the tomorrow PROJECT

Albertans Studying the Connection Between Lifestyle and Cancer

Survey 2004

This box contains your unique study number and gender

Date you joined the study:

Alberta Cancer Board

A research initiative of the Alberta Cancer Board

Office use only

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L	C	V	QA

Directions For Completing This Survey

- Survey 2004 may take about 30 to 40 minutes to answer.
- We appreciate you completing the survey. However, if you prefer not to answer a question, write 'Decline' beside it.
- Please use a pencil or a ballpoint pen. Do not use a felt pen.
- Shade in the bubbles completely, like this: ●
- Write numbers in boxes like this: | 2 | 1 |
- If you make an error, put an X through the incorrect bubble like this: 
- A tape measure is enclosed to take your body measurements on pages 16 and 17. Please report your measurements in feet, inches and pounds. The numbers will be changed to metric units at the study centre.
- Please leave the booklet stapled together - the pages will be separated at the study centre.
- Please take a moment before you return the questionnaire to complete the last 2 pages in the survey which ask for important information on how to keep in touch with you. We may need to contact you over the next few months to clarify some information.

Some questions ask you to update the information about your health **since you joined the study**, and will be indicated by the picture to the left. Please refer to the date you joined the study printed on the cover of this survey.

Other questions ask for new information about your health **throughout your lifetime**, and will be indicated by the picture to the left. Some of this information may be hard to recall, but make your best guess.

Not sure how to answer a question? Please feel free to contact us:

- Call our toll-free number from anywhere in Canada: 1.877.919.9292
- Call collect from outside Canada: 403.944.4122
- Email us at: tomorrow@cancerboard.ab.ca

We are interested in your feedback about the questionnaire and will use it to improve *The Tomorrow Project* for other participants.
Jot down your thoughts and suggestions on the back cover of this booklet.

Section **A**

The first section asks for information about your general health.

First, think about the time **since you joined the study**. (Refer to the date on the cover of this survey.)

S04_PHS_1
PHS 1 **Since you joined the study**, has a doctor told you that you have cancer? (Do not include skin cancer unless it was melanoma.)

○ Yes

○ No → Go to PHS 3

S04_PHS_2 S04_PHS_2_TYPE
PHS 2 What type of cancer? _____

S04_PHS_2_A_DATE
When was the cancer first diagnosed? (Approximate date) M M Y Y Y Y

S04_PHS_2_LOCA
Where was the cancer diagnosed? (Province or country) _____

Since you joined the study, has a doctor told you that you have any of the following conditions? (If you are not sure if you told us about the condition(s) in the last survey, mark the information again.)

		Yes	No
S04_PHS_3 PHS 3	High blood pressure	○	○
S04_PHS_4 PHS 4	Angina (chest pains from a heart problem)	○	○
S04_PHS_5 PHS 5	High cholesterol (fats, lipids) in your blood	○	○
S04_PHS_6 PHS 6	Heart attack	○	○
S04_PHS_7 PHS 7	Stroke	○	○
S04_PHS_8 PHS 8	Emphysema	○	○
S04_PHS_9 PHS 9	Chronic bronchitis	○	○
S04_PHS_10 PHS 10	Diabetes (not pregnancy-related)	○	○
S04_PHS_11 PHS 11	Polyps in your colon or rectum	○	○
S04_PHS_12 PHS 12	Ulcerative colitis	○	○
S04_PHS_13 PHS 13	Crohn's Disease	○	○
S04_PHS_14 PHS 14	Hepatitis	○	○
S04_PHS_15 PHS 15	Cirrhosis of your liver	○	○

Next, think about your **entire lifetime**.

During your lifetime, has a doctor ever told you that you have any of the following conditions?

		Yes	No
S04_PHS_16 PHS 16	Thyroid problems	○	○
S04_PHS_17 PHS 17	Arthritis	○	○
S04_PHS_18 PHS 18	Osteoporosis (thinning bones)	○	○
S04_PHS_19 PHS 19	Depression	○	○
S04_PHS_20 PHS 20	High blood sugar (not pregnancy-related) If you are diabetic, answer 'Yes'.	○	○

CHECKPOINT: Did you choose either 'Yes' or 'No' for all the questions above? (Choosing 'No', shows us that you haven't missed answering the question.)

Continue to think about your **entire lifetime**.

S04_PHS_21

PHS 21 Has a doctor ever told you that you have diabetes? (Do not include pregnancy-related diabetes that went away after the pregnancy ended.)

- ○ Yes
- ○ No → Go to Section B, page 5
- ○ Don't know (Please explain) _____ → Go to Section B, page 5

S04_PHS_22

PHS 22 How old were you when your diabetes was first diagnosed? ☐☐ Years of age

S04_PHS_23

PHS 23 Were you put on insulin injections as soon as your diabetes was diagnosed?

- ○ Yes
- ○ No
- ○ Don't know (Please explain) _____

S04_PHS_24

PHS 24 How do you currently control your diabetes? (Choose ALL that apply)

S04_PHS_24_1
S04_PHS_24_2
S04_PHS_24_3
S04_PHS_24_4

- ○ Diet
- ○ Physical activity
- ○ Pills or tablets
- ○ Insulin injections
- ○ Insulin pump
- ○ Other (Please specify) _____
- ○ I no longer have diabetes

S04_PHS_24_5
S04_PHS_24_6_OTHER
S04_PHS_24_7

Section B

Questions in this section ask how you feel about the risk of developing cancer and diabetes.

If you have ever been diagnosed with cancer, other than skin cancer, go to RPS 4.

S04_RPS_1

RPS 1 Compared to other people your age, what do you think are your chances of being diagnosed with cancer during your lifetime? (Do not include skin cancer, other than melanoma.)

○ 1	○ 2	○ 3	○ 4	○ 5
I am at much less risk than others				I am at much higher risk than others

S04_RPS_2

RPS 2 On a scale from 0% to 100%, what percentage of people your age in the general population do you think will be diagnosed with cancer in their lifetime?

S04_RPS_3 ____ **%**

RPS 3 On a scale from 0% to 100%, on which 0 means you definitely will not be diagnosed with cancer and 100 means you definitely will be diagnosed with cancer, what would you estimate to be your chance of being diagnosed with cancer in your lifetime?

____ **%**

** ** *

If you have ever been diagnosed with diabetes (not including pregnancy-related diabetes), go to Section C, page 6.

S04_RPS_4

RPS 4 Compared to other people your age, what do you think are your chances of being diagnosed with diabetes during your lifetime?

○ 1	○ 2	○ 3	○ 4	○ 5
I am at much less risk than others				I am at much higher risk than others

S04_RPS_5

RPS 5 On a scale from 0% to 100%, what percentage of people your age in the general population do you think will be diagnosed with diabetes in their lifetime?

____ **%**

S04_RPS_6

RPS 6 On a scale from 0% to 100%, on which 0 means you definitely will not be diagnosed with diabetes and 100 means you definitely will be diagnosed with diabetes, what would you estimate to be your chance of being diagnosed with diabetes in your lifetime?

____ **%**

Section C

This section updates information about screening tests you may have had **since you joined the study**. Refer to the date on the cover of this survey. If you are not sure if you told us about the tests in the last survey, please enter the information again.

S04_CCS_1

CSS 1 **Since you joined the study**, have you had a blood stool test?

A blood stool test is collected at home, not at a doctor's office, to look for hidden blood in your stool. You have a bowel movement and use a small stick to smear a sample on a special card. You usually collect samples three days in a row.

