DISC

GIRLS FOLLOW-UP STUDY

Background Information Questionnaire

21558

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)

This questionnaire asks general information about you.

1. What is your date of birth? ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)

2. What is your current age? ☐☐ years old

3. What is your race? **(Answer each item)**

A. White	○ Yes	○ No	E. Native Hawaiian or Other Pacific Islander	○ Yes	○ No
B. Black or African American	○ Yes	○ No	F. Some other race	○ Yes	○ No
C. Asian	○ Yes	○ No			
D. American Indian or Alaska Native	○ Yes	○ No			

Specify _____

4. Are you Spanish, Hispanic or Latino? ○ Yes ○ No

5. What is your ancestry or ethnic origin? Some examples include Irish, Mexican, Nigerian and Chinese.

Please specify one or more: _____

6. What is the highest level of education you have completed? **(Choose only one)**

- ○ Less than 8 years
- ○ 8-11 years (without graduation)
- ○ High school graduate or G.E.D.
- ○ Vocational or technical school after high school
- ○ Some college or university
- ○ Bachelor's degree
- ○ Graduate degree

7. Are you currently enrolled in school? ○ Yes, full-time ○ Yes, part-time ○ No

8. What is your occupation? _____

9. Do you currently work for pay? ○ Yes, full-time ○ Yes, part-time ○ No

10. Do you currently do volunteer work? ○ Yes, full-time ○ Yes, part-time ○ No

11. What is your current marital status? **(Choose only one)**

- ○ Single, never married
- ○ Married
- ○ Living as if married
- ○ Separated
- ○ Divorced
- ○ Widowed

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FAX to MMRI (410) 323 - 4729

DISC

Girls Follow-Up Study

Menstrual History Questionnaire

54499

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)

This questionnaire asks about your menstrual periods. Some of the questions ask you to give ages when certain things happened. If you are not sure about the exact age, please give your best estimate.

1. Have you ever had a menstrual period? ○ Yes ○ No (If No, Skip items 2 - 10)

2. How old were you when you had your first period? ☐☐ years old

3. Not including the first few years after you started your period, during most of your life, have your periods been regular? That is, when you were not pregnant, breast feeding, or using hormones for birth control, did your periods usually occur when expected? ○ Yes ○ No

4. Not including when you were pregnant, breast feeding, or using hormones for birth control, how many days are there usually between your periods? Please start with the first day of your period and count up to, but not including, the first day of your next period. ☐☐☐ days

5. Did you bring your menstrual calendar? ○ Yes ○ No

6. If you brought your menstrual calendar, what is the date you recorded for the start of your last period? If you do not have your calendar, what is the date your last period started? ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)
   (If less than one month from today, skip to item 8)

7. If longer than one month, why have you not had a period in the past month? **(Choose only one)**
   - ○ Normally have long intervals between periods
   - ○ Used birth control pills, patches, vaginal rings, or implants to skip periods
   - ○ Irregular / skipped periods
   - ○ Do not know
   - ○ Pregnancy
   - ○ Other (Specify)
   - ○ Hysterectomy (uterus removed) or ovaries removed _____

8. Not including when you were pregnant, breast feeding or using hormones for birth control, did you ever go without any period for at least one year? ○ Yes ○ No (If No, Skip items 9 - 10)

9. Not including when you were pregnant, breast feeding or using hormones for birth control, how long was the longest time you went without having a period? ☐☐.☐ years **(Refer to Decimal Table)**

10. Related to number 8, why did you go without a period? **(Choose only one)**
    - ○ Hysterectomy (uterus removed)
    - ○ Do not know
    - ○ Oophorectomy (ovaries removed)
    - ○ Other (Specify) _____

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FAX to MMRI (410) 323 - 4729

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GIRLS FOLLOW-UP STUDY

Pregnancy History Questionnaire

50016

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
(mon / day / year)

This questionnaire asks about your pregnancy history. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

1. Have you ever tried for one straight year to become pregnant and during that time did not become pregnant? ○ Yes ○ No **(If No, skip to item 9)**

2. Did you or your partner ever visit a doctor because you had trouble getting pregnant? ○ Yes ○ No

3. Do you know the reason you had trouble getting pregnant? **(Answer each item)**

A. Problems with ovaries	○ Yes	○ No	E. Partner had problem	○ Yes	○ No
B. Problems with fallopian tubes	○ Yes	○ No	F. No problem found	○ Yes	○ No
C. Problems with uterus or cervix	○ Yes	○ No	G. Do not know	○ Yes	○ No
D. Hormonal problem	○ Yes	○ No	H. Other fertility problem **(Specify)**	○ Yes	○ No

_____

4. Were you ever prescribed any medications to help you get pregnant? ○ Yes (complete table below) ○ No **(If No, skip to item 9)**

Please fill in the responses below for each medication you took to help you become pregnant.

