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California Teachers Study A+

We Need Your Help!

- **Fill in today's date.**

Month ☐☐ – Day ☐☐ – Year ☐☐

- **Please enter your current phone numbers.**

Primary Phone: ○ Cell ○ Home ○ Work

☐☐☐ – ☐☐☐ – ☐☐☐☐

Secondary Phone: ○ Cell ○ Home ○ Work

☐☐☐ – ☐☐☐ – ☐☐☐☐

MARKING INSTRUCTIONS

- No. 2 pencil (preferred) or blue or black ink pen only.
- Bubble completely.
- No stray marking.

Correct: ○ ○ ○ ●

Wrong:

E-mail: ______________________

- **Is there an error in your name or address at the left?**

○ **No** ○ **Yes (Please write the correct information)**

Name: ______________________

Street: ______________________

City: ______________ **State:** ______ **Zip:** ______

- **Maiden Name:** (or other last name) ______________________

- **In the event that we cannot reach you, is there someone else who is not living with you whom we could contact who would know how to get in touch with you? If so, please provide their contact information below.**

Name: ______________________

Street: ______________________

City: ______________ **State:** ______ **Zip:** ______

Phone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

E-mail: ______________________

California Teachers Study Beckman Research Institute of City of Hope
1500 E Duarte Rd Building 173, Suite 119 Duarte, CA 91010 (800) 568-9471

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SERIAL #

The following questions will ask you about your health and the health of your family, medications you use, and your daily life.

By completing this questionnaire, you are helping California Teachers Study researchers understand the causes of cancer and other diseases that affect women's health. Thank you for your participation!

1. All in all, how happy are you these days?
   ◯ Very happy ◯ Somewhat happy ◯ Not very happy

PHYSICAL ACTIVITY

2. During the **PAST 3 YEARS**, what was the average number of hours per week and average number of months per year that you did **STRENUOUS** exercise or sports (such as swimming laps, aerobics, calisthenics, cycling on hills, aerobic dancing, or running)?

Average Hours Per Week										Average Months Per Year			
None	½ hour	1 hour	1 ½ hours	2 hours	3 hours	4-6 hours	7-10 hours	11+ hours	Don't Know	1-3 months	4-6 mos	7-9 mos	10-12 months
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

3. During the **PAST 3 YEARS**, what was the average number of hours per week and average number of months per year that you did **MODERATE** exercise or sports (such as golf, volleyball, cycling on level streets, recreational tennis, ballroom dancing, jogging or walking for exercise)?

Average Hours Per Week										Average Months Per Year			
None	½ hour	1 hour	1 ½ hours	2 hours	3 hours	4-6 hours	7-10 hours	11+ hours	Don't Know	1-3 months	4-6 mos	7-9 mos	10-12 months
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

SOCIAL CONNECTION

4. How often do you feel...	Hardly ever (or never)	Some of the time	Often
that you lack companionship?	◯	◯	◯
left out?	◯	◯	◯
isolated from others?	◯	◯	◯

HEALTH CONDITIONS

5. Have you had a colonoscopy or sigmoidoscopy in the last 10 years?
   A colonoscopy examines the entire colon. Patients are often sedated during this procedure.
   A sigmoidoscopy examines the rectum and lower part of the colon. These exams are typically done without sedation.

	Yes, for screening	Yes, for symptoms	No
Colonoscopy	◯	◯	◯
Sigmoidoscopy	◯	◯	◯

6. If yes, how old were you at your most recent exam?

Age at most recent exam	
Colonoscopy AGE [ ][ ]	Sigmoidoscopy AGE [ ][ ]

7. Have you had a chest x-ray in the last 3 months?
   ◯ Yes, one x-ray ◯ Yes, more than one x-ray ◯ No ◯ Don't know

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8. Has a health professional ever told you that you had any of the conditions listed below? For each mark "Yes" or "No" as appropriate.

Condition	Yes	No	Have you EVER taken medication for this condition? Yes	No	Are you CURRENTLY taking medication for this condition? Yes	No
Arthritis: Osteoarthritis	○	○	○	○	○	○
Arthritis: Rheumatoid arthritis	○	○	○	○	○	○
Asthma	○	○	○	○	○	○
Chronic fatigue syndrome	○	○	○	○	○	○
Diabetes Type 2 ("Type 2 Diabetes")	○	○	○	○	○	○
Deep vein thrombosis (DVT)	○	○	○	○	○	○
Depression	○	○	○	○	○	○
High cholesterol	○	○	○	○	○	○
Hypertension / high blood pressure	○	○	○	○	○	○
Inflammatory bowel disease or Crohn's disease	○	○	○	○	○	○
Kidney disease (not kidney stones)	○	○	○	○	○	○
Kidney stones	○	○	○	○	○	○
Migraines	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○
Parkinson's disease	○	○	○	○	○	○
Periodontal disease or gum disease / gingivitis	○	○	○	○	○	○
Psoriasis	○	○	○	○	○	○
Shingles	○	○	○	○	○	○
Sleep apnea	○	○	○	○	○	○
Any other kind of sleep disorder, including but not limited to: restless leg syndrome, REM sleep behavior disorder, narcolepsy, cataplexy, chronic circadian disorder	○	○	○	○	○	○

