Interviewer's Name: ____ Interview Date:_______/_______/_______
Day Month Year

TOBAGO WOMEN'S HEALTH STUDY
BASELINE QUESTIONNAIRE
DEMOGRAPHICS

Please complete the following:

Name: ________________________ ______________ _________________ __________________
First Middle Maiden (nee) Last

Alias or Nickname: ____

Address: ____

____
Street Apt. No.

____
Town County Country

Date of Birth: _____/_____/______ Electricity Bill Pole Number_________________
Day Month Year

Telephone #: (____) ______ - _________ Home (____) ______ - _________ Work

T&T Registration No. __________________________________

Directions to residence: ____
____

Please list a relative or close friend who might be able to help us locate you if we lose contact with you in the future:

Name: _________________________________ Relationship: _______________________
Address:________________________________ Phone: ____________________________

Consent form signed: 1. No ___ 2. Yes ___

IF NO, DO NOT PROCEED UNTIL STUDY HAS BEEN EXPLAINED AND CONSENT FORM HAS BEEN SIGNED.
PLEASE CIRCLE THE APPROPRIATE RESPONSE IF CONSENT HAS NOT BEEN SIGNTED

Status: 1. Agrees to participate 2. Undecided/postponed 3. Mail contact only 4. Withdrawn

[Please record weight to one decimal place]

Body Weight (measured without shoes)
________ **.** ___ Kgs

Waist ______. __cm (at umbilicus)

Hips _______. __cm (at widest part of buttocks)

Height Measurement ***[****Please record height to one decimal place]*

Participant Facing: 1 Forward 2 Sideways 3 Unable (Please explain):
____
____

Measurement 1 ___ ___ ___ . ___ cm
Measurement 2 ___ ___ ___ . ___ cm

Perform measurements 3 and 4 if measurements 1 & 2 differ by 2 or more centimeters
Measurement 3 ___ ___ ___ . ___ cm
Measurement 4 ___ ___ ___ . ___ cm

Grip Strength

a. Do you have recent worsening of pain or arthritis?

$_0$ No – test both sides $_1$ Yes – test unaffected side

Right	Left
$_1$ weakened	$_1$ weakened
$_2$ unable	$_2$ unable
$_4$ refused	$_4$ refused

b. Do you have limited use (weakened) of one or both of your hands because of a previous injury?

$_0$ No – test both sides $_1$ Yes – test unaffected side

Right	Left
1. ________________ Kg	1. ________________ Kg
2. ________________ Kg	2. ________________ Kg

1. Place of Birth - Country of Birth? ____

2a. What is your race or ethnic background? (Please check appropriate boxes below)

	Afro-Caribbean	East Indian	Hispanic White	Syrian/ Lebanese	Other White	Chinese	Other, please list:	Unknown
Participant								

2b. What is the race or ethnic background of each of your grandparents? (Please check appropriate boxes below)

	Afro-Caribbean	East Indian	Hispanic White	Syrian/ Lebanese	Other White	Chinese	Other, please list:	Unknown
Father's Father								
Father's Mother								
Mother's Father								
Mother's Mother								

2c. Are you Hispanic in origin?   1. No___   2. Yes ___   3. Don't know ___

3. What is the highest grade or level of schooling you completed? (Mark only one response)

1. Less the 8 years
2. 8 thru 11 years
3. 12 years or completed secondary school
4. Post secondary training other than university (vocational or technical training)
5. Some university
6. University graduate
7. Postgraduate

4. What is your current marital status? (Check only one; if common-law marriage, check 1.)

1. Married or living as married
2. Widowed
3. Divorced
4. Separated
5. Never married

5. What is or was your weight and/or height at these ages? (Enter the weight in pounds in the space provided, include one decimal place)

a. Present Weight? ___ ___ ___ . ___ lbs
b. Weight at Age 20 (Non-pregnant weight)? ___ ___ ___ . ___ lbs
c. Weight at Age 30 (Non-pregnant weight)? ___ ___ ___ . ___ lbs
d. Weight at Age 40 (Non-pregnant weight)? ___ ___ ___ . ___ lbs
e. Weight at Age 50? ___ ___ ___ . ___ lbs
f. Height at Age 20? ___ ft ___ in

FAMILY HISTORY OF BROKEN BONES AND FRACTURES

6. **IN THE PAST 12 MONTHS,** have you fallen and landed on the floor or ground, or fallen and hit an object like a table or chair?

