2012-2013

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California Teachers Study

MARKING INSTRUCTIONS

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

Correct: ○ ○ ○ ●   **Wrong:** ⊗ ⊙ ⊘ ✓

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

MO		DAY		YEAR
				○ 2012
				○ 2013
0	0	0	0	○ 2014
1	1	1	1	○ 2015
	2	2	2	
	3	3	3	
	4		4	
	5		5	
	6		6	
	7		7	
	8		8	
	9		9	

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

Home: ☐☐☐ — ☐☐☐ — ☐☐☐☐

Cell: ☐☐☐ — ☐☐☐ — ☐☐☐☐

Work: ☐☐☐ — ☐☐☐ — ☐☐☐☐

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 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: ☐☐☐ — ☐☐☐ — ☐☐☐☐

California Teachers Study University of Southern California
1420 San Pablo Street Suite B105 Los Angeles CA 90089-9044 (800) 568-9471

DO NOT WRITE IN THIS AREA

SERIAL #

RESIDENCY, MARITAL STATUS, and EMPLOYMENT

	Less than a year	Number of years 1-4	5-9	10-14	15-19	20-29	30 or more
1. For how many years have you lived at your current residence?	◯	◯	◯	◯	◯	◯	◯

2. Were you a resident of California on December 31 in each of the following years?

2005	◯ No	◯ Yes	2007	◯ No	◯ Yes	2009	◯ No	◯ Yes	2011	◯ No	◯ Yes
2006	◯ No	◯ Yes	2008	◯ No	◯ Yes	2010	◯ No	◯ Yes	2012	◯ No	◯ Yes

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

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

SLEEP HABITS

The following questions relate to your **usual** sleep habits **during the past month only**. Your answers should indicate the most accurate reply for the majority of days and nights in the **past month**.

5. During the **past month**, how would you rate your sleep quality overall?
   ◯ Very Good ◯ Fairly Good ◯ Fairly Bad ◯ Very Bad

6. During the **past month**, on average how long has it usually taken you to fall asleep each night?
   ◯ Less than 15 minutes ◯ 16-30 minutes ◯ 31-60 minutes ◯ More than 60 minutes

7. During the **past month**, on average how many hours of actual sleep did you get each night?
   ◯ Less than 5 hours ◯ 5-6 hours ◯ 7 hours ◯ 8 hours ◯ 9 hours or more

8. During the **past month**, on average how often have you had trouble sleeping because you either couldn't fall asleep within a half hour or woke up in the middle of the night or early morning and had difficulty falling back to sleep?
   ◯ Not during the past month ◯ Less than 1 time/week ◯ 1-2 times/week ◯ 3 or more times/week

9. Are the sleep habits you reported above typical of your sleep habits in general:	No	Yes
Over the last year?	◯	◯
2-5 years ago?	◯	◯
6-10 years ago?	◯	◯
11 or more years ago?	◯	◯

10. During the **past month**, on average how often have you taken medicine (prescribed or "over the counter") to help you sleep (such as Tylenol PM, melatonin, Sleep-Ez, Ambien, or Lunesta)?
   ◯ Not during the past month ◯ Less than 1 time/week ◯ 1-2 times/week ◯ 3 or more times/week

11. One hears about "morning" and "evening" types of people. Which of these types did you consider yourself to be at different times in your life?	In your teens/ in college	In your 30's-40's	Now
Definitely a "morning" type	◯	◯	◯
More a "morning" than an "evening" type	◯	◯	◯
Neither a "morning" nor an "evening" type	◯	◯	◯
More an "evening" than a "morning" type	◯	◯	◯
Definitely an "evening" type	◯	◯	◯

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CURRENT LIFE EXPERIENCES

12. How often do you get colds, compared with other people your age?
   ◯ Less often ◯ About the same ◯ More often

13. On average, how many **hours** a week do you spend with at least one child under 5 years of age?
   ◯ Less than 1 ◯ 1-5 ◯ 6-10 ◯ 11-15 ◯ 16-20 ◯ More than 20