S04_CCS_1_DATE

- ○ Yes → In what year did you have your last blood stool test? Y Y Y Y
- ○ No → Go to CSS 3
- ○ Don't know → Go to CSS 3

S04_CCS_2

CSS 2 Why did you have the last blood stool test? (Choose ALL that apply)

S04_CCS_2_1
S04_CCS_2_2
S04_CCS_2_3
S04_CCS_2_4
S04_CCS_2_5
S04_CCS_2_6_OTHER

- ○ Family history of colon or rectal cancer
- ○ Part of regular checkup/routine screening
- ○ Age
- ○ Signs and symptoms of a possible problem
- ○ Follow-up of previous problem
- ○ Other (Please specify) _____

* * * * * *

S04_CCS_3

CSS 3 **Since you joined the study**, have you had a sigmoidoscopy?

A sigmoidoscopy is an exam in which a doctor inserts a flexible tube into the rectum and lower part of the colon (lower bowel) to look for signs of cancer or other problems. The procedure may be done in a doctor's office or clinic and does not usually require sedation.

- ○ Yes → In what year did you have your last sigmoidoscopy? Y Y Y Y
- ○ No → Go to CSS 5
- ○ Don't know → Go to CSS 5

S04_CCS_4

CSS 4 Why did you have the last sigmoidoscopy? (Choose ALL that apply)

S04_CCS_4_1
S04_CCS_4_2
S04_CCS_4_3
S04_CCS_4_4
S04_CCS_4_5
S04_CCS_4_6_OTHER

- ○ Family history of colon or rectal cancer
- ○ Part of regular checkup/routine screening
- ○ Age
- ○ Signs or symptoms of a possible problem
- ○ Follow-up of previous problem
- ○ Other (Please specify) _____

* * * * * *

S04_CCS_5

CSS 5 **Since you joined the study**, have you had a colonoscopy?

A colonoscopy is similar to a sigmoidoscopy but a longer tube is used to examine the entire colon. A colonoscopy is done in a clinic or hospital. Before the procedure is done, you are usually given medication through a needle in your arm to make you sleepy.

- ○ Yes → In what year did you have your last colonoscopy? Y Y Y Y
- ○ No → Go to CSS 7
- ○ Don't know → Go to CSS 7

S04_CCS_6

CSS 6 Why did you have the last colonoscopy? (Choose ALL that apply)

S04_CCS_6_1
S04_CCS_6_2
S04_CCS_6_3
S04_CCS_6_4
S04_CCS_6_5
S04_CCS_6_6_OTHER

- ○ Family history of colon or rectal cancer
- ○ Part of regular checkup/routine screening
- ○ Age
- ○ Signs or symptoms of a possible problem
- ○ Follow-up of previous problem
- ○ Other (Please specify) _____

S04_CCS_7

CSS 7 Recently, individuals have been able to pay for a "virtual colonoscopy" at private clinics in Alberta and elsewhere.

A "virtual colonoscopy" is a CAT scan of the colon that allows a radiologist to view the inner surface of the colon without having to insert a colonoscopy tube.

Have you ever had a "virtual colonoscopy"?

- ○ Yes, in Alberta → In what year? Y Y Y Y — S04_CCS_7_a_DATE
- ○ Yes, not in Alberta → In what year? Y Y Y Y — S04_CCS_7_b_DATE; In what province or country? _____ — S04_7_b_LOCA
- ○ No, I have never had one

WOMEN, GO TO SECTION E, PAGE 9

* * * * * *

Section D

This section is about a cancer screening test for men.
If you are FEMALE, go to Section E, page 9.

S04_PSA_1

PSA 1 **Since you joined the study**, have you had a Prostate Specific Antigen (PSA) test?

A PSA test is a specific blood test ordered by a doctor to test men for prostate cancer.

S04_PSA_1_DATE

- ○ Yes → In what year did you have your last PSA test? Y Y Y Y
- ○ No → Go to Section E, page 9
- ○ Don't know → Go to Section E, page 9

S04_PSA_2

PSA 2 Why did you have the last PSA test? (Choose ALL that apply)

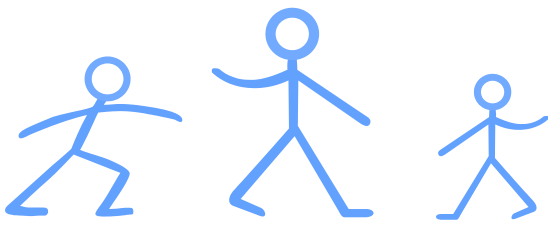
S04_PSA_2_1
S04_PSA_2_2
S04_PSA_2_3
S04_PSA_2_4
S04_PSA_2_5
S04_PSA_2_6_OTHER

- ○ Family history of prostate cancer
- ○ Part of regular checkup/routine screening
- ○ Age
- ○ Signs or symptoms of a possible problem
- ○ Follow-up of previous problem
- ○ Other (Please specify) _____

S04_PSA_3

PSA 3 Before sending you to a lab for the PSA blood test, did your doctor first feel your prostate by inserting a gloved finger in your rectum to check for prostate enlargement?

- ○ Yes
- ○ No
- ○ Don't know



Section **E**

This section asks about your exposure to the sun and other sources of ultraviolet (UV) light, such as tanning beds.

For these questions:

- A sunburn is any reddening or discomfort of your skin that lasts longer than 12 hours after exposure to the sun or other UV sources, such as tanning beds or sunlamps.
- A blistering sunburn means that fluid-filled bubbles form after exposure to the sun or UV light. This does not include times that your skin just peeled after sun exposure.

S04_SPS_1

SPS 1 After several months of not being in the sun, if you went out in the sun for **an hour** on a warm sunny day without sunscreen, a hat, or protective clothing, which of these things would happen to your skin? (If you do not go out in the sun, make your best guess of what would happen if you did.)

- ○ Get a severe sunburn with blisters
- ○ Have a severe sunburn for a few days with peeling
- ○ Burn mildly with some or no tanning
- ○ Turn darker without sunburn
- ○ Nothing would happen

S04_SPS_2

SPS 2 If you were out in the sun for a **long time repeatedly** (such as every day for two weeks) without sunscreen, a hat, or protective clothing, what would happen to your skin?

- ○ Very dark and deeply tanned
- ○ Moderately tanned
- ○ Mildly tanned
- ○ Only freckled or not tanned at all
- ○ Repeated sunburns

S04_SPS_3

SPS 3 What is the natural colour of your eyes?

- ○ Blue
- ○ Green
- ○ Hazel
- ○ Light Brown
- ○ Dark Brown
- ○ Other colour (Please specify) S04_SPS_3_OTHER _____

Now think about your **entire lifetime**. It may be difficult to recall some of the information, but please make your best guess.

S04_SPS_4

SPS 4 **During your lifetime**, did you ever have a blistering sunburn?

- ○ Yes → About how many blistering sunburns have you had in your life? S04_4_BURNS ☐☐ Blistering sunburns
- ○ No → Go to SPS 7
- ○ Don't know → Go to SPS 7

S04_SPS_5

SPS 5 How old were you the first time you got a blistering sunburn? ☐☐ Years of age

S04_SPS_6

SPS 6 How old were you the last time you got a blistering sunburn? ☐☐ Years of age

Next are some questions about your sun exposure in the **past 12 months**.