	A. Name of Medication	B. Age when you started taking medication?	C. How long took medication
5. 1st Med	_____	☐☐ years	☐☐ months
6. 2nd Med	_____	☐☐ years	☐☐ months
7. 3rd Med	_____	☐☐ years	☐☐ months
8. 4th Med	_____	☐☐ years	☐☐ months

9. Have you ever been pregnant or are you currently pregnant? Please include live births, still births, miscarriages, tubal, ectopic or molar pregnancies and induced or elective abortions. ○ Yes ○ No **(If No, skip items 10-18)**

10. How many times have you been pregnant? Be sure to count your current pregnancy if you are pregnant now, and include all pregnancies even if they did not result in a live birth. ☐☐ Times

11. Are you pregnant now? ○ Yes ○ No

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GIRLS FOLLOW-UP STUDY

Pregnancy History Questionnaire

64993

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
(mon / day / year)

Please fill in the responses below for each of your pregnancies, starting with your current pregnancy if you are pregnant now, or your most recent if you are not pregnant now. Be sure to include all pregnancies; live birth, stillbirth, miscarriage, tubal, ectopic or molar pregnancies, and induced or elective abortions. If you are currently breastfeeding please record the number of weeks you have breastfed so far.

	A. Month and year pregnancy ended?	B. Number of weeks pregnant?	C. Took pill or shot to dry up milk?	D. Was outcome a live birth?	E. If live birth, did you breastfeed?	F. If breastfed, number of weeks breastfed?
12.	☐☐ / ☐☐☐☐ (mon / year) **OR** ○ Currently pregnant	☐☐ wks	○ Yes ○ No ○ Unknown	○ Yes -> ○ No	○ Yes -> ○ No	☐☐ wks
13.	☐☐ / ☐☐☐☐ (mon / year)	☐☐ wks	○ Yes ○ No ○ Unknown	○ Yes -> ○ No	○ Yes -> ○ No	☐☐ wks
14.	☐☐ / ☐☐☐☐ (mon / year)	☐☐ wks	○ Yes ○ No ○ Unknown	○ Yes -> ○ No	○ Yes -> ○ No	☐☐ wks
15.	☐☐ / ☐☐☐☐ (mon / year)	☐☐ wks	○ Yes ○ No ○ Unknown	○ Yes -> ○ No	○ Yes -> ○ No	☐☐ wks
16.	☐☐ / ☐☐☐☐ (mon / year)	☐☐ wks	○ Yes ○ No ○ Unknown	○ Yes -> ○ No	○ Yes -> ○ No	☐☐ wks
17.	☐☐ / ☐☐☐☐ (mon / year)	☐☐ wks	○ Yes ○ No ○ Unknown	○ Yes -> ○ No	○ Yes -> ○ No	☐☐ wks
18.	☐☐ / ☐☐☐☐ (mon / year)	☐☐ wks	○ Yes ○ No ○ Unknown	○ Yes -> ○ No	○ Yes -> ○ No	☐☐ wks

DISC Staff Initials: _____ DISC Certification Number: ☐ - ☐☐

DISC

GIRLS FOLLOW-UP STUDY

Hormone Use Questionnaire

62754

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
(mon / day / year)

This questionnaire asks about your use of hormone medications. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate. The first questions are about birth control pills.

1. Did you ever take birth control pills for any reason? ○ Yes ○ No **(If No, skip to item 11)**

2. Do you currently take birth control pills? ○ Yes ○ No

   A. If **Yes**, what is the name of the birth control pill that you are currently taking? _____

   B. If **No**, when did you most recently stop taking birth control pills? ☐☐ / ☐☐☐☐ (mon / year)

Please provide the information below for each type/brand of birth control pills you ever took beginning with the pills you are currently taking or the pills you took most recently. If you stopped taking a particular brand for a month or more and then restarted the same brand, record each of the time periods on a different line. Some women use birth control pills to decrease how often they have their period. If you do not do this you probably have a period each month or 12 periods per year, so you would record 12 in column B. If you only have a period once every 3 months, you would record 04 in column B (12 divided by 3 = 4).