PHYSICAL ACTIVITY

14. During the **PAST YEAR**, what was your average total time per week spent on each of the following activities?

	Average Total Time Per Week										
	None	½ hour	1 hour	1 ½ hours	2-3 hours	4-6 hours	7-10 hours	11-20 hours	21-30 hours	31-39 hours	40+ hours
Standing or walking around at work or away from home	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Standing or walking around at home	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting at work	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting or driving in a car, bus or train	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting or reclining while watching television	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting or reclining while reading	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sitting for other reasons (playing games, working at a desk, sewing)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Participating in light-intensity activities such as shopping	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Walking, either for exercise or as part of your job activities	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Weight training exercise, such as at the gym	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

15. What is your normal walking pace?

Slow pace (Less than 2 mph)	Normal pace (2-2.9 mph)	Brisk pace (3-3.9 mph)	Very brisk pace (4 mph or faster)	Unable to walk
◯	◯	◯	◯	◯

16. 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	1-3 months	4-6 mos	7-9 mos	10-12 months
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

17. 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	1-3 months	4-6 mos	7-9 mos	10-12 months
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

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PHYSICAL ACTIVITY CONTINUED

18. The following items are about physical activities you might **CURRENTLY** do during a typical day. Does your health now limit you in these activities? If so, how much? (Mark one response on each line)

	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	○	○	○

DIET

19. Bitter tasting foods are described as unpleasant, sharp, or disagreeable. Do the following foods taste bitter to you when eaten **WITHOUT** butter or sugar?

	Yes, very bitter	Yes, a little bitter	No, not bitter	Do not eat/drink this food
Broccoli or cauliflower	○	○	○	○
Cabbage	○	○	○	○
Brussels sprouts or turnips	○	○	○	○
Collard greens or mustard greens	○	○	○	○
Zucchini	○	○	○	○
Asparagus	○	○	○	○
Grapefruit	○	○	○	○
Unsweetened chocolate	○	○	○	○
Dark chocolate	○	○	○	○
Tofu	○	○	○	○
Coffee	○	○	○	○
Beer	○	○	○	○
Unflavored soy milk	○	○	○	○
Unsweetened tonic water	○	○	○	○
Yellow mustard	○	○	○	○
Curry	○	○	○	○

MEDICATIONS

20. Do you **CURRENTLY** take any of the following medications regularly (at least once a week)?

	No or less than once per week	If yes, please indicate total tablets per week									
		1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-21	22-28	29+
'Baby' or low-dose aspirin	○	○	○	○	○	○	○	○	○	○	○
Aspirin or aspirin-containing product (e.g., Bayer, Bufferin, Excedrin)	○	○	○	○	○	○	○	○	○	○	○
Ibuprofen (e.g., Advil, Motrin)	○	○	○	○	○	○	○	○	○	○	○

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20 (*cont*). Do you **CURRENTLY** take any of the following medications regularly (at least once a week)?

	No or less than once per week	If yes, please indicate total tablets per week									
		1-2	3-4	5-6	7-8	9-10	11-12	13-14	15-21	22-28	29+
Naproxen, ketoprofen, meloxicam or other non-steroidal (e.g., Aleve, Feldene, Indocin, Naprosyn, Orudis, Relafen, Mobic)	○	○	○	○	○	○	○	○	○	○	○
Cox-2 inhibitor (e.g., Celebrex)	○	○	○	○	○	○	○	○	○	○	○
Acetaminophen (e.g., Aspirin-free Excedrin, Tylenol, Tempra)	○	○	○	○	○	○	○	○	○	○	○
Prescription pain medication with an opiate and acetaminophen such as hydrocodone with acetaminophen or oxycodone with acetaminophen (e.g., Vicodin, Percocet)	○	○	○	○	○	○	○	○	○	○	○