S04_SPS_7

SPS 7 In the **past 12 months**, have you used a sunlamp or tanning bed or booth to get a tan from artificial light?

○ Yes → How many times? S04_SPS_7_TIMES ☐☐☐ Times (Count each time you used a sunlamp, bed, or booth)

○ No

Think about times that you have been out in the sun in the **past 12 months** (working outdoors, taking part in recreational activities during the summer months or at high altitudes in the winter months, holidays at beaches or resorts, etc.).

When you were in the sun for 30 minutes or more, in the **past 12 months**, how often did you:

		Always	Often	Sometimes	Rarely	Never
S04_SPS_8 SPS 8	Seek shade?	○	○	○	○	○
S04_SPS_9 SPS 9	Wear a hat that shades your face, ears, and neck?	○	○	○	○	○
S04_SPS_10 SPS 10	Wear long pants or a long skirt specifically to protect yourself from the sun?	○	○	○	○	○
S04_SPS_11 SPS 11	Use sunscreen on your face?	○	○	○	○	○
S04_SPS_12 SPS 12	Use sunscreen on the rest of your body?	○	○	○	○	○

S04_SPS_13

SPS 13 In the **past 12 months**, if you used sunscreen on your face, what Sun Protection Factor (SPF) have you usually used?

○ I haven't used sunscreen on my face
○ Less than SPF 15
○ SPF 15 to 25
○ More than SPF 25
○ Don't know

S04_SPS_14

SPS 14 In the **past 12 months**, if you used sunscreen on the rest of your body, what Sun Protection Factor (SPF) have you usually used?

○ I haven't used sunscreen on my body
○ Less than SPF 15
○ SPF 15 to 25
○ More than SPF 25
○ Don't know

S04_SPS_15

SPS 15 In the **past 12 months**, if you used sunscreen, how often did you usually reapply it?

○ I haven't used sunscreen
○ Every hour
○ Every two hours
○ Every four hours
○ I don't usually reapply sunscreen after I put it on
○ Other (Please specify) _____

_____

This section updates information about cigarette smoking, and other types of tobacco use.

Section F

First, think about your **entire lifetime**.

S04_TOB_1

TOB 1 Have you smoked at least 100 cigarettes in your life? (About 4-5 packs in total)

- ○ Yes
- ○ No → Go to TOB 5
- ○ Don't know → Go to TOB 5

S04_TOB_2

TOB 2 Have you ever smoked more than one pack of cigarettes per day for one or more years? (More than 25 cigarettes per day)

- ○ Yes
- ○ No → Go to TOB 5
- ○ Don't know → Go to TOB 5

S04_TOB_3

TOB 3 For how many total years in your life did you smoke more than 25 cigarettes per day?

☐☐ Years

TOB 4 During the years that you smoked more than 25 cigarettes per day, on average, how many cigarettes did you usually smoke per day? (Your best guess)

S04_TOB_4

☐☐ Cigarettes per day

Now, think about the time **since you joined the study**. Refer to the date on the cover of the survey.

S04_TOB_5

TOB 5 **Since you joined the study**, did you smoke cigarettes daily for one month or more? (At least one cigarette every day for 30 days in a row)

- ○ Yes
- ○ No → Go to TOB 8
- ○ Don't know → Go to TOB 8

S04_TOB_6

TOB 6 **Since you joined the study**, for how many months did you smoke daily? (Do not include any months during which you may have quit.)

☐☐ Months

S04_TOB_7

TOB 7 **Since you joined the study**, how many cigarettes did you usually smoke while you were smoking daily?

☐☐ Cigarettes per day

S04_TOB_8

TOB 8 At the **present time**, do you smoke cigarettes daily, occasionally, or not at all?

- ○ Daily (At least one cigarette every day for the past 30 days)
- ○ Occasionally (At least one cigarette in the past 30 days, but not every day)
- ○ Not at all (No cigarettes at all in the past 30 days)

The following chart asks about your **lifetime** use of tobacco products other than cigarettes.

Please complete the row of answers for each type of tobacco listed below that you smoked at least once per week for six months or more.

Type of Tobacco Product	Did you ever smoke this product at least once per week for 6 months or more?	How many years did you smoke this product at least once per week?	How many did you smoke per week in total?	How often do you currently smoke this product? *
TOB 9 **Cigarillo**	○ Yes → ○ No → Go to TOB 10	☐☐ Years	☐☐ Cigarillos	○ Daily ○ Occasionally ○ Not at all
S04_TOB_9		S04_TOB_9_YEARS	S04_TOB_9_CIGARILLES	S04_TOB_9_FREQ
TOB 10 **Cigar**	○ Yes → ○ No → Go to TOB 11	☐☐ Years	☐☐ Cigars	○ Daily ○ Occasionally ○ Not at all
S04_TOB_10		S04_TOB_10_YEARS	S04_TOB_10_CIGARS	S04_TOB_10_FREQ
TOB 11 **Pipe**	○ Yes → ○ No → Go to TOB 12	☐☐ Years	☐☐ Pipes	○ Daily ○ Occasionally ○ Not at all
S04_TOB_11		S04_TOB_11_YEARS	S04_TOB_11_PIPES	S04_TOB_11_FREQ

*Daily: At least one cigarillo, cigar or pipe every day for the past 30 days
*Occasionally: At least one cigarillo, cigar or pipe in the past 30 days, but not every day
*Not at all: No cigarillos, cigars or pipes in the past 30 days.

The last questions are about spit tobacco (chewing tobacco and snuff) you used on a daily basis during your **entire lifetime**.

S04_TOB_12
TOB 12 **During your lifetime**, did you ever use spit tobacco daily for at least one year?

○ Yes
○ No → Go to Section G, page 13
○ Don't know → Go to Section G, page 13

S04_TOB_13
TOB 13 For how many years did you use some form of spit tobacco daily? (Do not include any periods during which you may have quit.)

☐☐ Years

S04_TBO_14
TOB 14 During the time you used spit tobacco daily, how many dips or chews did you usually use per day?

○ 1 to 5 dips or chews per day
○ 6 to 10 dips or chews per day
○ More than 10 dips or chews per day

This section asks about drinks of alcoholic beverages. Drinking alcohol has been linked to various types of chronic diseases, including cancer. Some research suggests alcohol is a risk factor, while other research suggests alcohol may protect against certain diseases. The questions below may be sensitive for some people, but your honest answers are appreciated.

Section G

In the following questions, the word "drink" includes store-bought and homemade alcohol and refers to:

- One 12-ounce bottle or can of beer, ale or lager or one glass of draft
- One 5-ounce glass of wine or sherry or one full wine cooler
- One drink or cocktail with 1.5 ounces of hard liquor or spirits (e.g. gin, vodka, scotch, rum, brandy, liqueurs etc.)

"On one day" means during one 24-hour period.

Think about drinking alcohol **throughout your lifetime**.

S04_ALC_1

ALC 1 Have you ever had a drink of wine, beer, liquor or anything containing alcohol even once? (Do not include small sips or alcohol used for religious purposes.)

○ Yes

○ No, I never drank alcohol → Go to Section H, page 15

S04_ALC_2

ALC 2 Not counting small sips, how old were you when you started drinking alcohol?

☐☐ Years of age

S04_ALC_3

ALC 3 Since you started drinking alcohol, for how many total years have you had at least one drink? (Do not include any years during which you did not drink any alcohol.)

☐☐ Years

Now think about drinking alcohol in the **past 12 months**.

