Black Women's Health Study 2011

PLEASE USE A BLUE OR BLACK BALLPOINT PEN

1. Please write in your age and date of birth.

Age ____ Month ____ / Day ____ / Year 19__

(example: June = 06)

2. Since March 2009, have you had a:
(Fill in all that apply.)

- ○ Physical exam
- ○ Blood sugar test
- ○ Eye exam
- ○ Pap smear
- ○ Mammogram
- ○ Pelvic exam
- ○ Pelvic ultrasound
- ○ Sigmoidoscopy
- ○ Colonoscopy
- ○ Dental cleaning

3. How many breast biopsies have you ever had? ____ number of biopsies

a. Your age at 1st biopsy ____ years old

b. Your age at 2nd biopsy ____ years old

4. How many children have you given birth to? ____ Number of births

5. How many months in total have you breastfed your children? (total for all) ____ Months

a. What is the longest you breastfed any child? ____ Months

Please continue to Question 6

6. Since March 2009, have you taken female hormones (like estrogen) for menopause?

- ○ No
- ○ Yes. If **yes**, how many months? ____ Months

Name of medication(s): ____

7. Since March 2009, have you had surgery to remove your ovaries or uterus? *(Fill in all that apply.)*

- ○ No
- ○ Both ovaries removed
- ○ One ovary only removed
- ○ Uterus removed

8. Are you enrolled in Medicare?

○ No ○ Yes ○ Don't know

If **yes**, are you enrolled in *(Fill in all that apply)*:

- ○ Medicare Part A
- ○ Medicare Part B
- ○ A Medicare Advantage Plan (a Medicare health plan offered by a private company, also called Medicare Part C)

a. Do you have other health insurance (for example through an employer, Medicaid)?

○ No ○ Yes ○ Don't know

9. Please write in your current weight. ____ Pounds

Please continue to Questions 10

10. During the past year, how many hours each week did you spend (on average)**:**

	None	less than 1 hr	1-2 hrs	3-4 hrs	5-6 hrs	7-9 hrs	10 or more hrs
Walking for exercise	○	○	○	○	○	○	○
Vigorous exercise (e.g., jogging, aerobics)	○	○	○	○	○	○	○
Walking to and from church, school, work	○	○	○	○	○	○	○

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11. Since March 2009, if you were diagnosed with any of the following conditions, please fill in the circle for yes and write in the year it was first diagnosed. *(e.g. 2009)*

	Yes	Year
1. Breast cancer	○	
2. Lung cancer	○	
3. Colon cancer	○	
4. Rectal cancer	○	
5. Other type of cancer. (Please write in the type)	○	
6. Diabetes (sugar, sugar diabetes)	○	
7. Heart attack	○	
8. Stroke	○	
9. Coronary bypass surgery	○	
10. Angioplasty or stent for artery repair	○	
11. Congestive heart failure (CHF)	○	
12. Atrial fibrillation	○	
13. End stage renal disease	○	
14. Blood clot (lungs or legs)	○	
15. Hypertension (high blood pressure)	○	
16. High cholesterol	○	
17. Endometriosis (confirmed by laparoscopy)	○	
18a. Fibroids in womb confirmed by ultrasound	○	
18b. Fibroids in womb confirmed by surgery (e.g. hysterectomy)	○	
19. Lupus (not discoid)	○	
20. Multiple sclerosis (MS)	○	
21. Asthma	○	
22. Colon or rectal polyp (benign)	○	
23. Depression treated with medication	○	
24. Glaucoma	○	
25. Cataracts	○	
26. Sarcoidosis	○	
27. Rheumatoid arthritis	○	
28. Hip Fracture	○	
29. Osteoarthritis	○	
30. Other serious illness	○	

12. Do you have chronic kidney disease?

○ No ○ Yes. If **yes**, are you on dialysis?

○ No ○ Yes

13. Do you take any of the following medications or vitamins at least 3 days a week?
(Fill in the circle for YES, leave blank for NO.)