Yes 1 ⬇

No 0 Don't Know -3
Please go to Question 7

a. If **YES**, how many times have you fallen in the past 12 months?

1 One 2 2 or 3 3 4 or 5 4 6 or more

7. Has a doctor ever said that you had a broken or fractured bone? **(MARK ONE BOX.)**

Yes 1 ⬇

No 0 Don't Know -3
Please go to Question 8

a. If **YES**: Please write down the names of all the bones you have broken (for example, "wrist" or "spine") and your age when you broke that bone.

Broken Bone	Age When Broken	Major trauma (car accident, sports or work injury)
______	______	Yes 1 No 0
______	______	Yes 1 No 0
______	______	Yes 1 No 0
______	______	Yes 1 No 0
______	______	Yes 1 No 0

8. Did your MOTHER ever break or fracture her hip? (Please answer for your natural mother – the mother who gave birth to you.) **(MARK ONE BOX.)**

Yes 1 ⬇

No 0 Not that I know of 2 Don't know -3
Please go to Question 9

If **YES**: At what age did your mother break her hip? ______

9. Is your natural mother still living? **(MARK ONE BOX.)**

Yes 1 | No 0 | Don't know -3

If **NO**, How old was your mother when she died?
_______ years old.

If **YES**, How old is she now?
_________ years old.

Where does your mother live now? a Tobago b Trinidad c Other: ______________

10. Did your FATHER ever break or fracture his hip? **(MARK ONE BOX.)**

Yes 1 | No 0 | Not that I know of 2 | Don't know -3

Please go to Question 11

If **YES**: At what age did your father break his hip?

11. Is your natural father still living? **(MARK ONE BOX.)**

Yes 1 | No 0 | Don't know -3

If **NO**, How old was your father when he died? ______ years old.

If **YES**, How old is he now?
_________ years old.

Where does your father live now? a Tobago b Trinidad c Other:____________

BACK PROBLEMS

12. DURING THE PAST 12 MONTHS, have you had any back pain?

Yes 1 | No 0 | Don't Know -3

Please go to Question 13

If **YES**, a. Do you currently have back pain? Yes 1 No 0 Don't know -3

b. How many different times have you been bothered by back pain in the past 12 months?

1 1 or 2 times
2 3 to 5 times
3 6 or more times
4 All the time, constantly

13. About how many hours per week do you spend watching television?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

TOTAL HOURS ____________

14. Not including time spent watching television, about how many hours per week do you spend reading or sitting?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

TOTAL HOURS ____________

15. On average, how many total minutes per week do you walk including: to and from work, transportation, shopping, etc.?

_____________________ Minutes

16. Overall, how would you rate your health?

1 Excellent
2 Good
3 Fair
4 Poor
5 Very Poor

17. COMPARED TO 12 MONTHS AGO, how would you rate your overall health?

1 Much better now / Somewhat better now
2 About the same now
3 Somewhat worse now / Much worse now

18. COMPARED TO PEOPLE YOUR OWN AGE, how would you rate your overall health?

1 Excellent
2 Good
3 Fair
4 Poor
5 Very Poor

MEDICAL HISTORY

19. Has the doctor ever told you that you have any of the following conditions? (Mark Yes, No, or Don't Know for each condition)

