Fall 97

California Teachers Study

Report Card

A+

A+

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Marking Instructions

- Answer each question as best as you can – estimate if you aren't sure.
- Use only a #2, ordinary pencil. **DO NOT USE PEN**
- Be certain to completely blacken in each of your answers, and erase completely if you make any changes.
- Do not make any other marks on this form.
- If you wish to make comments, please use a separate piece of paper.

Correct Mark ●

Incorrect Marks

1. Is there an error in your name or address at the left?

◯ No ◯ Yes (please write the correct information)

Name ____________________

Street ____________________

City ____________________ State ________ Zip ________

Phone # ____________________

General Health

2. During the last two years, were you hospitalized for an illness or did you have a surgical procedure?

◯ No
◯ Yes, for heart disease
◯ Yes, for cancer, (specify type) ____________________

____

◯ Yes, for other reason (specify) ____________________

____

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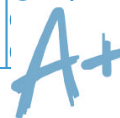
Secondhand Smoke

	AGE PERIOD					
	0-19	**20's**	**30's**	**40's**	**50's**	**60's+**
3. During each age period were you ever exposed to tobacco smoke from a household member (i.e. parent, spouse, roommate, etc.)?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
4. Who was this? (mark all that apply)	◯ Spouse ◯ Parent ◯ Other Household Member	◯ Spouse ◯ Parent ◯ Other Household Member	◯ Spouse ◯ Parent ◯ Other Household Member	◯ Spouse ◯ Parent ◯ Other Household Member	◯ Spouse ◯ Parent ◯ Other Household Member	◯ Spouse ◯ Parent ◯ Other Household Member
5. If YES, for how many years during this age period?	◯ < 6 years ◯ 6-10 years ◯ 11-15 years ◯ 16+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years
6. If YES, how many hours a day on average were you exposed to their tobacco smoke?	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours
7. If YES, on average how smoky was that household area?	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky

	0-19	**20's**	**30's**	**40's**	**50's**	**60's+**
8. Have you ever been exposed to the tobacco smoke of others in your workplace?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
9. If YES, for how many years during this age period?	◯ < 6 years ◯ 6-10 years ◯ 11-15 years ◯ 16+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years
10. If YES, how many hours a day on average were you exposed to the tobacco smoke of others?	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours
11. If YES, on average how smoky was your work area?	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky

	0-19	**20's**	**30's**	**40's**	**50's**	**60's+**
12. Have you been exposed to tobacco smoke in a non-work setting (for example, with friends, commuting, or in other social settings) for 2 or more hours a week on a regular basis?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
13. If YES, for how many years during this age period?	◯ < 6 years ◯ 6-10 years ◯ 11-15 years ◯ 16+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years	◯ < 1 year ◯ 1-3 years ◯ 4-6 years ◯ 7+ years
14. If YES, how many hours a week on average?	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours	◯ 2 hours or less ◯ 3-6 hours ◯ 7+ hours
15. If YES, on average how smoky was the area?	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky ◯ fairly smoky ◯ a little smoky	◯ very smoky	◯ very smoky	◯ very smoky	◯ very smoky



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Pregnancy Update

16. How many times have you been pregnant (live births and other pregnancies)?
◯ None (go to question 23) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 or more

17. Previously, you provided us with a history of all of your pregnancies to that date. Please indicate below information on any pregnancies that you have had since that last survey. (MARK ALL THAT APPLY)
◯ No pregnancy
◯ Live birth (single or multiple birth)
◯ Miscarriage
◯ Induced abortion
◯ Ectopic pregnancy
◯ Stillbirth (early fetal death)
◯ Currently pregnant

18. Considering all of your pregnancies, how many pregnancies did you have during which you experienced nausea or vomiting? ◯ None ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 or more

19. Considering any of those pregnancies during which you experienced nausea or vomiting, did you ever require treatment by your physician (by medication, intravenous fluids or hospitalization) for the nausea or vomiting?
◯ No (go to question 21) ◯ Yes

20. Did you require such treatment during your most recent pregnancy? ◯ No ◯ Yes

21. Again, considering ALL of your pregnancies, were you ever diagnosed with pre-eclampsia? [Note: pre-eclampsia is a condition that can occur during the second half of a pregnancy and is marked by elevated blood pressure, protein in the urine, and fluid retention by the mother.]
◯ No (go to question 23) ◯ Yes