MEDICATIONS

9. Do you currently take any of the following medications regularly, that is, at least once a week? PLEASE MARK ALL THAT APPLY.

- ○ Acetaminophen (e.g., Aspirin-free Excedrin, Tylenol, Tempra)
- ○ Aspirin or aspirin-containing product (e.g., Bayer, Bufferin, Excedrin)
- ○ 'Baby' or low-dose aspirin
- ○ Cox-2 inhibitor (e.g., Celebrex)
- ○ Ibuprofen (e.g., Advil, Motrin)
- ○ Naproxen, ketoprofen, meloxicam or other non-steroidal (e.g., Aleve, Feldene, Indocin, Naprosyn, Orudis, Relafen, Mobic)
- ○ Prescription pain medication with an opiate and acetaminophen such as hydrocodone with acetaminophen or oxycodone with acetaminophen (e.g., Vicodin, Percocet)
- ○ An antidepressant medication (e.g., fluoxetine (Prozac), paroxetine (Paxil, Brisdelle), sertraline (Zoloft), citalopram (Celexa), escitalopram (Lexapro), duloxetine (Cymbalta), bupropion (Wellbutrin), trazodone (Oleptro), or imipramine (Tofranil)
- ○ Metformin (Glucophage)
- ○ None of the above

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MEDICATIONS CONTINUED

10. **Do you currently take any of the following statin medications?**
Statin medications include lovastatin (Mevacor), atorvastatin (Lipitor), rosuvastatin (Crestor), pravastatin (Pravachol), simvastatin (Zocor), and fluvastatin (Lescol).
◯ Yes, regularly (daily for at least 2 months) ◯ Yes, but not regularly ◯ No

FAMILY HISTORY

Immediate family members include your biological mother, father, sister, brother, daughter, or son.

11. **Have any of your immediate family members ever been diagnosed with lung cancer?**
◯ Yes ◯ No ◯ Don't know

12. **If yes, who was diagnosed with lung cancer? PLEASE MARK ALL THAT APPLY.**
◯ My mother ◯ My sister ◯ My daughter
◯ My father ◯ My brother ◯ My son

13. **Have any of your immediate family members ever been diagnosed with colorectal cancer?**
◯ Yes ◯ No ◯ Don't know

14. **If yes, who was diagnosed with colorectal cancer? PLEASE MARK ALL THAT APPLY.**
◯ My mother ◯ My sister ◯ My daughter
◯ My father ◯ My brother ◯ My son

15. **Have any of your immediate family members ever been diagnosed with breast cancer?**
◯ Yes ◯ No ◯ Don't know

16. **If yes, who was diagnosed with breast cancer? PLEASE MARK ALL THAT APPLY.**
◯ My mother ◯ My sister ◯ My daughter
◯ My father ◯ My brother ◯ My son

GENETIC TESTING

Some individuals have had genetic testing to look for inherited changes in their normal genes. Genetic testing for inherited cancer is normally performed on a blood or saliva sample. This type of testing is different than looking for genetic changes in cancer cells.

17. **Have you ever had genetic testing of your normal cells to look for inherited cancer (e.g., BRCA1/BRCA2, Lynch Syndrome)?**
◯ Yes ◯ No

18. **If yes, what was the result of your genetic test?**
If you have had multiple genetic tests, please give the result of your most recent genetic test.
◯ No mutations were identified ◯ A mutation was identified ◯ Don't know

BODY SIZE

19. **How much do you CURRENTLY weigh?** [ ][ ][ ] *pounds*

20. **What is your CURRENT height?** [ ] *feet* [ ][ ] *inches*

SLEEP

Please mark one response for each question.	Yes	No
21. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	◯	◯
22. Do you often feel tired, fatigued, or sleepy during daytime?	◯	◯
23. Has anyone observed you stop breathing during your sleep?	◯	◯

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SLEEP CONTINUED

24. In the last two weeks, have you had difficulty falling asleep, staying asleep or waking up too early?
   - ◯ Yes
   - ◯ No (go to question **31**)

25. Please rate the severity of your insomnia problem(s):

	None	Mild	Moderate	Severe	Extreme
Difficulty falling asleep	◯	◯	◯	◯	◯
Difficulty staying asleep	◯	◯	◯	◯	◯
Problem waking up too early	◯	◯	◯	◯	◯

26. How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied	Satisfied	Moderately satisfied	Dissatisfied	Very dissatisfied
◯	◯	◯	◯	◯

27. To what extent do you consider your sleep problem to interfere with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?