	A. Name of birth control pill	B. Frequency of periods per year	C. Age started	D. Age stopped	E. Total number of years took pill
3. 1st	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years ○ Currently taking	☐☐.☐ years Refer to Decimal Table
4. 2nd	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
5. 3rd	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
6. 4th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
7. 5th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
8. 6th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
9. 7th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
10. 8th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years

DISC Staff Initials: _____ DISC Certification Number: ☐ - ☐☐

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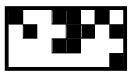
GIRLS FOLLOW-UP STUDY

Hormone Use Questionnaire



19736

Please Use Black Pen

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
(mon / day / year)

This questionnaire continues to ask about your use of hormone medications. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

These questions are about contraceptive or hormone patches.

11. Did you ever use a contraceptive patch or hormone skin patch to prevent pregnancy or for any other reason? ○ Yes ○ No **(If No, skip to item 18)**

12. Do you currently use a contraceptive patch? ○ Yes ○ No

A. If **Yes**, what is the name of the contraceptive patch that you are currently using? _____

B. If **No**, when did you most recently stop using a contraceptive patch? ☐☐ / ☐☐☐☐ (mon / year)

Please provide the information below for each type/brand of contraceptive patch you ever used beginning with the patch you are currently using or the patch you used most recently. If you stopped using a particular brand for a month or more and then restarted the same brand, record each of the time periods on a different line. Some women use a contraceptive patch to decrease how often they have their period. If you do not do this you probably have a period each month or 12 periods per year, so you would record 12 in column B. If you only have a period once every 3 months, you would record 04 in column B (12 divided by 3 = 4).

	A. Name of contraceptive patch	B. Frequency of periods per year	C. Age started	D. Age stopped	E. Total number of years used patch?
13. 1st	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years ○ Currently using	☐☐.☐ years Refer to Decimal Table
14. 2nd	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
15. 3rd	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
16. 4th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
17. 5th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years

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GIRLS FOLLOW-UP STUDY

Hormone Use Questionnaire

28751

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

This questionnaire continues to ask about your use of hormone medications. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

These questions are about vaginal rings.

18. Did you ever use a vaginal ring to prevent pregnancy or for any other reason? ○ Yes ○ No **(If No, skip to item 25)**

19. Do you currently use a vaginal ring? ○ Yes ○ No

A. If **Yes**, what is the name of the vaginal ring that you are currently using? _____

B. If **No**, when did you most recently stop using a vaginal ring? ☐☐ / ☐☐☐☐
mon year

Please provide the information below for each type/brand of vaginal rings you ever used beginning with the vaginal ring you are currently using or the vaginal ring you used most recently. If you stopped using a particular brand for a month or more and then restarted the same brand, record each of the time periods on a different line. Some women use a vaginal ring to decrease how often they have their period. If you do not do this you probably have a period each month or 12 periods per year, so you would record 12 in column B. If you only have a period once every 3 months, you would record 04 in column B (12 divided by 3 = 4).

	A. Name of vaginal ring	B. Frequency of periods per year	C. Age started	D. Age stopped	E. Total number of years used vaginal ring?
20. 1st	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years ○ Currently using	☐☐.☐ years Refer to Decimal Table
21. 2nd	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
22. 3rd	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
23. 4th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years
24. 5th	_____ ○ Unknown	☐☐ per year	☐☐ years	☐☐ years	☐☐.☐ years

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GIRLS FOLLOW-UP STUDY

Hormone Use Questionnaire

50785

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
(mon / day / year)

This questionnaire continues to ask about your use of hormone medications. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

These questions are about shots or implants to prevent pregnancy.

25. Did you ever have shots or an implant to prevent pregnancy? Some shots and implants used to prevent pregnancies are Depo-Provera and Norplant. ○ Yes ○ No **(If No, skip to item 32)**

26. Do you currently get shots or implants to prevent pregnancy? ○ Yes ○ No

A. If **Yes**, what is the name of the shot or implant that you are currently using? _____

B. If **No**, when did you most recently stop using shots or implants? ☐☐ / ☐☐☐☐ (mon / year)

Please provide the information below for each type/brand of shot or implant you ever used beginning with the shot or implant you are currently using or the shot or implant you used most recently. If you stopped using a particular brand for a month or more and then restarted the same brand, record each of the time periods on a different line.