	YES	NO	Don't Know
High blood pressure (hypertension)	1	0	-3
Coronary heart disease/heart attack	1	0	-3
Stroke	1	0	-3
Emphysema	1	0	-3
Chronic bronchitis	1	0	-3
Diabetes	1	0	-3
Colorectal polyp(s)	1	0	-3
Arthritis in the knee	1	0	-3
Arthritis in the hip	1	0	-3
Other arthritis	1	0	-3
Osteoporosis	1	0	-3
Hepatitis	1	0	-3
Cirrhosis	1	0	-3
Diverticulitis/diverticulosis	1	0	-3
Gall bladder stones or inflammation	1	0	-3
High Thyroid	1	0	-3
Low Thyroid	1	0	-3
Ulcer	1	0	-3
Nervous or emotional problems	1	0	-3

20. Have you ever been diagnosed as having any type of cancer? (Do not include Basal-Cell Skin Cancer)

Yes 1

No 0 Don't Know -3
Please go to Question 22

21. If **YES**, please complete this chart for each cancer. (Do not include Basal-Cell Skin Cancer). (If you have been diagnosed with more than 2 types of cancer, please include a separate page to record this information.)

What type of cancer did you have?		How old were you when you were diagnosed with this cancer?
1st Cancer	______ Type of cancer	______ Age
2nd Cancer	______ Type of cancer	______ Age

22. Has your mother, daughter(s), sister(s), or half-sister(s) ever been diagnosed as having breast cancer?

Yes 1

No 0 Don't Know -3
Please go to Question 24

23. Please complete this chart for each relative {mother, daughter(s), sister(s), or half-sister(s)} diagnosed with breast cancer? (If you have more than three relatives diagnosed with breast cancer, please include a separate page with this information.)

Who was diagnosed as having breast cancer, that is, what is her relationship to you?		How old was your relative when she was diagnosed as having breast cancer?
1st RELATIVE	______ Relationship	______ Age
2nd RELATIVE	______ Relationship	______ Age
3rd RELATIVE	______ Relationship	______ Age
4th RELATIVE	______ Relationship	______ Age

24. Has your father, son(s), brother(s) or half-brother(s) ever been diagnosed as having prostate cancer?

Yes 1

No 0 Don't Know -3
Please go to Question 26

25. Please complete this chart for each relative {father, son(s), brother(s) or half-brother(s)} diagnosed with prostate cancer? (If you have more than three relatives diagnosed with prostate cancer, please include a separate page with this information.)

Who was diagnosed as having prostate cancer, that is, what is his relationship to you?		How old was your relative when he was diagnosed as having prostate cancer?
1st RELATIVE	______ Relationship	______ Age
2nd RELATIVE	______ Relationship	______ Age
3rd RELATIVE	______ Relationship	______ Age
4th RELATIVE	______ Relationship	______ Age

REPRODUCTIVE HISTORY

26. Have you ever been pregnant? (Mark YES even if your pregnancy did not result in a live child birth)

Yes [1]

No [0] Don't Know [-3]
Please go to Question 27

If **YES**:

a. Age at first pregnancy? ____________ years old

b. How many of your pregnancies resulted in the birth of a live child?
___________ pregnancies

c. How many of your pregnancies lasted **6 months or longer**, but ended in still-birth?
___________ pregnancies

d. How many of your pregnancies lasted **less than 6 months** and ended in a miscarriage, a spontaneous abortion, or for some other reason?
___________ pregnancies

27. Did you ever breast-feed any children? (Mark YES even if you bottle-fed the child during the same time)

Yes [1]

No [0] Don't Know [-3]
Please go to Question 28

a. If **YES**, how many children did you breast-feed? __________________ children

28. How old were you at the time of your first menstrual period?

________ years old

29. About how old were you at the time of your last menstrual period? (Do not include menstrual bleeding due to taking hormone pills)

________ years old

Don't Know [-3]

Never had menstrual periods [0]
Please go to Question 32

30. Between the time you had your first menstrual period and your last menstrual period, did you ever go without any periods for at least one year? (Do not include when you were pregnant or breast feeding)

Yes [1]

No [0] Don't Know [-3]
Please go to Question 31

a. If **YES**, between your first menstrual period and your last, about how many years in total did you go without having a period? ___________ years