S04_ALC_4

ALC 4 Do you currently drink alcohol? (At least one drink in the past 12 months)

○ Yes

○ No → Go to Section H, page 15

S04_ALC_5

ALC 5 In the **past 12 months**, how often did you usually drink alcohol of any type?

○ Less than once a month
○ Once a month
○ 2 to 3 times a month
○ Once a week
○ 2 to 3 times a week
○ 4 to 6 times a week
○ Everyday

S04_ALC_6

ALC 6 In the **past 12 months**, how many drinks did you usually have on each day that you drank?

○ 1 or 2 drinks
○ 3 or 4 drinks
○ 5 or 6 drinks
○ 7 or 8 drinks
○ 9 or 10 drinks
○ 11 or 12 drinks
○ More than 12 drinks

→ If more than 12, how many? ☐☐ Drinks

S04_ALC_6_DRINKS_MORE

The following chart asks about different kinds of alcohol you drank in the **past 12 months**. Please complete the answers for each type of alcohol.

Type of Alcohol	How often did you usually drink this type of alcohol in the past 12 months?	How many drinks did you usually have each day when you drank this type of alcohol in the past 12 months?
ALC 7 **Beer:** 12 ounce can or bottle S04_ALC_7	○ Never → Go to ALC 8 ○ Less than once a month ○ Once a month ○ 2 to 3 times a month ○ Once a week ○ 2 to 3 times a week ○ 4 to 6 times a week ○ Every day	○ 1 to 2 beers ○ 3 to 4 beers ○ 5 to 6 beers ○ 7 to 8 beers ○ 9 to 10 beers ○ 11 to 12 beers ○ More than 12 beers → If more than 12, how many? ☐☐ S04_ALC_7_DRINKS S04_ALC_7_DRINKS_MORE
ALC 8 **Wine:** 5 ounce glass of wine or 1 full wine cooler S04_ALC_8 S04_ALC_8_DRINKS S04_ALC_DRINKS_8_MORE	○ Never → Go to ALC 9 ○ Less than once a month ○ Once a month ○ 2 to 3 times a month ○ Once a week ○ 2 to 3 times a week ○ 4 to 6 times a week ○ Every day	○ 1 to 2 glasses or coolers ○ 3 to 4 glasses or coolers ○ 5 to 6 glasses or coolers ○ 7 to 8 glasses or coolers ○ 9 to 10 glasses or coolers ○ 11 to 12 glasses or coolers ○ More than 12 glasses or coolers → If more than 12, how many? ☐☐
ALC 9 **Hard liquor:** 1.5 ounce drink on its own or in mixed drinks S04_ALC_9 S04_ALC_9_DRINKS S04_ALC_DRINKS_9_MORE	○ Never → Go to ALC 10 ○ Less than once a month ○ Once a month ○ 2 to 3 times a month ○ Once a week ○ 2 to 3 times a week ○ 4 to 6 times a week ○ Every day	○ 1 to 2 drinks ○ 3 to 4 drinks ○ 5 to 6 drinks ○ 7 to 8 drinks ○ 9 to 10 drinks ○ 11 to 12 drinks ○ More than 12 drinks → If more than 12, how many? ☐☐

S04_ACL_10
ALC 10 In the **past 12 months**, how often have you had 8 or more alcoholic beverages of any type on one day?

○ Never ○ Once a month ○ Once a week
○ Less than once a month ○ 2 to 3 times a month ○ More than once a week

S04_ACL_11
ALC 11 In the **past 12 months**, how often have you had 5 or more alcoholic beverages of any type on one day?

○ Never ○ Once a month ○ Once a week
○ Less than once a month ○ 2 to 3 times a month ○ More than once a week

Section H

This section asks questions about your sleep in the **past 4 weeks** and about shift work during your adult life.

S04_SLP_1

SLP 1 On the average, how many hours did you sleep each night during the **past 4 weeks**? (Record to the nearest hour)

☐☐ Hours per night

Think about any paid night shift work you have done during your **entire lifetime**. Night work means at least 7 to 8 hours of work between the hours of 7 PM and 9 AM.

S04_SLP_2

SLP 2 **During your entire life**, have you ever worked 3 or more nights per month?

○ Yes

○ No → Go to Section I, page 16

S04_SLP_3

SLP 3 For how many years in total did you work a schedule that included work during the day or evening, rotating with nights in the same month?

○ Did not work rotating shifts
○ Less than one year
○ 1 to 5 years
○ 6 to 10 years
○ 11 to 15 years
○ 16 to 20 years
○ 21 to 25 years
○ 26 to 30 years
○ More than 30 years

S04_SLP_3_YEARS

→ If more than 30 years, how many? ☐☐ Years

S04_SLP_4

SLP 4 For how many years in total did you work straight nights, that is, work that did not rotate with day or evening work?

○ Did not work straight nights
○ Less than one year
○ 1 to 5 years
○ 6 to 10 years
○ 11 to 15 years
○ 16 to 20 years
○ 21 to 25 years
○ 26 to 30 years
○ More than 30 years

S04_SLP_4_YEARS

→ If more than 30 years, how many? ☐☐ Years

Section

In this part of the survey, please update the measurements of your height, weight, abdomen, and buttocks.

Measurements should be made in a single session at least two hours after a meal, preferably with the help of another adult.
Weigh or measure yourself twice. Use the tape measure provided. The tape is divided in 1/8" sections.

Height

1. Remove your shoes.
2. Stand straight with your back and heels against a wall.
3. Lay a book flat on top of your head and make a mark on the wall.
4. Measure twice. The two measurements should be within a quarter-inch (2/8 inch) of each other. If not, take a third measurement and record the closest two measurements.
5. Record your height in feet and inches.

Examples: 5'4": [5] Feet [4] Inches **OR** 6' $1^{1/2}$": [6] Feet [1.5] Inches

BDY 1	First Measurement	S04_BDY_1_FEET	Feet	S04_BDY_1_INCHES	Inches
BDY 2	Second Measurement	S04_BDY_2_FEET	Feet	S04_BDY_2_INCHES	Inches

If you are currently more than 12 weeks pregnant, or have given birth in the past six months, please do not complete the next three measurements. We will follow up with you in the future.

PLEASE SHADE THE BUBBLE THAT APPLIES TO YOU:

- ○ I am currently more than 12 weeks pregnant
- ○ I am less than 6 months postpartum

→ Go to WGT 1, page 18

Weight

1. Use a scale if possible to get your current weight. Adjust your scale to zero.
2. Remove your shoes and wear light clothing.
3. Weigh yourself twice. The two weights should be within one pound of each other. If not, weigh yourself a third time and record the closest two weights.
4. Record your weight in pounds.

BDY 3	First Measurement	S04_BDY_3	Pounds
BDY 4	Second Measurement	S04_BDY_4	Pounds

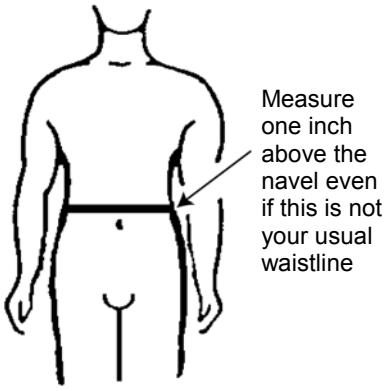
Abdomen and Buttocks

Take the next measurements either with your clothes off or in close fitting underwear.
1. Stand up straight in front of a mirror to position the measuring tape correctly.
2. Pull the tape measure so that it is snug and does not slide, but do not indent the skin.
3. Ensure that the tape is horizontal all the way around the body.
4. Measure twice. The two measurements should agree to within a quarter-inch (2/8 inch) of each other. If they do not, take a third measurement and record the closest two measurements.
5. Record the measurements in inches.