	A. Name of shot or implant	B. Age started	C. Age stopped	D. Total number of years used shot or implant?
27. 1st	_____ ○ Unknown	☐☐ years	☐☐ years ○ **Currently using**	☐☐.☐ years **Refer to Decimal Table**
28. 2nd	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
29. 3rd	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
30. 4th	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
31. 5th	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years

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FAX to MMRI (410) 323 - 4729

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GIRLS FOLLOW-UP STUDY

Hormone Use Questionnaire

Please Use Black Pen

Correction ○

9381

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)

Women sometimes take androgens like testosterone, androstenedione and DHEAS to make them more muscular or stronger, to increase their sex drive or to make them feel better. The next group of questions is about these hormones. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

32. Did you ever take androgens including testosterone, androstenedione and DHEAS? ○ Yes ○ No **(If No, skip to item 39)**

33. Do you currently take testosterone, androstenedione or DHEAS? ○ Yes ○ No

A. If **Yes**, what is the name of the testosterone, androstenedione or DHEAS that you are currently taking? _____

B. If **No**, when did you most recently stop taking testosterone, androstenedione and DHEAS? ☐☐ / ☐☐☐☐ (mon / year)

Please provide the information below for each type/brand of androgen you ever used beginning with the androgen you are currently using or the androgen you used most recently. If you stopped using a particular brand for a month or more and then restarted the same brand, record each of the time periods on a different line.

	A. Name of androgen	B. Age started	C. Age stopped	D. Total number of years used androgen?
34. 1st	_____ ○ Unknown	☐☐ years	☐☐ years ○ Currently using	☐☐.☐ years Refer to Decimal Table
35. 2nd	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
36. 3rd	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
37. 4th	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
38. 5th	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years

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FAX to MMRI (410) 323 - 4729

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GIRLS FOLLOW-UP STUDY

Hormone Use Questionnaire

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Correction ○

17132

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
(mon / day / year)

This questionnaire continues to ask about your use of hormone medications. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

39. Not including creams and suppositories that contain hormones, have you ever taken any other female or male hormones that you have not already reported? ○ Yes ○ No **(If No, skip to end)**

40. Not including creams and suppositories that contain hormones, are you currently taking any other female or male hormones that you have not already reported? ○ Yes ○ No

A. If **Yes**, what are you taking? _____

B. If **No**, when did you most recently stop taking female or male hormones? ☐☐ / ☐☐☐☐ (mon / year)

Please provide the information below for each type/brand of hormone you ever used beginning with the hormone you are currently using or the hormone you used most recently and have not already reported. If you stopped using a particular brand for a month or more and then restarted the same brand, record each of the time periods on a different line.

	A. Name of hormone	B. Age started	C. Age stopped	D. Total number of years used hormones?
41. 1st	_____ ○ Unknown	☐☐ years	☐☐ years ○ Currently using	☐☐.☐ years Refer to Decimal Table
42. 2nd	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
43. 3rd	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
44. 4th	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years
45. 5th	_____ ○ Unknown	☐☐ years	☐☐ years	☐☐.☐ years

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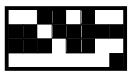
DISC

GIRLS FOLLOW-UP STUDY

DISC 05
Rev 0
08/29/2006



57324

Medical History Questionnaire

Please Use Black Pen

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

This questionnaire asks about certain diseases, conditions and surgeries you may have had. Did a doctor ever tell you that you had any of the following conditions? **(Answer each item)**

Condition	A. Doctor said you had			B. Description
	Yes	**No**	**Do not know**	**If yes, please describe**
1. High blood pressure or hypertension (Please do not answer yes if it only occured during pregnancy.)	○	○	○	
2. Diabetes (Please do not answer yes if it only occured during pregnancy.)	○	○	○	
3. High blood cholesterol	○	○	○	
4. Heart problem	○	○	○	
5. Asthma	○	○	○	
6. Lung problem not including asthma	○	○	○	
7. Thyroid gland problem	○	○	○	
8. Gallstone or other gall bladder problem	○	○	○	
9. Kidney or urinary bladder problem (please do not include urinary tract infections)	○	○	○	
10. Liver disease like hepatitis	○	○	○	
11. Chronic stomach or intestinal problem like colitis or an ulcer	○	○	○	
12. Depression	○	○	○	

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FAX to MMRI (410) 323 - 4729

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GIRLS FOLLOW-UP STUDY

Medical History Questionnaire

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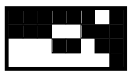

59163

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

This page of the questionnaire continues to ask about certain diseases, conditions and surgeries you may have had. Did a doctor ever tell you that you had any of the following conditions? **(Answer each item)**