31. Regarding menopause or the change of life, do you think you are: (Please read all choices to respondent before selecting one answer)

a. Without any sign	________
b. Just beginning	________
c. In the middle	________
d. Near the end	________
e. All through	________
f. Don't know	________
g. Refused	________

32. Now I am going to read some statements about some general attitudes and feelings that women your age may have. Please tell me whether you personally agree, neither agree nor disagree, or you disagree with them. (Please read questions a-e) *[PROMPT AT*: Do you personally agree, have no opinion, or disagree with …..]*

Statement:	**Agree**	**Neither Agree Nor Disagree**	**Disagree**	**Don't Know**	**Refused**
*a. The older a woman is, the more valued she is.	1	2	3	-3	-9
*b. A woman is less attractive after menopause.	1	2	3	-3	-9
c. Women who no longer have menstrual periods feel free and independent.	1	2	3	-3	-9
d. Menopause is a mid-life change that generally does not need medical attention.	1	2	3	-3	-9
*e. Women with little free time hardly notice the menopause.	1	2	3	-3	-9

33. Now I am going to read you some statements about your personal feelings. Please tell me whether you personally agree, neither agree nor disagree, or you disagree with them. (Please read questions a-e) *[PROMPT AT*: Do you personally agree, have no opinion, or disagree with …..]*

Statement:	**Agree**	**Neither Agree Nor Disagree**	**Disagree**	**Don't Know**	**Refused**
*a. Overall, going through menopause or the change of life will be or was a positive experience.	1	2	3	-3	-9
*b. As I age, I feel worse about myself.	1	2	3	-3	-9
c. During menopause or the change of life I expect to become or became irritable or depressed (sad).	1	2	3	-3	-9
d. I will feel or felt regret when my menstrual period stopped for the last time.	1	2	3	-3	-9
*e. I do not or did not know what to expect with menopause or the change of life.	1	2	3	-3	-9

34. Have you ever had a hysterectomy? (surgery to remove your uterus)

Yes [1] ⬇

No [0] Don't Know [-3]
Please go to Question 35

If **YES**:
a. How old were you when you had this surgery? ____________ years old

35. Have you ever had an ovary removed?

Yes [1] ⬇

No [0] Don't Know [-3]
Please go to Question 36

If **YES**:
a. How old were you when you had this surgery? ____________ years old
____________ years old

b. How many ovaries were removed?
One [1] Two (both) [2] Don't Know [-3]

36. Have you ever had thyroid removed?

Yes [1] ⬇

No [0] Don't Know [-3]
Please go to Question 37

If **YES**:
a. How old were you when you had this surgery? ____________ years old
____________ years old

37. Have you ever had a gallbladder operation?

Yes [1] ⬇

No [0] Don't Know [-3]
Please go to Question 38

If **YES**:
a. How old were you when you had this surgery? ____________ years old
____________ years old

38. Have you ever had wedge resection (i.e., "ovarian drilling")?

Yes [1] ⬇

No [0] Don't Know [-3]
Please go to Question 39

If **YES**:
a. How old were you when you had this surgery? ____________ years old
____________ years old

39. Lifetime Menstrual History *(complete for times when participant was not pregnant or using hormones)*:

Age (yrs)	Average Number of Menstrual Periods Per Year	Frequency of Menstrual Periods (please check only one box for each age grouping)					
		More than once per month	Once per month	Every other month	3-4 times per year	Rarely	No menstrual periods
Less than 20 years							
20-29							
30-39							
40-49							
50-59							
60-69							
70-79							
80-89							

HORMONE USE

40. Have you ever taken or used any of the following medications:

a. Oral Contraceptives or 'The Pill'?

Yes 1 ⬇ | No 0 | Don't know -3 — Please go to Question 40b.

If **YES**,

1. Are you still taking the pill? Yes 1 — Please go to Question a3. | No 0 ⬇

2. At what age did you stop taking the pill? ________ yrs

⬇ ⬇

3. How many years (in total) did you take the pill? ________ yrs

b. Hormones, HRT or Estrogen Pills?

Yes 1 ⬇ | No 0 | Don't know -3 — Please go to Question 40c.

