Black Women's Health Study 2015

1. **Please write in your age and date of birth.** ☐☐ Age ☐☐ / ☐☐ / 1 9 ☐☐ — Month / Day / Year (example: June = 06)

2. **Please estimate your usual sleep/wake time over the past 2 years on days you were not working and not using an alarm clock to wake up:**

   I usually fall asleep at: *(this may not be when you get into bed)* ☐☐ : ☐☐ (hour : min) ○ AM ○ PM

   I usually wake up at: *(this may not be when you get out of bed)* ☐☐ : ☐☐ (hour : min) ○ AM ○ PM

3. **One hears about morning and evening types of people. Which one of these do you consider yourself to be?**
   ○ Definitely a morning type ○ More of a morning type ○ More of an evening type ○ Definitely an evening type ○ Neither a morning nor evening type

4. **Thinking about the past month, how many nights a week did you have problems with your sleep?** *(Fill in only one circle)*

None	1	2	3	4	5	6	7
○	○	○	○	○	○	○	○

5. **Please rate the severity of any sleep problem(s) in the past month.**

	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	○	○	○	○	○
Difficulty staying asleep	○	○	○	○	○
Problem waking up too early	○	○	○	○	○

   How satisfied are you with your sleep pattern?
   ○ Very Satisfied ○ Moderately Satisfied ○ Satisfied ○ Dissatisfied ○ Very Dissatisfied

   How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life? ○ Not at all ○ A little ○ Somewhat ○ Much ○ Very much ○ Not applicable

   How worried/distressed are you about your current sleep problem?
   ○ Not at all ○ A little ○ Somewhat ○ Much ○ Very much ○ Not applicable

   To what extent do you consider your current sleep problem to interfere with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory)?
   ○ Not at all ○ A little ○ Somewhat ○ Much ○ Very much ○ Not applicable

6. **Do you have more trouble than usual remembering recent events?** ○ No ○ Yes

7. **Do you have more trouble than usual remembering a short list of items, such as a shopping list?** ○ No ○ Yes

8. **Do you have trouble remembering things from one second to the next?** ○ No ○ Yes

9. **Do you have any difficulty in understanding or following spoken instructions?** ○ No ○ Yes

10. **Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?** ○ No ○ Yes

11. **Do you have trouble finding your way around familiar streets?** ○ No ○ Yes

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12. If you were EVER 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., 2013).

Condition	Yes	Year
Breast cancer	○	
Lung cancer	○	
Colon cancer	○	
Rectal cancer	○	
Pancreatic cancer	○	
Multiple myeloma	○	
Uterine cancer (not including cervical cancer)	○	
Other type of cancer. (Please write in the type)	○	
Diabetes (sugar, sugar diabetes)	○	
Heart attack	○	
Stroke	○	
Coronary bypass surgery	○	
Angioplasty or stent for artery repair	○	
Congestive heart failure (CHF)	○	
Atrial fibrillation	○	
End stage renal disease	○	
Dialysis or kidney transplant	○	
Chronic kidney disease	○	
Dialysis or kidney transplant	○	
Hypertension (high blood pressure)	○	
High cholesterol	○	
Fibroids, confirmed by ultrasound	○	
Fibroids, confirmed by surgery (e.g. hysterectomy)	○	

Condition	Yes	Year
Lupus	○	
Multiple sclerosis	○	
Asthma	○	
Colon or rectal polyp (benign)	○	
Depression treated with medication	○	
Sarcoidosis	○	
Hip fracture (broken hip)	○	
Other serious illness	○	
	○	

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
○ Tylenol (Acetaminophen)
○ Ibuprofen, Naproxen, Aleve, or Motrin
○ Pills to lower cholesterol. Name:
○ Injections for diabetes
○ Metformin for diabetes
○ Other pills for diabetes. Name:
○ Diuretics (water pills) for high blood pressure or other reasons. Name:
○ Other blood pressure pills. Name:
○ Multi-Vitamins ○ Vitamin D ○ Folic acid

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

14. Has a dentist or dental hygienist ever told you that you had periodontal or gum disease? ○ No ○ Yes

15. In the past 4 years, how many teeth have you lost due to tooth decay or gum disease?

16. Did you ever have mastitis (infection, swelling of the breast) while you were breastfeeding? ○ No ○ Yes ○ Never breastfed

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17. In general, how would you rate:

	Excellent	Very Good	Good	Fair	Poor
a. your overall health?	○	○	○	○	○
b. your quality of life?	○	○	○	○	○
c. your physical health?	○	○	○	○	○
d. your mental health, including your mood and your ability to think?	○	○	○	○	○
e. the health of your teeth and gums?	○	○	○	○	○

18. During the past year,

a. how many hours <u>each week</u> 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)	○	○	○	○	○	○	○

b. how many hours <u>each day</u> 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
Sitting watching TV or videos	○	○	○	○	○	○	○
Sitting at work or during the day	○	○	○	○	○	○	○

19. Have you ever worked night shifts (most hours from midnight to morning, such as 11:00pm to 7:00am)?

○ No → If **no**, skip to Question 20.