Condition	A. Doctor said you had			B. Description
	Yes	**No**	**Do not know**	**If yes, please describe**
13. Anxiety disorder	○	○	○	_____
14. Psychological problem other than depression or anxiety	○	○	○	_____
15. Seizure disorder or epilepsy	○	○	○	_____
16. Stroke	○	○	○	_____
17. Other neurological disorders like multiple sclerosis	○	○	○	_____
18. Breast cysts	○	○	○	_____
19. Polycystic ovary syndrome (PCOS)	○	○	○	_____
20. Ovarian cysts not including PCOS	○	○	○	_____
21. Endometriosis	○	○	○	_____
22. Pelvic Inflammatory Disease (PID)	○	○	○	_____
23. Uterine fibroids	○	○	○	_____
24. Autoimmune disease like lupus or rheumatoid arthritis	○	○	○	_____
25. Cancer	○	○	○	_____
26. Any other health conditions	○	○	○	_____

DISC Staff Initials: _____ DISC Certification Number: ☐ - ☐☐

DISC

GIRLS FOLLOW-UP STUDY

Medical History Questionnaire

44342

Please Use Black Pen

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

The next group of questions ask about medical procedures and operations that you may have had. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

27. Did you ever have a mammogram? ○ Yes ○ No **(If No, skip to item 30)**

28. How old were you when you first had a mammogram? ☐☐ years old

29. In total, how many mammograms have you had in your whole life? ☐☐ number of mammograms

30. Have you ever had any type of breast surgery or procedure for any reason? ○ Yes ○ No **(If No, skip to item 33)**

31. How many breast surgeries or procedures have you had? ☐ number of surgeries/procedures

Please provide the information for each type of breast procedure or surgery that you ever had.

32. What was the procedure or surgery you had? **(Answer each item)** **If Yes, what was the date of the surgery or procedure?**

	1. Had procedure		2. Procedure date		3. Age at procedure
A. Biopsy - right breast	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
B. Biopsy - left breast	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
C. Cyst removed - right	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
D. Cyst removed - left	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
E. Lumpectomy - right	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
F. Lumpectomy - left breast	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
G. Mastectomy - right	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
H. Mastectomy - left breast	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
I. Breast implant surgery	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
J. Breast reduction surgery	○ Yes	○ No	☐☐ / ☐☐☐☐ (mon / year)	**OR**	☐☐ years
K. If biopsy or lumpectomy: Was cancer found?	○ Yes	○ No			

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FAX to MMRI (410) 323 - 4729

DISC

GIRLS FOLLOW-UP STUDY

Medical History Questionnaire

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25217

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

These questions continue to ask about medical procedures and operations that you may have had. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

33. Have you had a hysterectomy or your uterus removed? ○ Yes ○ No **(If No, skip to item 36)**

34. When did you have the hysterectomy? A. Date ☐☐ / ☐☐☐☐ (mon / year) **OR** B. Age ☐☐ years

35. What was the reason you had a hysterectomy? _____

36. Have you ever had an operation(s) where one or both of your ovaries were surgically removed? ○ Yes ○ No

37. Most women are born with two ovaries, how many ovaries do you currently have? ☐ number of ovaries

38. How many procedures or operations have you had on your ovaries? ☐ number of operations **(If 0 skip to item 41)**

Please provide the information for each procedure or operation that you ever had on your ovaries.

39. What was the procedure or operation that you had? **(Answer each item)** **If Yes, what was the date of the surgery or procedure?**

	1. Had procedure		2. Procedure date (mon / year)		3. Age at procedure (years)
A. Ovarian biopsy	○ Yes	○ No	☐☐ / ☐☐☐☐	**OR**	☐☐
B. Ovarian cyst removed	○ Yes	○ No	☐☐ / ☐☐☐☐	**OR**	☐☐
C. One ovary removed	○ Yes	○ No	☐☐ / ☐☐☐☐	**OR**	☐☐
D. Both ovaries removed	○ Yes	○ No	☐☐ / ☐☐☐☐	**OR**	☐☐
E. Part of an ovary removed	○ Yes	○ No	☐☐ / ☐☐☐☐	**OR**	☐☐
F. If biopsy: Was cancer found?	○ Yes	○ No			

40. If one or both ovaries were removed, what was the reason? _____

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DISC

GIRLS FOLLOW-UP STUDY

Medical History Questionnaire

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24342

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

These questions continue to ask about medical procedures and operations that you may have had. Some questions ask you to give specific ages and times, if you are not exactly sure please give your best estimate.