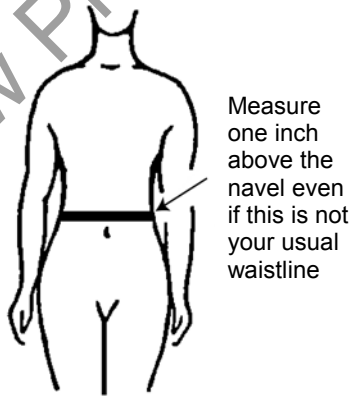
Abdomen

Measure one inch above your navel or "belly button", EVEN IF THIS IS NOT YOUR USUAL WAISTLINE. See the diagrams below that show the correct measurement location.

Male



Female



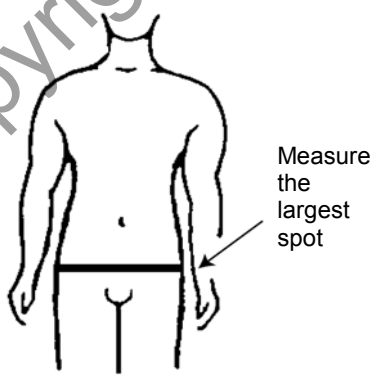
BDY 5 First Measurement S04_BDY_5 Inches

BDY 6 Second Measurement S04_BDY_6 Inches

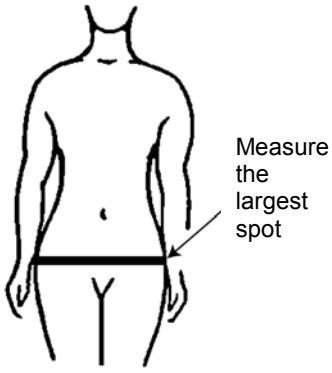
Buttocks

Slide the tape measure up and down until you find the largest spot between your waist and thighs. See the diagrams below that show the correct measurement location.

Male



Female



BDY 7 First Measurement S04_BDY_7 Inches

BDY 8 Second Measurement S04_BDY_8 Inches

Section J

Recent research has focused on connections between people's lifetime weight pattern and their health.

Some of the information may be hard to recall, but please make your best guess.

S04_WGT_1 S04_WGT_1_FEET S04_WGT_1_INCHES

WGT 1 How tall were you when you were 18 years old? ☐ Feet ☐ Inches (Round to the nearest inch)

S04_WGT_2

WGT 2 How much did you weigh when you were 18 years old? ☐ Pounds

S04_WGT_3

WGT 3 What is the most you ever weighed since you were 18 years old? (If you are a woman, do not count any times you were pregnant, nursing, or during the six months after a pregnancy.)

☐ Pounds (If you never weighed more than you did at 18, enter your weight at 18.)

S04_WGT_4

WGT 4 How old were you when you first weighed this amount?

☐☐ Years of age (If you never weighed more than you did at 18, enter 18 years.)

S04_WGT_5

WGT 5 What is the least you ever weighed since you were 18 years old?

☐ Pounds (If you never weighed less than you did at 18, enter your weight at 18.)

S04_WGT_6

WGT 6 How old were you when you first weighed this amount?

☐☐ Years of age (If you never weighed less than you did at 18, enter 18 years.)

S04_WGT_7

WGT 7 About how many times since you were age 18 did you purposely lose 20 pounds or more and then later gain all the weight back?

☐☐☐ Times (Enter 0 if you never lost and regained 20 pounds or more.)

S04_WGT_8

WGT 8 When you gain weight, where on your body do you mainly tend to add the weight? (Choose ONE)

- ○ Don't gain weight
- ○ Around the chest and shoulders
- ○ Around the waist/stomach
- ○ Around the hips, thighs and buttocks
- ○ Equally all over
- ○ Other (Please specify)_____

S04_WGT_9 S04_WGT_8_OTHER

WGT 9 How would you describe yourself now?

- ○ Overweight
- ○ Underweight
- ○ About the right weight
- ○ Don't Know

S04_WGT_10

WGT 10 **During your lifetime**, have you taken prescription medication that you think caused you to gain a lot of weight?

- ○ Yes
- ○ No → Go to WGT 12
- ○ Don't Know → Go to WGT 12

WGT 11 What type of prescription medication did you take that caused the weight gain? (Choose ALL that apply)

S04_WGT_11_1 ○ Antidepressants or antipsychotics (e.g. Elavil, Prozac, Paxil, Zoloft, Lithium, Clozaril, Zyprexa, Risperdal, etc.)
S04_WGT_11_2 ○ Anticonvulsant (anti-epilepsy) medication (e.g. Tegretol, Depakene, etc.)
S04_WGT_11_3 ○ Diabetes treatment drugs
S04_WGT_11_4 ○ Hormone replacement therapy, birth control pills or other female hormones
S04_WGT_11_5 ○ Steroids (e.g. Prednisone, etc.)
S04_WGT_11_6 ○ Thyroid medication
S04_WGT_11_7 ○ High blood pressure medication (e.g. Inderal, Lopresor, etc.)
S04_WGT_11_8 ○ Cancer related drugs (e.g. Tamoxifen, etc.)
S04_WGT_11_9 ○ Other (Please specify)_____

Now think about the time **since you joined the study**. Refer to the date on the cover of this survey.

S04_WGT_12
WGT 12 **Since you joined the study**, did you try to lose weight?

○ Yes
○ No ⟶ Go to Section K, page 20

WGT 13 How did you try to lose weight? (Choose ALL that apply)

S04_WGT_13_1 ○ Ate smaller amounts of food
S04_WGT_13_2 ○ Ate foods with lower calories
S04_WGT_13_3 ○ Ate less fat
S04_WGT_13_4 ○ Ate less carbohydrates
S04_WGT_13_5 ○ Exercised, took part in sports
S04_WGT_13_6 ○ Increased daily physical activity level (e.g. walked more, took the stairs, etc.)
S04_WGT_13_7 ○ Skipped meals
S04_WGT_13_8 ○ Ate "diet" foods or products
S04_WGT_13_9 ○ Used a liquid diet formula
S04_WGT_13_10 ○ Followed a specific diet plan (e.g. Atkins, Zone, South Beach or Pritkin, etc.)
S04_WGT_13_11 (Please specify) _____
S04_WGT_13_12 ○ Joined a weight loss program (e.g. Weight Watchers, Jenny Craig, TOPS or Overeaters Anonymous, etc.)
S04_WGT_13_13 (Please specify) _____
S04_WGT_13_14 ○ Took diet pills prescribed by a doctor
S04_WGT_13_15 ○ Took other pills, medicines, herbs or supplements not needing a prescription
○ Took laxatives or threw up on purpose
○ Other (Please specify)_____

Section **K**

Your health plays an important role in your overall quality of life. There are many areas of research that examine links between quality of life and the development of chronic diseases, including cancer.