21. Do you **CURRENTLY** take any of the following statin medications?

	No	Yes, regularly (daily for at least 2 months)	Yes, but not regularly
Statin medications such as lovastatin (Mevacor), atorvastatin (Lipitor), rosuvastatin (Crestor), pravastatin (Pravachol), simvastatin (Zocor), fluvastatin (Lescol)	○	○	○

22. Have you **EVER** taken any of the following medications to prevent or treat osteoporosis?
Bisphosphonates (such as Boniva, Fosamax, Actonel, Aclasta, Atelvia, Reclast) or Raloxifene (Evista)

○ No (go to question **23**)　○ Don't know
○ Yes

Are you **CURRENTLY** taking any of the following medications to prevent or treat osteoporosis:	No	If yes, please indicate how many years you have taken the medication			
		Less than 1 year	1-2 years	3-4 years	5 or more years
Bisphosphonates (such as Boniva, Fosamax, Actonel, Aclasta, Atelvia, Reclast)	○	○	○	○	○
Raloxifene (Evista)	○	○	○	○	○

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ORAL CONTRACEPTIVES

23. We last asked you about your use of birth control pills (oral contraceptives) in the questionnaire mailed out in 2000. Since **January 2000**, have you used birth control pills (oral contraceptives) for one month or longer?

- ◯ No (go to question **25**)
- ◯ Yes but I am no longer taking them → How **OLD** were you when you stopped taking oral contraceptives? → AGE
- ◯ Yes and I am currently taking them

24. Since **January 2000**, how many **years in total** have you used birth control pills (exclude those time periods when you temporarily stopped)?

◯ Less than 1 year ◯ 1-2 ◯ 3-4 ◯ 5-9 ◯ 10 or more ◯ Don't know

MENSTRUAL PERIODS

25. 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			
0	0	1	0	0	0
1	1	2	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

and

AGE	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

years

◯ Don't know

26. 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; I have since stopped taking hormone therapy
- ◯ 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
- ◯ I am not having regular menstrual periods because I am breast-feeding (either with or without oral contraceptive use)

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MENOPAUSAL HORMONE THERAPY

27. Since **2005**, have you used prescription female hormones (Not including oral contraceptives):
- ◯ No (go to question **30**)
- ◯ Yes

a) How many years in total did you use hormones since **January 2005**?

◯ Less than 1 ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ 7 or more ◯ Don't know

b) If you used oral conjugated estrogen (e.g., Premarin) or oral estradiol (e.g., Estrace) since 2005, what dose did you usually take?

◯ Conjugated Estrogens		◯ Estradiol	
◯ 0.30 mg/day or less	◯ 0.45 mg/day	◯ 0.5 mg/day	◯ 1.0 mg/day
◯ 0.625 mg/day	◯ 0.9 mg/day	◯ 2.0 mg/day	◯ Unsure
◯ 1.25 mg/day	◯ Unsure		

c) If you used oral progesterone/progestin (e.g., Provera) since 2005, what dose did you usually take?

◯ 2.5 mg/day ◯ 5 mg/day ◯ 10 mg/day ◯ Unsure

28. Which of the following types of female hormones did you use since **2005** (MARK ANY THAT APPLY):

◯ **Pills**

What type of pills?
- ◯ Estrogen
- ◯ Progesterone/Progestin
- ◯ Combined (Estrogen + Progesterone in the same pill)

Are you currently using pills?
- ◯ Yes
- ◯ No → When did you stop using pills? YEAR 2 0 __ __

◯ **Patches**

What type of patch?
- ◯ Estrogen
- ◯ Combined (Estrogen + Progesterone in the same patch)

Are you currently using patches?
- ◯ Yes
- ◯ No → When did you stop using patches? YEAR 2 0 __ __

◯ **Vaginal estrogen creams or gels**

Are you currently using vaginal estrogen creams or gels?
- ◯ Yes
- ◯ No → When did you stop using vaginal estrogen creams or gels? YEAR 2 0 __ __