Not at all interfering	A little interfering	Somewhat interfering	Much interfering	Very much interfering
◯	◯	◯	◯	◯

28. How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all noticeable	A little noticeable	Somewhat noticeable	Much noticeable	Very much noticeable
◯	◯	◯	◯	◯

29. How worried/distressed are you about your current sleep problem?

Not at all worried	A little	Somewhat	Much	Very much worried
◯	◯	◯	◯	◯

30. Have you experienced the sleep problems reported above at least three nights a week for a month or longer?
   ◯ Yes ◯ No

WATER

31. During your usual adult life, please indicate how much you typically drink the following beverages. Only include those drinks that were made with household tap water.

	1 a day	2 a day	3 a day	4 a day	5 a day	6+ a day	Occasionally, i.e., not every day	Drank but don't know how much	Never
A glass of water	◯	◯	◯	◯	◯	◯	◯	◯	◯
A cup of coffee	◯	◯	◯	◯	◯	◯	◯	◯	◯
A cup of hot tea	◯	◯	◯	◯	◯	◯	◯	◯	◯
A glass of iced tea	◯	◯	◯	◯	◯	◯	◯	◯	◯

32. During your usual adult life, on average, how many baths or showers did you take per week in your home? Please enter a number between 0 and 21. ☐☐ *baths/showers*

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WATER CONTINUED

33. What is the primary source of drinking water at your current home?
- ◯ Municipal water (including both filtered and unfiltered water)
- ◯ Private well (including both filtered and unfiltered water)
- ◯ Bottled water
- ◯ Other water source (please specify): ______________________
- ◯ Don't know

34. Is the tap water that you use for drinking or cooking in your current home filtered or treated in the home to remove chemicals and minerals? This includes filtering pitchers like Brita or PUR but does NOT include water softeners.
- ◯ Yes, using a filter like Brita or PUR in a pitcher or on a faucet
- ◯ Yes, filtered water from my refrigerator
- ◯ Yes, using reverse osmosis (under sink or whole house)
- ◯ Yes, filtered with another type of filter (under sink or whole house)
- ◯ Yes, other (please specify): ______________________
- ◯ No
- ◯ Don't know

35. In what year did you move into your current home? YEAR [ ][ ][ ][ ]

RESIDENCY, MARITAL STATUS, AND EMPLOYMENT

36. Have you lived outside of California since 2012?
- ◯ Yes
- ◯ No

37. If yes, were you a resident of California on December 31st in each of the following years?

2012	2013	2014	2015	2016	2017
◯ Yes	◯ Yes	◯ Yes	◯ Yes	◯ Yes	◯ Yes
◯ No	◯ No	◯ No	◯ No	◯ No	◯ No

38. What is your current marital status?
- ◯ Married or living with partner
- ◯ Divorced
- ◯ Separated
- ◯ Widowed
- ◯ Never Married

39. What is your current employment status? PLEASE MARK ALL THAT APPLY.
- ◯ Currently employed in public, charter, or private schools
- ◯ Other employment
- ◯ Not currently working, but planning to re-enter the work force
- ◯ Homemaker
- ◯ Unable to work
- ◯ Retired

FINANCIAL STRESS

40. How worried are you right now about...

	Very worried	Moderately worried	Not too worried	Not worried at all	Prefer not to answer	Don't know
Not having enough money for retirement	◯	◯	◯	◯	◯	◯
Not being able to pay medical costs of a serious illness or accident	◯	◯	◯	◯	◯	◯

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FINANCIAL STRESS CONTINUED

41. In the past 12 months, did you or anyone in your household have problems paying, or were unable to pay, any medical bills? Please include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care.
   - ◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know

42. Do you or does anyone in your household currently have any medical bills that are being paid off over time? This could include medical bills being paid off with a credit card, through personal loans, or bill-paying arrangements with hospitals or other providers. The bills can be from earlier years as well as this year.
   - ◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know

43. Do you or does anyone in your household currently have any medical bills that you are unable to pay at all?
   - ◯ Yes ◯ No ◯ Prefer not to answer ◯ Don't know

44. What is your household's current annual income from all sources?
   - ◯ Less than $25,000
   - ◯ $25,000 to $49,999
   - ◯ $50,000 to $74,999
   - ◯ $75,000 to $99,999
   - ◯ $100,000 to $149,999
   - ◯ $150,000 to $199,999
   - ◯ $200,000 or more

45.	None	1	2	3	4	5	6	7+
How many people, **including yourself**, are supported by this income?		◯	◯	◯	◯	◯	◯	◯
How many are under the age of 18?	◯	◯	◯	◯	◯	◯	◯	◯
How many are over the age of 64?	◯	◯	◯	◯	◯	◯	◯	◯

MEDICINAL CANNABIS

In 1996, Proposition 215 legalized the personal use of medicinal cannabis and marijuana in California.