S04_QOL_1

QOL 1 In general, would you say your health is:

○ Excellent ○ Good ○ Poor
○ Very good ○ Fair

For how long (if at all) has your health limited you in each of the following activities? (Mark one circle on each line)

		Limited for more than 3 months	Limited for 3 months or less	Not Limited at All
S04_QOL_2				
QOL 2	The kinds or amounts of vigorous activities you can do, like lifting heavy objects, running or participating in strenuous sports	○	○	○
S04_QOL_3				
QOL 3	The kinds or amounts of moderate activities you can do, like moving a table, carrying groceries or bowling	○	○	○
S04_QOL_4				
QOL 4	Walking uphill or climbing a few flights of stairs	○	○	○
S04_QOL_5				
QOL 5	Bending, lifting or stooping	○	○	○
S04_QOL_6				
QOL 6	Walking one block	○	○	○
S04_QOL_7				
QOL 7	Eating, dressing, bathing, or using the toilet	○	○	○

S04_QOL_8

QOL 8 How much bodily pain have you had during the **past 4 weeks**?

○ None ○ Mild ○ Severe
○ Very mild ○ Moderate ○ Very severe

S04_QOL_9

QOL 9 Does your health keep you from working at a job, doing work around the house or going to school?

○ Yes, for more than 3 months
○ Yes, for 3 months or less
○ No

S04_QOL_10

QOL 10 Have you been unable to do certain kinds or amounts of work, housework or schoolwork because of your health?

○ Yes, for more than 3 months
○ Yes, for 3 months or less
○ No

For each of the following questions, please mark the circle for the one answer that comes closest to the way you have been feeling during the **past month**. (Mark one circle on each line)

S04_QOL_11		All of the Time	Most of the Time	A Good Bit of the	Some of the Time	A Little of the Time	None of the Time
QOL 11	How much of the time, during the **past month**, has your health limited your social activities (like visiting with friends or close relatives)?	○	○	○	○	○	○
S04_QOL_12							
QOL 12	How much of the time, during the **past month**, have you been a very nervous (anxious) person?	○	○	○	○	○	○
S04_QOL_13							
QOL 13	During the **past month**, how much of the time have you felt calm and peaceful?	○	○	○	○	○	○
S04_QOL_14							
QOL 14	How much of the time, during the **past month**, have you felt downhearted and blue?	○	○	○	○	○	○
S04_QOL_15							
QOL 15	During the **past month**, how much of the time have you been a happy person?	○	○	○	○	○	○
S04_QOL_16							
QOL 16	How often, during the **past month**, have you felt so down in the dumps that nothing could cheer you up?	○	○	○	○	○	○

Please mark the circle that best describes whether each of the following statements is true or false for you. (Mark one circle on each line)

S04_QOL_17		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
QOL 17	I am somewhat ill	○	○	○	○	○
S04_QOL_18						
QOL 18	I am as healthy as anybody I know	○	○	○	○	○
S04_QOL_19						
QOL 19	My health is excellent	○	○	○	○	○
S04_QOL_20						
QOL 20	I have been feeling bad lately	○	○	○	○	○

The next few questions ask how you usually take medication.

S04_QOL_21

QOL 21 When a doctor gives you a prescription for medication with instructions to take it for 1 to 2 weeks, for example antibiotics for a minor infection, which of the following best describes you?

- ○ I always finish the whole prescription
- ○ I usually finish the whole prescription
- ○ I take the prescription until I feel better and then stop
- ○ I rarely fill the prescription
- ○ Other _____ S04_QOL_21_OTHER

S04_QOL_22

QOL 22 When a doctor prescribes a daily medication that you need to take for a long time, for example, for high blood pressure, which of the following best describes you?

- ○ I take the medication every day
- ○ I miss less than once a week
- ○ I miss about once a week
- ○ I miss 2 to 3 times a week
- ○ I miss more than I take
- ○ I have never been on long-term medication
- ○ Other _____ S04_QOL_22_OTHER

S04_QOL_23

QOL 23 People may decide to take non-prescription products on a daily basis to improve their health, not because a doctor has recommended it. Examples include vitamins, herbs, diet supplements or aspirin. Which of the following best describes you?

- ○ I have never decided to take a non-prescription product daily
- ○ I take the product every day
- ○ I miss less than once a week
- ○ I miss about once a week
- ○ I miss 2 to 3 times a week
- ○ I miss more than I take
- ○ Other _____ S04_QOL_23_OTHER

MEN, GO TO SECTION M, PAGE 30

Section **L**

This section is for WOMEN only. MEN, please go to Section M, page 30.

The section starts with questions about changes in your reproductive health **since you joined the study** and continues with questions about menopause and the use of female hormones during your lifetime. If you are not sure if you already reported the information to us on the last survey, please enter it again.

S04_WRH_1

WRH 1 **Since you joined the study**, did you have a Pap smear test?

○ Yes → In what year did you have your last Pap test? S04_WRH_1_DATE Y Y Y Y

○ No

S04_WRH_2 ○ Don't know

WRH 2 **Since you joined the study**, did you have a mammogram (a breast x-ray)? S04_WRH_2_DATE

○ Yes → In what year did you have your last mammogram? Y Y Y Y

○ No → Go to WRH 4

○ Don't know → Go to WRH 4

S04_WRH_3

WRH 3 Why did you have your last mammogram **since you joined the study**? (Choose ALL that apply)

S04_WRH_3_1 ○ Family history of breast cancer

S04_WRH_3_2 ○ On hormone replacement therapy

S04_WRH_3_3 ○ Part of regular checkup/routine screening

S04_WRH_3_4 ○ Breast problem

S04_WRH_3_5 ○ Age

S04_WRH_3_6 ○ Other (Please specify)_____

S04_WRH_3_7_OTHER ○ Previously detected lump _____

S04_WRH_4

WRH 4 **Since you joined the study**, did you have an operation to have both of your ovaries removed? (If you had 2 separate operations to remove your ovaries, please answer yes if the second operation was **since you joined the study**.)

○ Yes → At what age did you have both your ovaries removed? (If you had 2 separate operations to remove your ovaries, please indicate your age at the time of your last surgery.) S04_WRH_4_YEARS ☐☐ Years of age

○ No

S04_WRH_5

WRH 5 **Since you joined the study**, did you have a hysterectomy? A hysterectomy is an operation to have your uterus (womb) removed.

○ Yes → At what age did you have your uterus removed? S04_WRH_5_YEARS ☐☐ Years of age

○ No

S04_WRH_6

WRH 6 Did you have a menstrual period in the **past 12 months**?

○ Yes → Go to WRH 8

○ No

○ Don't know (Please explain) S04_WRH_6_OTHER _____ → Go to WRH 8

S04_WRH_7

WRH 7 Why did your menstrual periods stop?

○ Natural menopause (Periods stopped by themselves)

→ How old were you when you had your last natural period? ☐☐ Years of age S04_WRH_7_1

○ Surgery

→ What type of surgery? (Choose ALL that apply)

○ Hysterectomy (uterus removed)

○ Ovaries removed

○ Other surgery (Please specify) S04_WRH_7_2_OTHER _____

○ Medication (Please specify) S04_WRH_7_3_OTHER _____

○ Other reason (Please specify) S04_WRH_7_4_OTHER _____

The next questions are about women's health around the time of menopause. Please answer questions WRH 8 through 10 even if you have not reached menopause.