41. Did you ever have surgery to remove all or part of your thyroid gland? ○ Yes ○ No **(If No, skip to item 44)**

42. How old were you when you had all or part of your thyroid gland removed? ☐☐ years old

43. What was the reason you had all or part of your thyroid gland removed? _____

44. Did you ever have surgery to remove your gall bladder? ○ Yes ○ No **(If No, skip to item 47)**

45. How old were you when you had your gall bladder removed? ☐☐ years old

46. What was the reason you had your gall bladder removed? _____

47. Did you ever have any other surgeries? ○ Yes ○ No

If Yes, please describe. _____

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FAX to MMRI (410) 323 - 4729

DISC

Medication Use Questionnaire

Please Use Black Pen

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year) Correction ○

This questionnaire asks about your medication use including prescription and non-prescription drugs. This does not include vitamins, minerals or dietary supplements.

Have you ever taken any of the following medications on a regular basis, that is four or more times per week for at least two weeks? If Yes, please list the names of all medications under the category or mark unknown. Age started would be the first time you ever took the medication and stopped is the most recent age you stopped taking the medication. Total years would be the total length of time you took all the medications listed in this category.

Medication	A. Have you taken this type?	B. Medication name(s)	C. Age started this type of medication?	D. Age stopped this type of medication	E. Total years took this type of medication?
1. Cortisone or prednisone not including creams or ointments	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	☐☐ years	☐☐ years ○ Currently taking	☐☐.☐ years (Refer to Decimal Table)
2. Asthma medication including inhalers (eg. Advair)	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	☐☐ years	☐☐ years ○ Currently taking	☐☐.☐ years (Refer to Decimal Table)
3. Thyroid medication	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	☐☐ years	☐☐ years ○ Currently taking	☐☐.☐ years (Refer to Decimal Table)
4. Insulin	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	☐☐ years	☐☐ years ○ Currently taking	☐☐.☐ years (Refer to Decimal Table)
5. Diabetes medication other than insulin	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	☐☐ years	☐☐ years ○ Currently taking	☐☐.☐ years (Refer to Decimal Table)
6. Phenobarbitol or other medication to prevent seizures	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	☐☐ years	☐☐ years ○ Currently taking	☐☐.☐ years (Refer to Decimal Table)
7. Anti-depressant medication (eg. Zoloft, Prozac)	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	☐☐ years	☐☐ years ○ Currently taking	☐☐.☐ years (Refer to Decimal Table)

48340

FAX to MMRI (410) 323 - 4729

DISC Staff Initials: _____

DISC Certification Number: ☐ - ☐☐

DISC

Medication Use Questionnaire

Please Use Black Pen

ID: [ ] - [ ][ ][ ][ ] - [ ] Letter Code: [ ][ ][ ][ ][ ][ ] Date: mon [ ][ ] / day [ ][ ] / year [ ][ ][ ][ ]

Correction ○

Medication	A. Have you taken this type?	B. Medication name(s)	C. Age started this type of medication?	D. Age stopped this type of medication	E. Total years took this type of medication?
8. Antibiotics	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)
9. Sedatives or anti-anxiety medication including sleeping pills (eg. Valium, Xanax)	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)
10. Simulants to keep you awake (eg. No-Doz)	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)
11. Laxatives	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)
12. Medication for weight control	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)
13. Blood pressure medication	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)
14. Cholesterol lowering medication	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)
15. Retinoids (eg. Accutane, Soriatane)	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)
16. Any other medication	○ Yes -> ○ No ○ Unknown	_____ ○ Name Unknown	[ ][ ] years	[ ][ ] years ○ Currently taking	[ ][ ] . [ ] years (Refer to Decimal Table)

58145

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DISC Staff Initials: _____

DISC Certification Number: [ ] - [ ][ ]

DISC

Girls Follow-Up Study

20459

Smoking History Questionnaire

Please Use Black Pen

Correction ○

ID: ___ - ____ - ___ **Letter Code:** ______ **Date:** mon __ / day __ / year ____

This questionnaire asks about your smoking history.

1. Have you ever smoked more than 100 cigarettes in your life? ○ Yes ○ No **(If No, skip items 2 - 7)**

2. During the entire time you smoked, on average how many cigarettes did you smoke? (*1 pack = 20 cigarettes*)
   A. ____ # of cigarettes Per B. ○ Day ○ Week ○ Month ○ Year

3. How old were you when you first started smoking cigarettes on a regular basis? ____ years old

4. Do you currently smoke cigarettes? ○ Yes ○ No **(If No, skip to item 6)**

5. On average, how many cigarettes do you currently smoke? (*1 pack = 20 cigarettes*)
   A. ____ # of cigarettes Per B. ○ Day ○ Week ○ Month ○ Year **(Skip to item 7)**

6. How old were you when you stopped smoking? ____ years old

7. Not counting the times when you may have quit smoking, how many years were you a smoker or have you smoked? (Round to nearest year) ____ years

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FAX to MMRI (410) 323 - 4729

DISC

Girls Follow-Up Study

DISC 08
Rev 0
03/21/2006

63082

Alcohol History Questionnaire

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

This questionnaire is about alcoholic drinks.