The following questions ask about the use of medicinal cannabis/marijuana and its health implications. We understand that opinions on medicinal marijuana may vary. If you would prefer not to answer these questions, please mark "Prefer not to answer" on the next question.

46. Have you ever used cannabis for medical purposes?
   - ◯ Yes ◯ No (Skip to Q49) ◯ Prefer not to answer (Skip to Q49)

47. If yes, the last time you used cannabis for medicinal purposes, how did you consume it?
   - ◯ Smoking
   - ◯ Vaporizing
   - ◯ Eating
   - ◯ Drinking
   - ◯ Cream
   - ◯ Other
   - ◯ Prefer not to answer

48. If yes, listed below are common reasons why people use cannabis for medicinal purposes. Please mark the most important reasons you have used medicinal cannabis.
   - ◯ To relieve anxiety or panic
   - ◯ To relieve pain
   - ◯ To improve sleep
   - ◯ To relax
   - ◯ Other
   - ◯ As a substitute for prescription medication

SEXUAL ORIENTATION

Research shows that individuals have unique health needs based on their sexual orientation and gender identity. We are asking the following questions to better understand those health experiences.

If you would prefer not to answer these questions, please mark "Prefer not to answer."

49. Which of the following best represents how you think of yourself?
   - ◯ Straight
   - ◯ Lesbian or gay
   - ◯ Bisexual
   - ◯ Other
   - ◯ Don't know/Not sure
   - ◯ Prefer not to answer

50. Which sex were you assigned at birth?
   - ◯ Female ◯ Male ◯ Intersex ◯ Prefer not to answer

51. Please mark the gender identity that best describes you currently:
   - ◯ Female ◯ Male ◯ Transgender ◯ Intersex ◯ Other ◯ Prefer not to answer

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MENOPAUSAL HORMONE THERAPY

52. Have you used prescription female hormones since 2012? Please do not include oral contraceptives.
- ◯ Yes
- ◯ No

53. If yes, which of the following types of female hormones did you use since **2012**?
PLEASE MARK ALL THAT APPLY.

◯ **Pills**

What type of female hormone pills?
- ◯ Oral conjugated estrogen (e.g., Premarin)
- ◯ Oral estradiol (e.g., Estrace)
- ◯ Progesterone/Progestin
- ◯ Combined (Estrogen + Progesterone in the same pill)

How many years in total did you use female hormone pills since 2012?
- ◯ Less than 1 year
- ◯ 1 year
- ◯ 2 years
- ◯ 3 years
- ◯ 4 years
- ◯ 5 years
- ◯ 6 years
- ◯ 7 years

Are you currently using female hormone pills?
- ◯ No
- ◯ Yes

When did you stop using pills? YEAR 2 0 __ __

◯ **Patches**

Are you currently using patches?
- ◯ Yes
- ◯ No

◯ **Vaginal estrogen creams or gels**

Are you currently using vaginal estrogen creams or gels?
- ◯ Yes
- ◯ No

MENOPAUSAL STATUS

54. Which of the following best describes your current menstrual status:
- ◯ My periods stopped on their own: I had natural menopause
- ◯ My periods stopped after surgery to remove my uterus or both ovaries
- ◯ My periods stopped after radiation or chemotherapy
- ◯ My periods stopped for another reason (please specify): ____________
- ◯ I began taking hormone therapy before my periods stopped and I am still taking hormone therapy
- ◯ I am still having regular menstrual periods
- ◯ I am perimenopausal, that is, I am still having menstrual periods but they are not regular (they are heavy, continuous, or not occurring monthly)
- ◯ I am not having regular menstrual periods because I am pregnant or breastfeeding

55. When was your last menstrual period? Please tell us the date *and* how old you were at the time. Please estimate if you do not remember the exact date or age:

MO __ __ YEAR __ __ __ __ *and* AGE __ __ *years* ◯ Don't know

Please now place your questionnaire in the mailing envelope and send it back to us.

Thank you for your participation.
You have made the California Teachers Study one of the preeminent studies of women's health.

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