WRH 8 Women get information about menopause from many sources. Which sources, if any, have been the most useful to you? (Choose ALL that apply)

S04_WRH_8_1 ○ Family doctor

S04_WRH_8_2 ○ Gynecologist

S04_WRH_8_3 ○ Nurse or other health professional

S04_WRH_8_4 ○ Friends and relatives

S04_WRH_8_5 ○ Internet

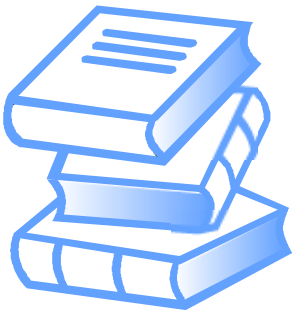
S04_WRH_8_6 ○ Natural products provider

S04_WRH_8_7 ○ Books, magazines, newspapers

S04_WRH_8_8 ○ Have not gotten any menopause information

S04_WRH_8_9 ○ Other (Please specify) _____

S04_WRH_8_9_OTHER _____



WRH 9 Women often use alternative or complementary products or foods around the time of menopause to control menopause symptoms. Included is a wide range of herbs, vitamins, gels and foods.

Which of the following products or foods have you used for one month or more, primarily to control menopause symptoms? (Check all you have ever taken in your life, including the time before you joined the study.)

S04_WRH_9_1 ○ Black Cohosh	S04_WRH_9_8 ○ Ginseng	S04_WRH_9_15 ○ Wild Yam
S04_WRH_9_2 ○ Chasteberry	S04_WRH_9_9 ○ Melatonin	S04_WRH_9_16 ○ Soy containing foods
S04_WRH_9_3 ○ DHEA	S04_WRH_9_10 ○ Promensil	S04_WRH_9_17 ○ Lignan containing foods
S04_WRH_9_4 ○ Dong Quai	S04_WRH_9_11 ○ St. John's Wort	S04_WRH_9_18 ○ Coumestan containing foods
S04_WRH_9_5 ○ Estriol	S04_WRH_9_12 ○ Valerian Root	S04_WRH_9_19 ○ None
S04_WRH_9_6 ○ Evening Primrose	S04_WRH_9_13 ○ Vitamin B6	S04_WRH_9_20 ○ Other (Please specify)
S04_WRH_9_7 ○ Gingko Biloba	S04_WRH_9_14 ○ Vitamin E	_____

Prescription medications for menopause contain one or more female hormones, commonly estrogen and progestin, to replace what the body does not produce beginning around the time of menopause. Commonly called hormone replacement therapy (HRT), menopause medications are available in various forms: pills, patches, skin gels, vaginal creams and rings and injections.

S04_WRH_10
WRH 10 Have you ever used medications for menopause that were prescribed by a doctor?

○ Yes
○ No → Go to Section M, page 30
○ Don't know (Please specify) _____ → Go to Section M, page 30

Think about the first time you took prescription medications for menopause.

S04_WRH_11
WRH 11 How old were you when you first started taking menopause medication? (Your best guess)

☐☐ Years of age

S04_WRH_12
WRH 12 Who prescribed your medication the first time you used it?

○ General practitioner or family doctor
○ Gynecologist
○ Other (Please specify) S04_WRH_12_OTHER _____

S04_WRH_13

WRH 13 Which statement is the most accurate about your decision to start prescription menopause medication? (Choose ONE)

○ A doctor recommended it

○ I asked a doctor to prescribe it

○ Other (Please specify) _____ S04_WRH_13_OTHER

S04_WRH_14

WRH 14 What was your most important reason for deciding to start prescription menopause medication? (Choose one)

○ To reduce symptoms of menopause → S04_WRH_14_1
(e.g. hot flashes, wakefulness, vaginal dryness, etc.)

How would you rate your symptoms when you started?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Mild Severe

○ To prevent chronic diseases
(e.g. osteoporosis, heart disease)

○ Because my doctor recommended it

○ Other (Please specify)_____ S04_WRH_14_OTHER

S04_WRH_15

WRH 15 How long have you taken prescription menopause medication in your life? (Add all the years from when you started until now. If you stopped and restarted, add the years and months you took the medication and round to the nearest year.)

○ Less than one month ○ 4-5 years

○ One month to one year ○ 6-9 years

○ 2-3 years ○ 10 years or more → How many years? ☐☐ Years

S04_WRH_15_YEARS

The next questions focus on the time **since you joined the study**.

S04_WRH_16

WRH 16 During the time **since you joined the study**, have you used prescription menopause medication at any time? (Do not include birth control pills used to prevent pregnancy.)

○ Yes

○ No → Go to Section M, page 30

○ Don't know (Please explain) _____ → Go to Section M, page 30.

S04_WRH_17

WRH 17 Are you currently using prescription menopause medication (within the past 30 days)?

○ Yes

○ No

S04_WRH_18

WRH 18 Which pattern represents your experience using prescription menopause medication **since you joined the study?**

S04_WRH_18_1

○ I have taken medication continuously since I joined the study.

For how many months have you used the medication? ☐ Months → Go to WRH 20

○ I was not on medication when I joined the study but have since started.

When did you start? S04_WRH_18_2_AGE S04_WRH_18_2_MONTHS

M M Y Y Y Y

For how many months did you use the medication? ☐ Months → Go to WRH 20

○ I was taking medication when I joined the study but have since stopped.

When did you stop? S04_WRH_18_3_AGE S04_WRH_18_3_MONTHS

M M Y Y Y Y

For how many months did you use the medication? ☐ Months

S04_WRH_18_4_MONTHS

○ I have stopped and restarted medication since I joined the study.

When did you stop? S04_WRH_18_4_STOP_AGE

M M Y Y Y Y

When did you restart? S04_WRH_18_4_RESTART_AGE

M M Y Y Y Y

For how many months did you use the medication? ☐ Months S04_WRH_18_4_MONTHS

S04_WRH_19

WRH 19 Which statement is the most accurate about how you decided to stop prescription menopause medication during the time **since you joined the study**?

○ I decided on my own and just stopped using medication

○ I decided to stop medication after consultation with my doctor

○ My doctor would no longer prescribe medication for me

○ Other reason (Please specify) S04_WRH_19_OTHER _____

_____

WRH 20 A list of the most common Canadian prescription menopause medications follows:

- Please record ALL the types of medication you used during the time **since you joined the study**.
- Choose the specific dose of each type of medication you took. If you took more than 1 dose, choose the one you took the longest. If you do not know the dose, choose DK (Don't Know).
- Record the approximate number of months you took each type of medication or product.