If **YES**,

1. At what age did you start taking estrogen? _______ yrs

2. What is the name & dosage of the estrogen that you took for the longest period of time?

________________________ name

__________________ dose/formula

3. Are you still taking estrogen? Yes 1 — Please go to Question b5. | No 0 ⬇

4. At what age did you stop taking the estrogen? ________ yrs

⬇ ⬇

5. How many years (in total) did you take estrogen? ________ yrs

c. Progestin Pills?

Yes [1] ⬇

No [0] Don't know [-3]
Please go to Question 40d.

If **YES**,

1. At what age did you start taking progestin? _______ yrs

2. What is the name & dosage of the progestin that you took for the longest period of time? ____________________________ name ______________________ dose/formula

3. Are you still taking progestin? Yes [1] No [0] ⬇

Please go to Question c5. ⬇

4. At what age did you stop taking progestin? ________ yrs ⬇

I

5. How many years (in total) did you take progestin? ________ yrs

d. Estrogen Skin Patch?

Yes [1] ⬇

No [0] Don't know [-3]
Please go to Question 40e.

If **YES**,

1. At what age did you start using the patch? _______ yrs

2. What is the name & dosage of the patch that you used for the longest period of time? ____________________________ name ______________________ dose/formula

3. Are you still using the patch? Yes [1] No [0] ⬇

Please go to Question d5. ⬇

4. At what age did you stop using the patch? ________ yrs ⬇

5. How many years (in total) did you use the skin patch? ________ yrs

e. Prednisone, Cortisone, or other steroid?

Yes 1 ⬇ | No 0 | Don't know -3 — Please go to Question 40f.

If **YES,**

1. At what age did you start taking Prednisone, Cortisone, or other steroid? ________ yrs

2. Are you still taking Prednisone, Cortisone, or other steroid? Yes 1 No 0

3. How many years (in total) did you take Prednisone, Cortisone, or other steroid? ________ yrs

f. Thyroid Pills or Supplements?

Yes 1 ⬇ | No 0 | Don't know -3 — Please go to Question 40g.

If **YES,**

1. At what age did you start taking Thyroid Pills or Supplements? ________ yrs

2. Are you still taking Thyroid Pills or Supplements? Yes 1 No 0

3. How many years (in total) did you take Thyroid Pills or Supplements? ________ yrs

g. Hormonal Injections?

Yes 1 ⬇ | No 0 | Don't know -3 — Please go to Question 41.

If **YES,**

1. At what age did you start taking Hormonal Injections?? ________ yrs

2. Are you still taking Hormonal Injections?? Yes 1 No 0

3. How many years (in total) did you take Hormonal Injections?? ________ yrs

41. Have you ever used any of the following herbs?

a.	Noni	1 Yes	0 No
b.	Evening Primrose Oil	1 Yes	0 No
c.	Others, please describe: ________________________	1 Yes	0 No
	________________________	1 Yes	0 No
	________________________	1 Yes	0 No

ALCOHOL / CAFFEINE / SMOKING HISTORY

42. Have you ever, at any time in your life, had any kind of ALCOHOLIC beverages?

Yes 1

No 0 Don't Know -3 Please go to Question 43

If **YES**:

a. At what age did you begin drinking alcoholic beverages? __________ years old

b. Was there ever a time in your life when you drank more than you do now? Yes 1 No 0

c. In the last 12 months, about how often did you drink any kind of alcoholic beverage?

Every day	1
Nearly every day	2
3 or 4 times a week	3
Once or twice a month	4
2 or 3 times a month	5
About once a month	6
6-11 times a year	7
1-5 times a year	8
Not during the past 12 months	9

d. When you drink wine, beer or hard liquor, how many drinks would you usually have at one time?