1. In your entire life, have you had at least 12 drinks of any kinds of alcoholic beverage (wine, beer, liquor)? ○ Yes ○ No **(If No, skip items 2-4)**

2. When did you start drinking alcohol? Please do not include sips of alcohol for religious or other reasons. ☐☐ years old

3. Do you currently drink alcohol? ○ Yes ○ No **(If No, skip to item 4)**

   A. How often do you have drinks containing alcohol? Again, please do not include sips of alcohol for religious or other reasons. Please record the number of occasions not the number of drinks you consumed.

   1. ☐☐ # of occasions Per
   2. ○ Day ○ Week ○ Month ○ Year

   B. On the days you drink, how many drinks do you usually have per day? A drink is a 12 ounce can or glass of beer, a four ounce glass of wine, or one shot of liquor. ☐☐ # of drinks per day

Skip item 4

4. When did you stop drinking alcohol? ☐☐ years old

   A. Before you stopped drinking, how often did you have drinks containing alcohol? Again, please do not include sips of alcohol for religious or other reasons. Please record the number of occasions not the number of drinks you consumed.

   1. ☐☐ # of occasions Per
   2. ○ Day ○ Week ○ Month ○ Year

   B. On the days you drank, how many drinks did you usually have per day? A drink is a 12 ounce can or glass of beer, a four ounce glass of wine or a shot of liquor. ☐☐ # of drinks per day

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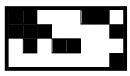
DISC

GIRLS FOLLOW-UP STUDY



57688

Developmental History and Exercise Questionnaire

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

These questions ask about your weight and exercise. Please answer each question as accurately as possible. There are no right or wrong answers.

1. How much did you weigh when you were 12 years old? ☐☐☐ pounds

2. How much did you weigh when you were 18 years old? (If you were pregnant, how much did you weigh before you became pregnant?) ☐☐☐ pounds

3. How much did you weigh when you were 25 years old? (If you were pregnant how much did you weigh before you became pregnant? If you are younger than 25 please record your current weight.) ☐☐☐ pounds

On a usual weekday and a usual weekend during the past month, how much time did you spend at each activity level listed below in one day (a 24 hour period)? The total number of hours spent on all activities on a weekday must add up to 24 hours. The total number of hours spent on all activities on a weekend day must equal 24 hours.

Activity	A. Weekday	B. Weekend Day
4. Sleeping	☐☐ hours	☐☐ hours
5. Sedentary or Seated Activities: *some examples* Eating; TV, radio, music, videos, etc.; Reading; Cards, board games; Playing musical instruments; Computer activities Other seated activities	☐☐ hours	☐☐ hours
6. Light or Casual Activities: *some examples* Household chores Standing, walking, activities which require standing or walking Volleyball, ping pong, boating, sailing, bowling, fishing, horseback riding, archery Easy bike riding	☐☐ hours	☐☐ hours
7. Moderate or Stop/Start Activities: *some examples* Heavy yard chores Calisthentics Fast walking, hiking, hard biking, carrying heavy objects Frisbee, softball, golf, recreational skating, recreational swimming in a pool or at beach, dancing, aerobics, ballet, gymnastics, surfing, water skiing, weight lifting, shooting baskets or basketball half court, doubles tennis All sports participation with a start/stop rather than sustained activity level	☐☐ hours	☐☐ hours
8. Intense or Sustained Activities: *some examples* Running, swimming laps, jogging, jump rope, cross country or downhill skiing, basketball full court, soccer, field hockey, ice hockey, singles tennis, racquetball, figure skating, paddle ball, lacrosse, touch football, rowing Code activities as intense only if you are certain activities are sustained for the entire period of time.	☐☐ hours	☐☐ hours
9. Total hours in items 4 - 8 [Must add up to 24]	☐☐ hours	☐☐ hours

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DISC

Girls Follow-Up Study

2833

Family History Questionnaire

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)

This questionnaire asks about your parent's health. Please only provide information about your biological parents, do not include adoptive, foster or step parents.