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

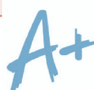
Combined: (pills)
- ◯ Prempro (beige)
- ◯ Prempro (gold)
- ◯ Prempro (peach)
- ◯ Prempro (light blue)
- ◯ Premphase (maroon & blue)
- ◯ Femhrt (white)

Combined: (patch)
- ◯ Combipatch
- ◯ Other combined (specify) ____________

Estrogen:
- ◯ Oral Premarin or conjugated estrogens
- ◯ Oral Estrace or estradiol
- ◯ Estrogen gels, creams, or sprays on skin
- ◯ Patch estrogen
- ◯ Vaginal estrogen creams or gels
- ◯ Other estrogen (specify) ____________

Progesterone/Progestin:
- ◯ Provera/Cycrin/medroxyprogesterone acetate
- ◯ Micronized (e.g., Prometrium)
- ◯ Other progesterone (specify) ____________

Other hormones you are **CURRENTLY** using (specify) ____________



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MENOPAUSAL HORMONE THERAPY CONTINUED

30. Have you **EVER** used bio-identical hormones (these are hormones from a compounding pharmacy)?
- ◯ No
- ◯ Yes

HEALTH

31. Has a health professional ever told you that you have diabetes?
- ◯ No
- ◯ Yes → ◯ Type I (also known as insulin-dependent diabetes or IDDM)
  - ◯ Type II (also known as non-insulin dependent diabetes or NIDDM)

a) How old were you when you were diagnosed? AGE [ ][ ]

b) Was your diabetes treated when you were first diagnosed?
- ◯ Not treated

Treated by (MARK ANY THAT APPLY): ◯ Diet ◯ Injection ◯ Metformin or Glucophage ◯ Another medication ◯ Other

c) How is your diabetes **CURRENTLY** treated?
- ◯ Not treated

Treated by (MARK ANY THAT APPLY): ◯ Diet ◯ Injection ◯ Metformin or Glucophage ◯ Another medication ◯ Other

d) Do you use a blood glucose kit to monitor your blood glucose levels?
◯ No ◯ Yes → ◯ More than once a day ◯ Usually once a day ◯ Only occasionally

e) Have you had your Hemoglobin A1C measured in the past six months?
◯ No ◯ Yes → Was it: ◯ Less than 6% ◯ Don't know ◯ 6% to less than 7% ◯ 7%-8% ◯ Over 8%

32. How often do you feel	Hardly ever (or never)	Some of the time	Often
That you lack companionship?	◯	◯	◯
Left out?	◯	◯	◯
Isolated from others?	◯	◯	◯

MEDICAL IMAGING

33. Have you ever had an **MRI**? An **MRI** is when you lie down and are placed in a narrow tube that might make you feel a little claustrophobic and makes a metallic "dinging" noise that sounds like a jack hammer.

		If yes, how many times?														
	Never had	Before 1990					Between 1990-1999					2000 or later				
		0	1-3	4-7	8-10	11+	0	1-3	4-7	8-10	11+	0	1-3	4-7	8-10	11+
Any MRI	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

34. Have you ever had a **CAT/PET scan**? A **CAT** or **CT** scan or **PET** scan is when you lie down on a table and move into and out of a big "donut"-shaped machine, which hums softly.

		If yes, how many times?														
Part of the body scanned	Never had	Before 1990					Between 1990-1999					2000 or later				
		0	1-3	4-7	8-10	11+	0	1-3	4-7	8-10	11+	0	1-3	4-7	8-10	11+
Head	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Neck	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Chest	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Spine	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Abdomen/pelvis	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Heart angiography	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

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MEDICAL SCREENING

35. Have you **EVER** had a screening mammogram?
- ◯ No (go to question **38**)
- ◯ Yes

36. When was your **LAST** screening mammogram?
- ◯ Less than 1 year ago
- ◯ 1-2 years ago
- ◯ 3 years ago
- ◯ 4 or more years ago
- ◯ Don't know

37. Over the last 10 years, on average, how often did you have a screening mammogram?
- ◯ Every year
- ◯ Every 2 years
- ◯ Every 3 years
- ◯ Other