22. Were you diagnosed with this condition during your most recent pregnancy? ◯ No ◯ Yes

X-rays and Radiation Treatment

23. How many times have you had any of the following types of x-rays before and after age 20?

	Before Age 20						After Age 20					
	None	1-4	5-9	10-14	15-19	20+	None	1-4	5-9	10-14	15-19	20+
Mammograms							◯	◯	◯	◯	◯	◯
X-rays for broken ribs or collar bones	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Chest or back x-rays as part of a routine physical exam	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Chest x-rays (for heart, lung or other problems)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Upper or Lower GI (gastrointestinal) series	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Spinal x-rays (for back and spine problems)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Intravenous Pyelograms (IVP) for kidney problems	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Fluoroscopy (x-ray which the doctor views while it is being performed) - do not include ultrasound	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
CT scan (of back or chest) - do not include MRI	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

24. Have you ever received radiation treatment for any medical condition (including cancer, scars, acne, birthmarks, thyroid problems, ring worm, tonsillitis, or respiratory problems such as tuberculosis)? - do not include UV (ultraviolet) or sunlamp treatment
◯ Yes ◯ No (go to question 26)

25. If yes, please record your age, the part of your body that was treated, and the total number of radiation treatments that you received for each condition for which you received treatment.

Condition 1			Condition 2			Condition 3		
Your Age	Part of Body	Number of Treatments	Your Age	Part of Body	Number of Treatments	Your Age	Part of Body	Number of Treatments
◯ 1-10	◯ Head/Neck	◯ 0-10	◯ 1-10	◯ Head/Neck	◯ 0-10	◯ 1-10	◯ Head/Neck	◯ 0-10
◯ 11-19	◯ Torso	◯ 11-19	◯ 11-19	◯ Torso	◯ 11-19	◯ 11-19	◯ Torso	◯ 11-19
◯ 20-50	◯ Limbs	◯ 20-30	◯ 20-50	◯ Limbs	◯ 20-30	◯ 20-50	◯ Limbs	◯ 20-30
◯ 51+		◯ 31+	◯ 51+		◯ 31+	◯ 51+		◯ 31+

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Diet Questions

26. We would like information on a few food items that were not included on the first survey.

These questions concern how often you usually ate/drank certain foods/beverages during the past year.

FIRST: Mark the column to show HOW OFTEN, on average, you ate the food.
SECOND: Mark the column to show HOW MUCH of each food you usually ate on the days you ate it.

FOOD/BEVERAGE	HOW OFTEN									HOW MUCH			
	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MON.	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4 PER DAY	5+ PER DAY	MEDIUM SERVING	YOUR SERVING SIZE S	M	L
Raisins	○	○	○	○	○	○	○	○	○	1/2 cup	S	M	L
Dried apricots	○	○	○	○	○	○	○	○	○	1/2 cup	S	M	L
Soybean sprouts or seeds	○	○	○	○	○	○	○	○	○	1/2 cup	S	M	L
Regular bean sprouts (**not** alfalfa or soybean sprouts)	○	○	○	○	○	○	○	○	○	1/2 cup	S	M	L
Canned chili (not homemade)	○	○	○	○	○	○	○	○	○	1 cup	S	M	L
Garbanzo beans, ceci beans, or chick peas	○	○	○	○	○	○	○	○	○	3/4 cup	S	M	L
Orange juice or grapefruit juice	○	○	○	○	○	○	○	○	○	6 oz. glass	4 oz.	6 oz.	8 oz.
Diet shakes, or nutritional supplements (such as Slim Fast, Sweet Sucess, Boost, etc.)	○	○	○	○	○	○	○	○	○	1 med. glass or can	5 oz.	8 oz.	10 oz.
Soy milk (including on cereal and in coffee or tea)	○	○	○	○	○	○	○	○	○	8 oz. glass	5 oz.	8 oz.	10 oz.
Coffee (regular or decaf)	○	○	○	○	○	○	○	○	○	1 med. cup	S	M	L
Tea (herbal or regular, hot or iced)	○	○	○	○	○	○	○	○	○	1 med. cup	S	M	L

Body Measurements

27. Please refer to the enclosed instruction page for taking body measurements. Follow the instructions on that page and record the measurements below. Please write in the measurements in the open blocks as well as fill in the appropriate bubbles below.

Waist measurements First		Waist measurements Second		Buttocks measurements First		Buttocks measurements Second	
0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9

Additional Information

28. Fill in today's date.

MO		DAY		YEAR
				○ 1997
				○ 1998
0	0	0	0	○ 1999
1	1	1	1	
	2	2	2	
	3	3	3	
	4		4	
	5		5	
	6		6	
	7		7	
	8		8	
	9		9	

29. In case we lose touch with you, please give us the name of someone NOT LIVING WITH YOU, who would know how to contact you.

Name ____________________

Street ____________________

City ____________________

State ____________________

Zip ____________________

Phone Number ____________________

Thanks from the California Teachers Study!!