SCCS
Southern Community Cohort Study

Please complete this survey ONLY if you are

FU1 W2 F

Marking Instructions

Please use a No. 2 pencil or black or blue ink only.
Print legible numbers and capital block letters in the boxes.

Correct Numbers and Letters	Correct Mark	Incorrect Marks
1 2 3 A B C	■ X	✓ ▬ •

1. What is your date of birth? Month ☐☐ Day ☐☐ Year 19☐☐

What is your CURRENT:

2. Cigarette smoking status: ☐ Non-smoker ☐ Smoker → How many cigarettes per day? ☐☐☐

3. Total household income, per year (please mark one)

☐ <$15,000 ☐ $15,000-$24,999 ☐ $25,000-$49,999 ☐ $50,000-$99,999 ☐ $100,000 or more

4. Health insurance coverage (please mark ALL that apply)

☐ None ☐ Medicaid ☐ Medicare ☐ Private insurance ☐ Military ☐ Other type

5. Usual source of medical care (please mark one)

☐ Community health center or free clinic ☐ Private doctor's office ☐ Emergency room ☐ Veterans Affairs (VA)
☐ Hospital (not in the emergency room) ☐ Other source ☐ You have no source

6. Marital status (please mark one)

☐ Married, or living as married with a partner ☐ Separated or divorced ☐ Widowed ☐ Single, never been married

7. Employment status (please mark the one that *best* describes your situation)

☐ Work for pay, full time ☐ Work for pay, part time ☐ Unemployed ☐ On disability ☐ Retired ☐ Housewife

8. About how many HOURS PER DAY, on average, do you spend OUTDOORS on weekdays and weekends?

Weekdays:	☐ None	☐ less than 1	☐ 1 to 2	☐ 3 to 4	☐ 5 to 6	☐ 7 to 8	☐ more than 8
Weekends:	☐ None	☐ less than 1	☐ 1 to 2	☐ 3 to 4	☐ 5 to 6	☐ 7 to 8	☐ more than 8

9. In a 24-hour period, how many HOURS do you typically spend:

Sitting: Hours ☐☐ | **Sleeping:** Hours ☐☐

10. After joining this study in , have you been diagnosed with any of the following conditions?

To the best of your memory, please tell us the month and year when a doctor diagnosed this condition.

	Yes	No	Month	Year
Diabetes/high blood sugar	☐	☐	☐☐	200☐
→ If yes, are you currently taking medication to control your diabetes: ☐ Yes ☐ No				
Polyps in your colon or rectum (benign, not cancer)	☐	☐	☐☐	200☐
Fibroids in your uterus/womb	☐	☐	☐☐	200☐

11. After joining this study in , have the following events occurred?

To the best of your memory, please tell us the month and year when this happened. If it happened more than once after you joined the study, tell us the first time it happened after .

	Yes	No	Month	Year
Heart attack or myocardial infarction (MI)	☐	☐	☐☐	200☐
Stroke (not a mini-stroke or TIA)	☐	☐	☐☐	200☐
Hip fracture (broken hip)	☐	☐	☐☐	200☐
Back or spinal fracture (include compression fracture)	☐	☐	☐☐	200☐

12. Have you EVER had:

To the best of your memory, please tell us the month and year when this occurred.

	Yes	No	Month	Year
Uterus/womb removed	☐	☐	☐☐	☐☐☐☐

	One	Both	No	Month	Year
Any ovaries removed	☐	☐	☐	☐☐	☐☐☐☐

13. After joining this study in , have you been diagnosed with any type of CANCER?

☐ No ☐ Yes → **What type of cancer?**

→ **Skip to Question 15**

- ☐ Bladder
- ☐ Brain
- ☐ Breast
- ☐ Cervix
- ☐ Colon
- ☐ Esophagus
- ☐ Kidney
- ☐ Leukemia
- ☐ Liver
- ☐ Lung
- ☐ Melanoma
- ☐ Mouth or throat
- ☐ Multiple myeloma
- ☐ Non-Hodgkin lymphoma
- ☐ Ovary
- ☐ Pancreas
- ☐ Rectum
- ☐ Stomach
- ☐ Thyroid
- ☐ Uterus/endometrium
- ☐ Other (Describe below)

14. Please tell us when and where your cancer was treated:

Date of Diagnosis: Month ☐☐ Year 200☐

Name of hospital:

City and State of hospital:

15. How much do you currently weigh? Pounds ☐☐☐

16. How much did you weigh *when you were BORN?* *(Example: 8 pounds 2 ounces)* Pounds ☐☐ Ounces ☐☐ or ☐ Don't know

17. Have you been through menopause, or have your natural menstrual periods stopped for at least six months?

☐ No ☐ Yes → **Why did your periods stop?** (please mark **one**)

- ☐ Natural menopause
- ☐ Radiation, chemotherapy, or medication
- ☐ Surgery that removed uterus or ovaries
- ☐ Other reason

How old were you when your natural menstrual periods stopped? Age ☐☐

18. Are you currently taking hormone replacement therapy (HRT)?

☐ No ☐ Yes → **If yes, what is the name of the HRT:** (mark **ALL** that apply)

