- ○ PROTESTANT
- ○ CATHOLIC
- ○ JEWISH
- ○ EASTERN ORTHODOX (GREEK OR RUSSIAN)
- ○ MORMON
- ○ SEVENTH DAY ADVENTIST
- ○ OTHER

We are requesting your Social Security Number and the name of a close friend or relative because it would be helpful in locating your whereabouts if we need to contact you in the future.

119. What is your Social Security Number?

___ - ___ - ___

○ MARK HERE IF YOU DO NOT HAVE A SOCIAL SECURITY NUMBER.

120. Please provide the name, address and telephone number of a close friend or relative who does not live with you, but will always know your whereabouts:

NAME _____

STREET/RR _____

CITY _____

STATE _____ ZIP CODE _____

TELEPHONE NO. _____ - _____

AREA CODE PHONE NUMBER

What is this person's relationship to you?

_____

OFFICE USE ONLY 120 ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

121. If we need additional information or for clarification of your answers, we may need to contact you by telephone. What is your telephone number?

___ - ___ - ___

AREA CODE PHONE NUMBER

○ MARK HERE IF YOU HAVE NO PHONE.

122. What is your current marital status?

- ○ NEVER MARRIED → GO TO QUESTION 125
- ○ CURRENTLY MARRIED
- ○ SEPARATED OR DIVORCED
- ○ WIDOWED

123. What was your maiden name? (If your current last name is the same as your maiden name, enter it as your maiden name.)

_____

124. How old were you when you were married for the first time? ___ YEARS OLD

125. What is your current employment status? (Fill in all that apply.)

- ○ EMPLOYED
- ○ HOMEMAKER
- ○ RETIRED
- ○ DISABLED, UNABLE TO WORK
- ○ UNEMPLOYED
- ○ STUDENT
- ○ OTHER

126. What kind of work have you usually done most of your life? (Fill in only one)

- ○ HOMEMAKER, NOT EMPLOYED OUTSIDE THE HOME
- ○ PROFESSIONAL, ADMINISTRATOR, OR EXECUTIVE (For example: teacher, doctor, lawyer, RN, bank officer, office manager or sales/retail manager)
- ○ CLERICAL WORK, ADMINISTRATIVE SUPPORT, SALES OR TECHNICIANS (For example: office workers, sales clerks or supervisors, lab technicians, LPN's, legal assistants, bookkeepers)
- ○ CRAFTS, TRADES, FACTORY WORK, SERVICE OR LABOR (For example: restaurant workers, hair stylist, seamstress, baker)
- ○ FARMER, FARM WORKER
- ○ NEVER WORKED
- ○ OTHER (Please Specify)

_____

127. Do you live:

- ○ ON A FARM
- ○ RURAL AREA, BUT NOT A FARM
- ○ CITY OR TOWN, POPULATION UNDER 1,000
- ○ CITY OR TOWN, POPULATION 1,000-2,499
- ○ CITY OR TOWN, POULATION 2,500-10,000
- ○ CITY OR TOWN, POPULATION OVER 10,000

128. Are you now a permanent resident of Iowa?

- ○ NO
- ○ YES

You have now completed all the health history and background sections. All that remains is the section on body measurements.

BODY MEASUREMENTS

INSTRUCTIONS

1. Measure and record the distance around five body areas: your torso, buttocks, upper right arm, right wrist, and right calf.

2. Measurements should be made in one session and at least two hours after a meal.

3. Measurements should be made while either unclothed or in minimal clothing, such as underwear. You must be standing for measurements of the torso, buttocks, and arm.

4. Because it is difficult to make body measurements by oneself, we ask that you make the measurements with the help of a spouse, relative, or close friend. Stand in front of a mirror to help position the measuring tape.

5. Take a look at the enclosed measuring tape. The tape is marked on one side in inches and the other side in centimeters (smaller numbers from 1 to 152). We will be using the inches scale. To make a measurement, apply the tape end that starts with 1 inch to the body part and encircle it as described.

6. Two measurements of each body area will be recorded to the nearest quarter inch. We ask for two measurements to assure accuracy and consistency. If accurately made, the two measurements should agree within one half inch of each other. If not, take a third measurement and record the closest two measurements in the boxes provided.

7. To record a measurement, enter the numbers in the boxes provided. Round the measurement up to the next quarter inch if the measurement falls between quarter inch markings. Accuracy is very important.

8. The important points for accurate measurement are:

   a) Careful location of the correct site to be measured.

   b) Pulling the measuring tape snug (but not indenting the skin) so it does not slide.

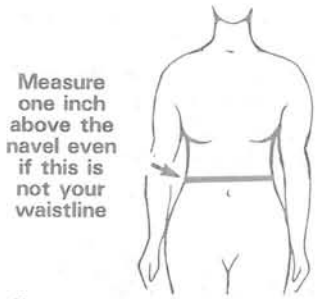
   c) Assuring the tape is horizontal all of the way around the body part during measurement.

   d) Careful recording of the results in the boxes provided.

129. TORSO

1. This measurement should be taken while you are standing (do not slouch) and breathing quietly, with the torso unclothed (a close-fitting slip can be worn). DO NOT WEAR A GIRDLE OR PANTYHOSE during this measurement.