1	1
2-4	2
5-8	3
8+	4

e. Have you stopped drinking alcohol? Yes 1

No 0 (Go to Q. 43)

If **YES:**

At what age did you stop drinking alcohol? ________________ Years

43. Do you currently drink any of the following CAFFEINATED beverages?

	NO	YES	If yes, how many cups/cans per day? (less than 1 cup/can per day = 0.5) Cups with Milk	Cups without Milk
A. Regular Coffee (not decaffeinated)	0	1		
B. Regular Tea (not decaffeinated)	0	1		
			How many glasses/cans per day?	
C. Caffeinated Sodas (Pepsi, Coke)	0	1		

44. Have you smoked at least 100 cigarettes in your entire life?

Yes 1 | No 0 | Don't Know -3

45. Have you ever smoked cigarettes regularly for six months or longer?

Yes 1 | No 0 | Don't Know -3

Please go to Question 50

a. If **YES**, at what age did you start smoking cigarettes regularly?
(Enter age first started smoking in the space provided) __________

46. Do you smoke regularly now?

Yes 1 | No 0 | Don't Know -3

Please go to Question 49

47. At what age did you last stop smoking cigarettes regularly? _____ _____ years old

48. How many cigarettes did or do you usually smoke per day?

1. 1-10
2. 11-20
3. 21-30
4. 31-40
5. 41-60
6. 61-80
7. 81 or more

49. Did or do you more often smoke filter or non-filter cigarettes?

1. Filter more often
2. Non-filter more often
3. Both about equally

CALCIUM INTAKE

50. For the period of your life indicated below, check the box that best describe how often you drank milk (include whole, low fat, and skim milk)	About every meal (3 or more glasses a day)	About every day but not every meal (1 or 2 glasses a day)	Every week, but not every day	Rarely or never
When I was in my teens (ages 12-17):	3	2	1	0
When I was pregnant or breast-feeding:	3	2	1	0
When I was 18-50 (not including times I was pregnant or breast-feeding):	3	2	1	0
From age 50 on:	3	2	1	0

51. How often do you eat each of the following foods all year round?

Type of Food:	Never	A few times per year	1 time per month	2-3 times per month	1 time per week	2 times per week	3-4 times per week	5-6 times per week	Every Day
Sardines without bones	0	1	2	3	4	5	6	7	8
Sardines with bones	0	1	2	3	4	5	6	7	8
Fish heads without bones	0	1	2	3	4	5	6	7	8
Fish heads with bones	0	1	2	3	4	5	6	7	8
Fried jacks (fried dry)	0	1	2	3	4	5	6	7	8
Chewed bones from meat, fish, or poultry	0	1	2	3	4	5	6	7	8
Callaloo soup	0	1	2	3	4	5	6	7	8
Legumes (dried beans, peas, lentils & etc.)	0	1	2	3	4	5	6	7	8
Green leafy vegetables (dasheen leaves, spinach, patch choy, & etc.)	0	1	2	3	4	5	6	7	8
Bone soup	0	1	2	3	4	5	6	7	8
Cottage cheese	0	1	2	3	4	5	6	7	8
Cheddar cheese	0	1	2	3	4	5	6	7	8
Other cheeses or cheese spread	0	1	2	3	4	5	6	7	8
Yogurt	0	1	2	3	4	5	6	7	8
Pizza	0	1	2	3	4	5	6	7	8

52. How often do you eat the following foods:

Type of Food:	Never	A few times per year	1 time per month	2-3 times per month	1 time per week	2 times per week	3-4 times per week	5-6 times per week	Every Day
Ketchup on food or cooked in stew & etc.	0	1	2	3	4	5	6	7	8
Cooked tomatoes or stewed tomatoes (excluding catsup) in sauce or gravy	0	1	2	3	4	5	6	7	8
Raw tomatoes (sliced, in salsa, in salad)	0	1	2	3	4	5	6	7	8
Raw guava **in season**	0	1	2	3	4	5	6	7	8
Raw guava **out of season**	0	1	2	3	4	5	6	7	8
Cooked or stewed guava **in season**	0	1	2	3	4	5	6	7	8
Cooked or stewed guava **out of season**	0	1	2	3	4	5	6	7	8
Ripe mango **in season**	0	1	2	3	4	5	6	7	8
Ripe mango **out of season**	0	1	2	3	4	5	6	7	8
Cooked or stewed mango **in season**	0	1	2	3	4	5	6	7	8
Cooked or stewed mango **out of season**	0	1	2	3	4	5	6	7	8
Papaya **in season**	0	1	2	3	4	5	6	7	8
Papaya **out of season**	0	1	2	3	4	5	6	7	8
Pink grapefruit **in season**	0	1	2	3	4	5	6	7	8
Pink grapefruit **out of season**	0	1	2	3	4	5	6	7	8