○ Yes → If **yes**, **how old were you when you started working night shifts?** [|] years old

Over your life, what is the total number of years during which you worked:

<u>Rotating night shift</u> (at least 2 nights/month in addition to days or evenings)? [|] years

<u>Night shifts only</u> (at least 2 nights/week without regular day or evening shifts)? [|] years

If you currently work night shifts, please indicate the start and end times of all your shifts (day, evening, night):

	Start (hour : min)		End (hour : min)		Number of shifts per month
Shift 1:	[|] : [|]	○ AM ○ PM	[|] : [|]	○ AM ○ PM	[|] per month
Shift 2:	[|] : [|]	○ AM ○ PM	[|] : [|]	○ AM ○ PM	[|] per month
Shift 3:	[|] : [|]	○ AM ○ PM	[|] : [|]	○ AM ○ PM	[|] per month

20. Please write in your current weight. [| |] Pounds

21. Since March 2013, have you had a:
(Fill in all that apply.)

○ Physical exam
○ Blood sugar test
○ Pap smear
○ Mammogram
○ Breast biopsy
○ Pelvic ultrasound
○ Colonoscopy
○ Dental cleaning

Please continue to Question 22

22. Since March 2013, have you used birth control pills?
○ No ○ Yes If **yes**, how many months? [|] Months

23. Since March 2013, have you taken female hormones (like estrogen) for menopause?
○ No ○ Yes If **yes**, how many months? [|] Months

Name of medication(s): [ ]

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24. For all family members who are biologically related to you, fill in the circle if they have ever had any of the following cancers.

	Mother	Father	Any Sister	Any Brother	Any Daughter	Any Son
Breast cancer	○	○	○	○	○	○
Lung cancer	○	○	○	○	○	○
Colon/rectal cancer	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○
Prostate cancer		○		○		○
Ovarian cancer	○		○		○	
Other cancer, type:	○ ☐	○ ☐	○ ☐	○ ☐	○ ☐	○ ☐

25. Since March 2013, have you had surgery to remove your ovaries or uterus?
(Fill in all that apply.)

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

26. Women whose periods have stopped permanently (at least 12 months) are considered to have gone through menopause, even if they have not had symptoms (hot flashes, etc.). Which of the following best describes you?

○ I still have my usual menstrual periods
○ I am currently going through menopause
○ My menstrual periods have stopped permanently
○ My periods stopped but I have periods now due to use of female hormones
○ I don't know if my periods have stopped because I began taking female hormones when I still had periods
○ Uncertain (Please describe): ☐

→ Age periods stopped: ☐☐
→ Reason periods stopped: ○ Natural menopause ○ Surgery ○ Other: ☐

27. How many cigarettes do you currently smoke each day? ☐☐

28. Have you ever used e-cigarettes?

○ No ○ Yes If **yes**, age started? ☐☐ years old

If **yes**, how long did you use them? ☐☐ years

Please continue to Question 29

29. Thinking about the <u>last 12 months</u>, have you posted a health-related question online or shared your own personal health experience online?

○ No ○ Yes ○ Don't know

30. The LAST time you posted or shared health material online, did you post it:

To get feedback from a health professional?
○ No ○ Yes ○ Not applicable

To be read by a more general audience of friends or other internet users?
○ No ○ Yes ○ Not applicable

31. Do you have any of the following:
(Fill in all circles that apply.)

○ Smart phone
○ Tablet (e.g., Apple® iPad®)
○ Other mobile device ☐

32. What kind of health apps do you currently have on your mobile device?
(Fill in all circles that apply.)

○ Exercise, fitness, pedometer, tracker
○ Diet, food, calorie counter
○ Weight
○ Medical conditions/symptoms
○ Medication management (tracking, alerts etc.)
○ Other (specify) ☐

33. Has using an app changed your approach to maintaining your health or the health of someone you care for?

○ No ○ Yes ○ Don't know