2. Measure the torso at a point one inch above the navel ("belly button"), EVEN IF THIS IS NOT YOUR USUAL WAISTLINE. Be sure the tape is applied snugly but not tight, and that it is horizontal.



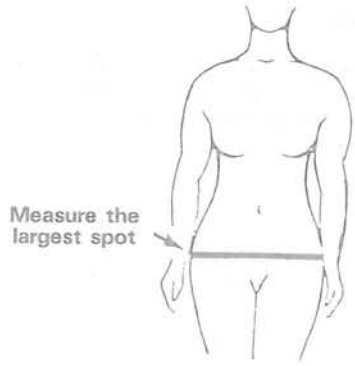
3. Record your first measurement to the nearest quarter inch. Release the tape measure and make a second remeasurement. If accurately made, the two measurements should agree within one half inch of each other. If the measurements are not within one half inch of each other, take a third measurement and record the closest two measurements in the boxes provided.

First Measurement ☐ Inches Second Measurement ☐ Inches

130. BUTTOCKS

1. The buttocks should be measured with you standing either unclothed or wearing close fitting underwear. Do not wear a girdle or pantyhose.

2. Slide the tape up and down until you find the largest spot between your waist and thighs. When sliding the tape to the correct spot be sure it is kept horizontal.



3. Record your measurements to the nearest quarter inch.

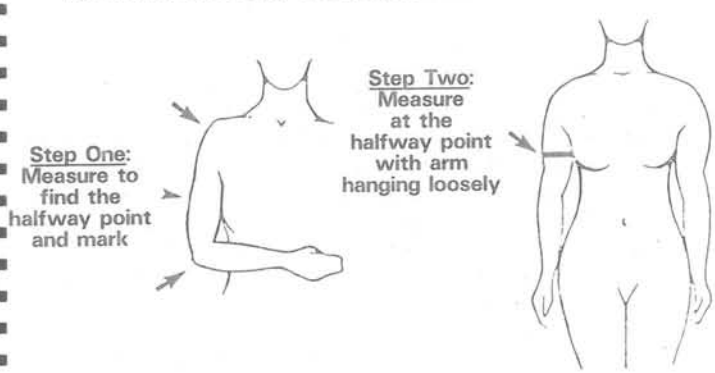
First Measurement ☐ Inches Second Measurement ☐ Inches

131. UPPER RIGHT ARM

1. The right upper arm should be measured. The left arm should be used only if the right arm is absent or disabled.

2. With the upper arm unclothed, the measuring partner should find the sharp outer angle of the shoulder and the tip of the elbow (determined with the arm bent at the elbow). Measure the distance between these two points, and make a light mark at the halfway point on the arm.

3. To measure, allow the arm to hang loosely. Wrap the measuring tape arond the arm at the point where it has been marked. The tape should be applied snugly-not so tight that it indents the skin but not so loosely that it can slide. Be sure that the tape is horizontal, as shown in the figure.



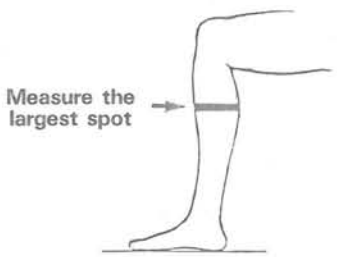
4. Record the measurements to the nearest quarter inch in the boxes below.

First Measurement ☐ Inches Second Measurement ☐ Inches

132. RIGHT CALF

1. The calf should be measured while you are seated, with both feet on the floor and the lower right leg bare. The left leg should be used only if the right leg is absent or disabled.

2. Measure the largest part of the right calf. Start at the middle of the calf muscle and slide the tape up or down until you find the largest spot between your knee and ankle.



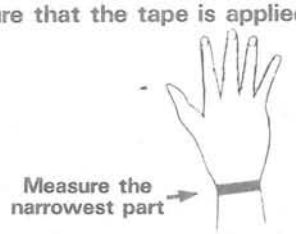
3. Record your measurements to the nearest quarter inch.

First Measurement ☐ Inches Second Measurement ☐ Inches

133. RIGHT WRIST

1. Your right wrist should be measured. The left wrist should be used only if the right wrist is absent or disabled. We recommend that another person help with this measurement.

2. Measure the wrist at the narrowest point. To find this, slide the tape until you find the smallest reading. Be sure that the tape is applied snugly.



3. Record your measurements to the nearest quarter inch.

First Measurement ☐ Inches Second Measurement ☐ Inches

134. Which of the following describes you? (choose one)

- ◯ RIGHT HANDED
- ◯ LEFT HANDED
- ◯ AMBIDEXTROUS (can work equally on all tasks with either the right or left hand)

135. What would be your ideal weight if you had complete control of the matter?

☐ Pounds

136. Would you say, in general, your health is:

- ◯ EXCELLENT
- ◯ GOOD
- ◯ FAIR
- ◯ POOR

If you have completed all the sections YOU ARE NOW FINISHED. The tape measure is yours to keep. Please place the completed questionnaire in the postage-paid envelope provided, seal it, and mail it to us.

Thank you again for your time and cooperation. You have contributed greatly to research efforts on improving health.

UNIVERSITY OF IOWA
AND
UNIVERSITY OF MINNESOTA