- ☐ Cenestin
- ☐ Climara
- ☐ Estracep
- ☐ Estratest
- ☐ Estrogen or Estradiol
- ☐ Herbal preparation or soy
- ☐ Premarin
- ☐ Prempro
- ☐ Provera
- ☐ Vivelle
- ☐ Other (specify)

For how many years have you taken HRT? Years ☐☐ (enter 00 years if less than one year)

19. Have you EVER had a breast biopsy? (where a doctor collects a small sample of breast tissue or cells, using a needle or other method)

☐ No ☐ Yes → How many breast biopsies have you had **in your lifetime?** Total ☐☐ What was your age at your **first** breast biopsy? Age ☐☐ What was your age at your **most recent** breast biopsy? Age ☐☐

20. About how many adult teeth have you lost in your lifetime due to tooth decay or gum disease?

☐ None ☐ 1 to 4 ☐ 5 to10 ☐ more than 10 but not all of them ☐ all of them

21. How many decayed teeth or cavities do you currently have that have not been treated?

☐ None ☐ 1 or 2 ☐ 3 to 5 ☐ 6 or more ☐ not applicable because all your teeth are dentures or you have no teeth

22. Has a dentist or doctor ever told you that you have had gum disease (gingivitis or periodontitis)?

☐ No ☐ Yes → If yes, how old were you at the time of first diagnosis? Age ☐☐

23. Do you currently take any of the following at least once per week? If yes, how many pills/tablets per week?

	Yes	No	
Baby aspirin	☐	☐	☐☐☐
Regular aspirin	☐	☐	☐☐☐
Multivitamin	☐	☐	☐☐☐
Vitamin D supplement (with or without calcium)	☐	☐	☐☐☐

24. Have you EVER TAKEN, or do you CURRENTLY TAKE, the following prescription medications?

	No	Currently take	Took in the past	Length of time taken (years) (enter 00 years if less than one year)	Age when first started taking
Raloxifene (Evista)	☐	☐	☐	☐☐	☐☐
Tamoxifen (Nolvadex)	☐	☐	☐	☐☐	☐☐

25. Do you currently take prescription medication to lower your cholesterol?

☐ Yes ☐ No → **Which one(s):** (mark **ALL** that apply)

☐ Crestor (Rosuvastatin) ☐ Lescol (Fluvastatin) ☐ Lipitor (Atorvastatin) ☐ Lopid (Gemfibrozil) ☐ Mevacor (Lovastatin) ☐ Pravachol (Pravastatin) ☐ Vytorin (Ezetimibe/Simvastatin) ☐ Zetia (Ezetimibe) ☐ Zocor (Simvastatin) ☐ Other(s) (specify)

26. After joining this study in , have you had a:

	Don't know	No	Yes
Colonoscopy (a long tube inserted into the entire colon to look for colorectal polyps or cancer, while you are sedated)	☐	☐	☐
Sigmoidoscopy (a tube inserted partway into the colon to look for colorectal polyps or cancer)	☐	☐	☐
A test to check your stool/feces for blood (to detect colorectal cancer)	☐	☐	☐
Mammogram (x-ray to check for breast cancer)	☐	☐	☐
Pap smear	☐	☐	☐
Blood test to check for diabetes	☐	☐	☐

27. Please tell us if your FAMILY MEMBERS have ever been diagnosed with these cancers (mark **ALL** that apply):
(Note: **full** sister and **full** brother means that you have the same biological mother **and** biological father.)

Breast cancer:	☐ No	☐ Birth mother	☐ 1 full sister	☐ More than 1 full sister	
Prostate cancer:	☐ No	☐ Birth father	☐ 1 full brother	☐ More than 1 full brother	
Lung cancer:	☐ No	☐ Birth mother	☐ Birth father	☐ 1 full brother or sister	☐ More than 1 full brother or sister
Colorectal cancer:	☐ No	☐ Birth mother	☐ Birth father	☐ 1 full brother or sister	☐ More than 1 full brother or sister

28. In general, would you say your health is: Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐

29. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table , pushing a vacuum cleaner, bowling, or playing golf.	☐	☐	☐
b. Climbing several flights of stairs	☐	☐	☐

30. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Were limited in the kind of work or other activities	☐	☐	☐	☐	☐

31. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Did work or activities less carefully than usual	☐	☐	☐	☐	☐

32. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐

33. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐
c. Have you felt downhearted and depressed?	☐	☐	☐	☐	☐

34. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

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

Please update YOUR information below:

Name:

Address:

City: **State:** **ZIP Code:**

Please update YOUR telephone numbers for our records:

YOUR HOME NUMBER (☐☐☐) ☐☐☐ - ☐☐☐☐

YOUR CELL NUMBER (☐☐☐) ☐☐☐ - ☐☐☐☐

Can you please provide us with the name and telephone number of a close friend or family member (not living with you) who would know how to get in touch with you if you moved:

Name of friend/family member NOT LIVING WITH YOU:

Telephone number of friend/family member:

(☐☐☐) ☐☐☐ - ☐☐☐☐