38. Have you **EVER** had any of the following breast procedures: a fine needle aspiration (FNA), core biopsy, or surgical biopsy?
- ◯ No
- ◯ Yes →

If yes, were you told you had a diagnosis of Atypical Hyperplasia or Atypia?
- ◯ No
- ◯ Yes

At what **age** were you **first** told you had Atypical Hyperplasia or Atypia? → AGE [ ][ ]

39. Have you **EVER** had any of the following procedures?

	(Virtual) CT Colonoscopy	Colonoscopy	Sigmoidoscopy
No	◯	◯	◯
Yes, for screening	◯	◯	◯
Yes, for symptoms	◯	◯	◯
AGE at most recent exam	AGE [ ][ ]	AGE [ ][ ]	AGE [ ][ ]

40. If you had a colonoscopy or sigmoidoscopy, was the outcome of these procedures any of the following (MARK ANY THAT APPLY):
- ◯ Benign colon polyp
- ◯ Benign rectal polyp
- ◯ Colon or rectal cancer
- ◯ None of these
- ◯ Don't know

VITAMINS and SUPPLEMENTS

41. During the **PAST YEAR** have you taken any of the following supplements regularly (at least once a week)?	HOW OFTEN?				FOR HOW MANY YEARS?					
	Don't take	1-3 days/ week	4-6 days/ week	Every day	Less than 1 yr	1 yr	2 yrs	3-4 yrs	5-9 yrs	10+ yrs
Multi-vitamins	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

The following questions are about single supplements only (NOT the vitamins contained in multi-vitamin pills):	Don't take	1-3 days/ week	4-6 days/ week	Every day	Less than 1 yr	1 yr	2 yrs	3-4 yrs	5-9 yrs	10+ yrs
Vitamin B12	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Calcium and Vitamin D in combination	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Vitamin D3 (also known as cholecalciferol) as a separate supplement	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Calcium (including Tums, OsCal, etc.)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Niacin	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Omega-3 fatty acids (for example, fish oil, cod liver oil, flax seed oil)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Soy pills	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Chondroitin and/or Glucosamine	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

42. If you take vitamin D3 as a single supplement, how much vitamin D3 do you take each time you take it?
- ◯ 400 IU
- ◯ 800-1000 IU
- ◯ 2000 IU
- ◯ 4000 or more IU

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MEDICAL CONDITIONS

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

Condition	No	Yes	Don't know	If yes, how old were you when you were first told this? Less than 35 years	35-49 years	50-64 years	65-74 years	75+ years	Did you EVER take medication for this condition? No	Yes	Are you CURRENTLY taking medication for this condition? No	Yes
Hypertension												
Heart attack												
Stroke												
Deep venous thrombosis												
Chronic obstructive pulmonary disease (COPD)												
Osteoporosis												
Pneumonia												
Parkinson's disease												
Depression												
Shingles												
Ulcer												
Kidney stones												
Kidney disease (not kidney stones)												
Chronic fatigue syndrome												
Arthritis												
Osteoarthritis												
Rheumatoid arthritis												
Systemic Lupus Erythematosis (SLE or Lupus)												
Inflammatory bowel disease or Crohn's disease												
Multiple Sclerosis												
Psoriasis												

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BODY SIZE

44. How much do you **CURRENTLY** weigh? (if pregnant, please provide your weight before pregnancy)

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

pounds

45. Please find a flexible tape measure and measure your waist at a point **one inch above your navel** ("belly button") – even if this is not your usual waistline – and record the measurement here. If the measurement falls between inch markings, please round down to the nearest inch. If you don't have a flexible tape measure you can use a piece of string or ribbon which can then be measured with a ruler or metal tape measure.