53. How often do you take each of the following supplements all year round?

Supplements:	Never	A few times per year	1 time per month	2-3 times per month	1 time per week	2 times per week	3-4 times per week	5-6 times per week	Every Day
Calcium	0	1	2	3	4	5	6	7	8
Multivitamins	0	1	2	3	4	5	6	7	8

54. In the table below, please list the number of your relatives that are still living, and the number of these relatives who live on Tobago and Trinidad:

Relative	Total Number Still Living	Number Living on Tobago	Number Living on Trinidad
Full sisters (same mother and father as you)			
Sisters' Children			
Half sisters (same mother and different father)			
Half sisters (same father and different mother)			
Full brothers (same mother and father as you)			
Brothers' Children			
Half brothers (same mother and different father)			
Half brothers (same father and different mother)			
Brothers and Sisters of your Father			
Their children (your nieces and nephews on your father's side)			
Brothers and Sisters of your Mother			
Their children (your nieces and nephews on your mother's side)			
Biological Daughters			
Biological Sons			
Grandchildren			
Great Grandchildren			

55. About how many of your relatives do you think would participate in a *Tobago Family Health Study* (a study similar to the one you are participating in)? __________

PRESCRIPTION AND OVER-THE COUNTER MEDICATIONS QUESTIONNAIRE

56. Please record the name of the prescription or non-prescription medication and duration of use. Mark duration of use and whether it is a prescription drug.

Medication 1
a. Name:
b. Duration of use: < 1 month 1-12 mos 1-3 yrs 3-5 yrs > 5 yrs Don't Know
c. Prescription Medication: Yes No

Medication 2
a. Name:
b. Duration of use: < 1 month 1-12 mos 1-3 yrs 3-5 yrs > 5 yrs Don't Know
c. Prescription Medication: Yes No

Medication 3
a. Name:
b. Duration of use: < 1 month 1-12 mos 1-3 yrs 3-5 yrs > 5 yrs Don't Know
c. Prescription Medication: Yes No

Medication 4
a. Name:
b. Duration of use: < 1 month 1-12 mos 1-3 yrs 3-5 yrs > 5 yrs Don't Know
c. Prescription Medication: Yes No

Medication 5
a. Name:
b. Duration of use: < 1 month 1-12 mos 1-3 yrs 3-5 yrs > 5 yrs Don't Know
c. Prescription Medication: Yes No

Medication 6
a. Name:
b. Duration of use: < 1 month 1-12 mos 1-3 yrs 3-5 yrs > 5 yrs Don't Know
c. Prescription Medication: Yes No

57. Do you take any of the following medications three or more times per week?

a. Aspirin (Bayer, baby aspirin, children's aspirin, Ecotrin, Excedrin, and etc.)?
$_1$ Yes $_0$ No

b. Acetaminophen (Tylenol, Tylenol with codeine, etc.)?
$_1$ Yes $_0$ No

c. Ibuprofin (Advil, Motrin, and etc.)?
$_1$ Yes $_0$ No

Naproxen Sodium (Aleve, and etc.)?
$_1$ Yes $_0$ No

58. Were you troubled by acne after your teen years?

Yes 1 ⬇ | No 0 Don't Know -3 — Please go to Question 61

If **YES**:

a. For how long? ______ years

b. Do you currently have acne? Yes 1 No 0

c. Where is/was the acne located? (check all that apply)

Face or head 1 Shoulder, back, or chest 2

59. Have you ever been troubled by unwanted body hair?

Yes 1 ⬇ | No 0 Don't Know -3 — Please go to Question 62

If **YES**: (check all that apply)

a. Where is/was the unwanted body hair?