Medication Type	What dose did you take the longest?	How many months in total did you take the medication (all doses)?
Estrogen pills:		
S04_WRH_20_A_, S04_WRH_20_A_1_DOSE ○ Premarin (Congest, CES, PMS-CES)	○ 0.3 mg (green) ○ 0.9 mg (pink) ○ DK ○ 0.625 mg (maroon) ○ 1.25 mg (yellow)	S04_WRH_20_A_1_MONTH Months
S04_WRH_20_A_2, S04_WRH_20_A_2_DOSE ○ Estrace	○ 0.5 mg (white) ○ 2 mg (turquoise) ○ 1 mg (lavender) ○ DK	S04_WRH_20_A_2_MONTH Months
S04_WRH_20_A_3, S04_WRH_20_A_3_DOSE ○ Ogen	○ 0.625 mg (yellow) ○ 2.5 mg (blue) ○ 1.25 mg (peach) ○ DK	S04_WRH_20_A_3_MONTH Months
Progesterone pills: S04_WRH_20_A_4	S04_WRH_20_A_4_DOSE	S04_WRH_20_A_1_MONTH
○ Provera (Gen-Medroxy, Novo-Medrone, Ratio-MPA, Apo-Medroxy, PMS-Medroxyprogesterone)	○ 2.5 mg (orange) ○ 10 mg (white) ○ 5.0 mg (blue) ○ DK	Months
○ Prometrium S04_WRH_20_A_5	S04_WRH_20_A_5_DOSE ○ 100 mg (1 pill) ○ 200 mg (2 pills) ○ DK	S04_WRH_20_A_5_MONTH Months
Estrogen/progesterone combination pills:		
S04_WRH_20_A_6 ○ FemHRT 1/5	White	S04_WRH_20_A_6_MONTH Months
○ Premplus S04_WRH_20_A_7	→	S04_WRH_20_A_7_MONTH Months
Estrogen patch:		
S04_WRH_20_B_1 ○ Estraderm	S04_WRH_20_B_1_DOSE ○ 25 ug ○ 50 ug ○ 100 ug ○ DK	S04_WRH_20_B_1_MONTH Months
S04_WRH_20_B_2, S04_WRH_20_B_2_DOSE ○ Estradot (Rhoxal-estradiol) or Vivelle	○ 25 ug ○ 50 ug ○ 100 ug ○ 37.5 ug ○ 75 ug ○ DK	S04_WRH_20_B_2_MONTH Months
S04_WRH_20_B_3, S04_WRH_20_B_3_DOSE ○ Climara	○ 50 ug ○ 100 ug ○ DK	S04_WRH_20_B_3_MONTH Months
S04_WRH_20_B_4 S04_WRH_20_B_4_DOSE ○ Oesclim	○ 25 ug ○ 50 ug ○ DK	S04_WRH_20_B_4_MONTH Months
Estrogen and progesterone patch:		
S04_WRH_20_B_5, S04_WRH_20_B_5_DOSE ○ Estalis (same patch all month)	○ 140/50 ○ 250/50 ○ DK	S04_WRH_20_B_5_MONTH Months
S04_WRH_20_B_6, S04_WRH_20_B_6_DOSE ○ Estalis Sequi (2 types of patch during month)	○ 140/50 ○ 250/50 ○ DK	S04_WRH_20_B_6_MONTH Months
S04_WRH_20_B_7 S04_WRH_20_B_7_DOSE ○ Estracomb	→	S04_WRH_20_B_7_MONTH Months

Continued on page 29...

...Continued from page 28

Medication Type	What dose did you take the longest?	How many months in total did you take the medication (all doses)?
Estrogen gel:		
S04_WRH_20_C ○ Estrogel	S04_WRH_20_C_PUMPS Number of pumps per day	S04_WRH_20_C_MONTHS Months
Vaginal cream or insert:		
S04_WRH_20_D_1 ○ Premarin vaginal cream		S04_WRH_20_D_1_MONTHS Months
S04_WRH_20_D_2 ○ Ortho-dienestrol vaginal cream		S04_WRH_20_D_2_MONTHS Months
S04_WRH_20_D_3 ○ Oestrilin vaginal cream		S04_WRH_20_D_3_MONTHS Months
S04_WRH_20_D_4 ○ Vagifem vaginal tablet		S04_WRH_20_D_4_MONTHS Months
S04_WRH_20_D_5 ○ Estring vaginal ring		S04_WRH_20_D_5_MONTHS Months
S04_WRH_20_D_6 ○ Oestrilin vaginal cone		S04_WRH_20_D_6_MONTHS Months
S04_WRH_20_D_7 ○ Progesterone vaginal cream by prescription		S04_WRH_20_D_7_MONTHS Months
Hormone replacement injection:		
○ Please specify S04_WRH_20_E_1 _____ _____		S04_WRH_20_E_1_MONTHS Months
Osteoporosis Medications:		
S04_WRH_20_F_1 ○ Evista	60 mg	S04_WRH_20_F_1_MONTHS Months
S04_WRH_20_F_2, S04_WRH_20_F_2_DOSE ○ Fosamax (Nova-Alendronate)	○ 5 mg (white, round) once a day ○ 10 mg (white, oval) once a day ○ 70 mg (white, oval) once a week ○ DK	S04_WRH_20_F_2_MONTHS Months
S04_WRH_20_F_3, S04_WRH_20_F_3_DOSE ○ Didrocal or Didronel	14 pills (followed by 76 blue pills if Didrocal)	S04_WRH_20_F_3_MONTHS Months
S04_WRH_20_F_4, S04_WRH_20_F_4_DOSE ○ Actonel	○ 5 mg (yellow) once a day ○ 35 mg (white) once a week ○ DK	S04_WRH_20_F_4_MONTHS Months
S04_WRH_20_F_5, S04_WRH_20_F_5_PUFFS ○ Nasal Calcitonin (Miacalcin)	Number of puffs per day	S04_WRH_20_F_5_MONTHS Months
Miscellaneous:		
S04_WRH_20_G_1 ○ Progesterone creams (made by pharmacist)	S04_WRH_20_G_1_DOSE ○ 3% ○ 6% ○ DK	S04_WRH_20_G_1_MONTHS Months
S04_WRH_20_G_2 ○ Estriol products (made by pharmacist)	S04_WRH_20_G_2_TYPE ○ Bi-Est ○ Tri-Est ○ DK	S04_WRH_20_G_2_MONTHS Months
○ Other type of menopause medication (Please specify) S04_WRH_20_G_3 _____	Dose: _____	Months S04_WRH_20_G_3_MONTHS

Section

M

Finally, a few questions to update your personal information. All information you provide will be kept completely confidential.

S04_DGR_1

DGR 1 What is your current marital status? (Please choose the ONE that best describes your current situation.)

- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Not married, but living with someone
- ○ Single, never married

S04_DGR_2

DGR 2 What is your current employment status? (Please choose the ONE that best describes your current situation.)

If you are self-employed, have a home-based business or are involved in an occupation like farming or ranching, please choose full-time or part-time as appropriate.

- ○ Working full-time (30 hours or more per week)
- ○ Working part-time (Less than 30 hours per week)
- ○ Not employed, but looking for work
- ○ Homemaker
- ○ Student
- ○ Retired
- ○ Other S04_DGR_2_OTHER

This final question asks about your ethnic origins, that is the ethnic or cultural groups to which your ancestors belonged. There is evidence that some ethnic groups are more likely to develop certain health problems. In addition, the information will help to determine if a wide range of Albertans have joined *The Tomorrow Project.*

DGR 3 What are your ethnic or cultural groups? (Please choose ALL that apply)

S04_DGR_3_1
S04_DGR_3_2
S04_DGR_3_3
S04_DGR_3_4
S04_DGR_3_5
S04_DGR_3_6

- ○ Aboriginal (e.g. Inuit, Metis, North American Indian)
- ○ Black (e.g. Afro-American, Afro-Canadian, Afro-Caribbean)
- ○ Caucasian (e.g. European, Middle Eastern, North African)
- ○ Asian (e.g. Chinese, Japanese, Korean, Vietnamese, Thai)
- ○ Pacific Asian (e.g. Filipino, Indonesian, Polynesian)
- ○ East Indian
- ○ Jewish
- ○ Hutterite
- ○ French Canadian
- ○ Other (Please specify) S04_DGR_3_10_OTHER

S04_DGR_3_7
S04_DGR_3_8
S04_DGR_3_9
S04_DGR_3_10

DGR 4 What is your current age? ☐☐ Years of age

Date survey completed:

M M D D Y Y Y Y

Thanks for answering the health questions.
Please complete the next 2 important pages.