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

inches

46. Have you lost height as you have aged?
○ No ○ Yes → ○ Less than 1 inch ○ 1 inch ○ 2 inches ○ 3 or more inches

47. Have you had gastric bypass or lap-band surgery?
○ No ○ Yes → ○ Lap-band ○ Roux-en-Y bypass ○ Other gastric bypass surgery

PERSONAL CARE PRACTICES

48. Do/did you ever:

		If yes: For how many **YEARS** total have you done this routinely?	For each age period, how often? When you were:	Never	Sometimes	Often	Always
a) Use facial creams/makeup with SPF (UV protection)?	○ Yes →	○ Under 1	Age <15 →	○	○	○	○
		○ 1-5	Ages 15-25 →	○	○	○	○
	○ No	○ 6-10	Ages 26-40 →	○	○	○	○
		○ 11-20	Ages 41-60 →	○	○	○	○
		○ 21+	Ages 61 and older →	○	○	○	○
b) Apply sunscreen when spending time in the sun?	○ Yes →	○ Under 1	Age <15 →	○	○	○	○
		○ 1-5	Ages 15-25 →	○	○	○	○
	○ No	○ 6-10	Ages 26-40 →	○	○	○	○
		○ 11-20	Ages 41-60 →	○	○	○	○
		○ 21+	Ages 61 and older →	○	○	○	○
c) Use a tanning bed or tanning booth?	○ Yes →	○ Under 1	Age <15 →	○	○	○	
		○ 1-5	Ages 15-25 →	○	○	○	
	○ No	○ 6-10	Ages 26-40 →	○	○	○	
		○ 11-20	Ages 41-60 →	○	○	○	
		○ 21+	Ages 61 and older →	○	○	○	
d) Apply nail polish on your fingernails or toenails?	○ Yes →	○ Under 1	Age <15 →	○	○	○	○
		○ 1-5	Ages 15-25 →	○	○	○	○
	○ No	○ 6-10	Ages 26-40 →	○	○	○	○
		○ 11-20	Ages 41-60 →	○	○	○	○
		○ 21+	Ages 61 and older →	○	○	○	○
e) Have artificial nails applied?	○ Yes →	○ Under 1	Age <15 →	○	○	○	
		○ 1-5	Ages 15-25 →	○	○	○	
	○ No	○ 6-10	Ages 26-40 →	○	○	○	
		○ 11-20	Ages 41-60 →	○	○	○	
		○ 21+	Ages 61 and older →	○	○	○	

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CHILDREN'S HEALTH HISTORY

49. Has a doctor or health professional ever told you or your child that your child had cancer or other common health conditions?

	Male Child	Female Child	Is this child still alive?		Current age or age at death	Has this child ever been diagnosed with cancer?	Age at child's **first** cancer diagnosis	Other conditions (MARK ANY THAT APPLY)						
			Yes	No				Asthma	Age at child's asthma diagnosis	Autism	Diabetes Type 1	Diabetes Type 2	Age at child's diabetes diagnosis
Child #1	○	○	○	○	☐☐	○ No ○ Yes (specify type) ____	☐☐	○	☐☐	○	○	○	☐☐
Child #2	○	○	○	○	☐☐	○ No ○ Yes (specify type) ____	☐☐	○	☐☐	○	○	○	☐☐
Child #3	○	○	○	○	☐☐	○ No ○ Yes (specify type) ____	☐☐	○	☐☐	○	○	○	☐☐
Child #4	○	○	○	○	☐☐	○ No ○ Yes (specify type) ____	☐☐	○	☐☐	○	○	○	☐☐
Child #5	○	○	○	○	☐☐	○ No ○ Yes (specify type) ____	☐☐	○	☐☐	○	○	○	☐☐
Child #6	○	○	○	○	☐☐	○ No ○ Yes (specify type) ____	☐☐	○	☐☐	○	○	○	☐☐
Child #7	○	○	○	○	☐☐	○ No ○ Yes (specify type) ____	☐☐	○	☐☐	○	○	○	☐☐
Child #8	○	○	○	○	☐☐	○ No ○ Yes (specify type) ____	☐☐	○	☐☐	○	○	○	☐☐

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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