Upper lip
Chin
Neck
Chest
Lower stomach
Inner upper thighs
Sideburns
Lower back

60. Have any of your male relatives (grandfather, father, brother, or son) developed baldness before age 30 years?

Yes 1 Possible 2 ⬇ | No 0 Don't Know -3 — Please End Survey

If **YES**: (check all that apply)

Maternal grandfather
Paternal grandfather
Father
Brother
Son

Questions to be completed by Tobago Women's Study Staff

61. Who was interviewed to answer the questions on this form?

a. Answered by the woman participating in the study
b. Answered by someone else (specify relationship) ______________________________

FOR PITTSBURGH OFFICE USE ONLY

Data Entry Date____/____/____ Data Entry ID# _________

BIOLOGICAL SAMPLE COLLECTION FORM

1. Date of Collection: _______/_______/_______ Blood Drawn By: ___________________________
Day Month Year Name

Name: _________________ _________________ _______________ __________________
First Middle Maiden (nee) Last

FOR LAB USE ONLY: Please complete if actual date of draw is different from the date above

Actual Date of Draw: _______/_______/_______ _______________________
Day Month Year Lab Tech

---

2. Time of most recent food intake ___ ___:___ ___ am pm (circle one)

3. Peripheral venous blood (15 ml red top vacutainer): _____ (one) _____ (two) _____ (three) _____ (four)

   No ______ Yes ______ If no, reason: _______________________

4. Time of blood draw: ___ ___: ___ ___ am pm (circle one)

5. Serum aliquots (1-2 ml each) Please circle number of aliquots:

   1 2 3 4 5 6 7 8 9 10

   11 12 13 14 15 16 17 18 19 20

6. Number of blood clots (save all available): _____ (one) _____ (two) _____ (three) _____ (four)

7. Spot urine collected?

   No ______ Yes ______ If no, reason: _______________________

8. Time of spot urine collection: ___ ___: ___ ___ am pm (circle one)

9. Time of finger prick for fasting blood sugar: ___ ___: ___ ___ am pm (circle one)

10. Whole blood fasting glucose?

    No ___Yes ___ Reading: ___ ___ ___ ___ (mg/dl)

11. Glucometer Brand Name: _____________________________________

Name: ____________ ____________ _____________ ____________ Date: ______ / ____ / ______
First Middle Maiden (nee) Last Month Day Year

Blood Pressure and Pulse

(Measured after 5 minutes of quiet seated resting, legs not crossed)

12. Name of Blood Pressure Observer: ______________________

13. Pulse ____ beats in 30 second x 2 = ______ beats/minute. Arm circumference: _________cm

14. Cuff: child adult large adult (circle one)

15. Pulse Obliteration Pressure: _____ + 30 = _____ (Peak inflation pressure)

	Systolic	Diastolic
Reading 1:	_______________	________________
Reading 2:	_______________	________________
Reading 3:	_______________	________________

16. Have you ever been told that you had high blood pressure? (please check appropriate response)

No 0 — Please go to Question 18

Yes 1

17. If **YES:** About how long ago was your high blood pressure first diagnosed

________|__________ (Probe for month is less than 1 year)
Month Year

18. Have you ever taken high blood pressure medication prescribed for you by a doctor?

Yes 1 | No 0 | Don't Know -3 — Please go to Question 19

a. If **YES**, are you currently taking medication prescribed by a doctor for high blood pressure?

Yes 1 | No 0 | Don't Know -3

19. Referral for high blood pressure indicated: (Please circle one response)
   1. No, blood pressure normal
   2. No, currently being treated
   3. Yes, currently being treated but needs checkup
   4. Yes, not currently being treated, needs referral

20. Referral for high sugar in blood or urine indicated: (Please circle one response)
   1. No, sugar levels in blood and urine normal
   2. No, currently being treated
   3. Yes, currently being treated but needs checkup
   4. Yes, not currently being treated, needs referral