- ○ Aspirin
- ○ Ibuprofen, Naproxen, Aleve, or Motrin
- ○ Pills to lower cholesterol Name:
- ○ Injections for diabetes
- ○ Pills for diabetes Name:
- ○ Diuretics (water pills) for high blood pressure or other reasons Name:
- ○ Other blood pressure pills Name:
- ○ Inhalers or pills for asthma Name:
- ○ Multi-Vitamins ○ Folic acid by itself
- ○ Calcium ○ Vitamin D

Please list all other medications or supplements that you currently take at least 3 days a week:

14. Overall, how would you rate the health of your teeth and gums?

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

15. In the past four (4) years, how many teeth have you lost?

Teeth lost

16. Has a dentist ever told you that you have gum disease with bone loss?

○ No ○ Yes

17. What is your current work status: *(Fill in all that apply.)*

○ Full time ○ Part time ○ Homemaker ○ Student

○ Retired ○ Disabled ○ Unemployed

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18. During the past year, how often have you leaked or lost control of your urine?

○ Never ○ Less than once/month ○ Once/month ○ 2-3 times/month ○ About once/week ○ Almost every day

When you lose your urine, how much usually leaks?

○ A few drops ○ Enough to wet your underwear ○ Enough to wet your outer clothing ○ Enough to wet the floor

When you lose urine, what is the usual cause?

a) ○ Coughing, sneezing, laughing or doing physical activity
b) ○ A sudden urgent need to go to the bathroom
c) ○ Both a) and b) equally
d) ○ In other circumstances

19. On average, how often in the past year have you experienced any amount of accidental bowel leakage?

	Never	Less than once per month	1-3 per month	About once per week	Several times per week	Nearly daily
a. Liquid stool	○	○	○	○	○	○
b. Solid stool	○	○	○	○	○	○

20. How many hours each week do you participate in any groups such as a social or work group, church-connected group, self-help group, charity, public service or community group?

○ None ○ 1-2 hours ○ 3-5 hours ○ 6-10 hours ○ 11-15 hours ○ 16 or more hours

	None	1-2	3-5	6-9	10 or more
21. Apart from your children, how many relatives do you have with whom you feel close?	○	○	○	○	○
22. How many close friends do you have?	○	○	○	○	○

23. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?

○ None of the time ○ A little of the time ○ Some of the time ○ Most of the time ○ All of the time

24. How many people can you count on to provide you with emotional support?

○ None ○ 1 ○ 2 ○ 3 or more

25. With whom do you live? *(Fill in all that apply.)*

○ Alone ○ With spouse/partner ○ With 1 or more children
○ With 1 or more parents ○ With other family ○ With 1 or more friends

26. Outside of your employment, how many hours per week do you provide regular care to any of the following?

	Zero hours	1-8 hours	9-20 hours	21-35 hours	36-72 hours	73+ hours
a. Your disabled child or grandchild	○	○	○	○	○	○
b. Your other children or grandchildren	○	○	○	○	○	○
c. Disabled or ill spouse/partner	○	○	○	○	○	○
d. Disabled or ill parent or other person	○	○	○	○	○	○

	Not applicable	Not at all	Just a little bit	Moderately	Extremely
27. How stressful would you say your caretaking responsibilities are?	○	○	○	○	○
28. How rewarding would you say your caretaking responsibilities are?	○	○	○	○	○

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	Excellent	Very Good	Good	Fair	Poor
29. In general, would you say your health is:	○	○	○	○	○
30. In general, would you say your quality of life is:	○	○	○	○	○
31. In general, how would you rate your physical health?	○	○	○	○	○
32. In general, how would you rate your mental health, including your mood and your ability to think?	○	○	○	○	○
33. In general, how would you rate your satisfaction with your social activities and relationships?	○	○	○	○	○
34. In general, please rate how well you carry out your usual social activities and roles. (At home, at work, your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	○	○	○	○	○

	Completely	Mostly	Moderately	A little	Not at all
35. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	○	○	○	○	○

	Never	Rarely	Sometimes	Often	Always
36. In the <u>past 7 days</u>, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	○	○	○	○	○

	None	Mild	Moderate	Severe	Very severe
37. In the <u>past 7 days</u>, how would you rate your fatigue on average?	○	○	○	○	○

38. In the <u>past 7 days</u>, how would you rate your pain on average?

No pain										Worst imaginable pain
○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

39. Please answer the following questions about your eating habits over the <u>past year</u>:

	Definitely true	Mostly true	Mostly false	Definitely false
a. When I feel anxious, blue or lonely, I find myself eating.	○	○	○	○
b. Sometimes when I start eating, I just can't seem to stop.	○	○	○	○
c. I consciously hold back at meals in order not to gain weight.	○	○	○	○

d. How often do you feel hungry?

○ Only at meal time ○ Sometimes between meals ○ Often between meals ○ Almost always