1. Did your biological mother ever have breast cancer? ○ Yes ○ No ○ Do not know **(If No or Unknown, skip to item 2)**

   A. How old was she when she was first diagnosed with breast cancer? ☐☐ years old ○ Do not know

2. Did your biological mother ever have any other type of cancer? ○ Yes ○ No ○ Do not know

   A. If Yes, please specify _____

3. Did your biological mother ever have heart disease? ○ Yes ○ No ○ Do not know **(If No or Unknown, skip to item 4)**

   A. If Yes, please specify _____

   B. How old was she when she was first diagnosed with heart disease? ☐☐ years old ○ Do not know

4. Did your biological mother ever have diabetes?
   (Please do not include if only when she was pregnant) ○ Yes ○ No ○ Do not know **(If No or Unknown, skip to item 5)**

   A. How old was she when she was first diagnosed with diabetes? ☐☐ years old ○ Do not know

5. Is your biological mother still living? ○ Yes ○ No ○ Do not know **(If No, skip to item 6)** **(If Unknown skip to item 7)**

   A. If Yes, how old is she? ☐☐ years old ○ Do not know **(Skip to item 7)**

6. How old was your biologial mother when she died? ☐☐ years old ○ Do not know

   A.What was your biological mother's cause of death?

   Please specify _____ ○ Do not know

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FAX to MMRI (410) 323 - 4729

DISC

Girls Follow-Up Study

Family History Questionnaire

34568

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)

This questionnaire asks about your parent's health. Please only provide information about your biological parents, do not include adoptive, foster or step parents.

7. Did your biological father ever have any type of cancer? ○ Yes ○ No ○ Do not know **(If No or Unknown, skip to item 8)**

   A. If Yes, please specify _____

8. Did your biological father ever have heart disease? ○ Yes ○ No ○ Do not know **(If No or Unknown, skip to item 9)**

   A. If Yes, please specify _____

   B. How old was he when he was first diagnosed with heart disease? ☐☐ years old ○ Do not know

9. Did your biological father ever have diabetes? ○ Yes ○ No ○ Do not know **(If No or Unknown, skip to item 10)**

   A. How old was he when he was first diagnosed with diabetes? ☐☐ years old ○ Do not know

10. Is your biological father still living? ○ Yes ○ No ○ Do not know **(If No, skip to item 11) (If unknown skip item 11)**

    A. If Yes, how old is he? ☐☐ years old ○ Do not know **(Skip item 11)**

11. How old was your father when he died? ☐☐ years old ○ Do not know

    A. What was your biological father's cause of death?

    Please specify _____ ○ Do not know

DISC Staff Initials: _____ DISC Certification Number: ☐ - ☐☐

FAX to MMRI (410) 323 - 4729

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GIRLS FOLLOW-UP STUDY

Historical Leisure Activity Questionnaire

22255

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Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

This questionnaire asks about your physical activities from high school through the past year.

Please identify all activities done more than 10 times from high school through the past year, not including time spent in school physical education classes.

1 Jogging (outdoor, treadmill)
2 Swimming (laps, snorkeling)
3 Bicycling (indoor, outdoor)
4 Softball
5 Volleyball
6 Bowling
7 Basketball
8 Skating (roller, ice, blading)
9 Martial Arts (karate, judo)
10 Tai Chi
11 Calisthenics/Toning
12 Soccer
13 Racquetball/Handball/Squash
14 Horseback Riding
15 Frisbee
16 Ultimate Frisbee
17 Aerobic Dance/Step Aerobics
18 Water Aerobics
19 Dance (Square, Line, Ballroom Ballet, Jazz, Tap)
20 Gardening or Yardwork
21 Badminton
22 Strength/Weight Training
23 Rock Climbing
24 Scuba Diving
25 Stair Master
26 Fencing
27 Hiking
28 Tennis
29 Golf
30 Canoeing/Rowing/Kayaking
31 Water Skiing
32 Jumping Rope
33 Snow Skiing (X-country/Nordic Track)
34 Snow Skiing (Downhill)
35 Snow boarding
36 Snow Shoeing
37 Yoga
38 Elliptical Trainer
39 Pilates
40 Walking for Exercise (outdoor, dog walking, indoor, treadmill)
41 Band/Drill Team
42 Cheerleading
43 Skateboarding
44 Field Hockey
45 Diving
46 Lacrosse
47 Gymnastics
48 Sailing
49 Dodge Ball
50 Housework (cooking, washing dishes, laundry)
51 Housecleaning (mopping, vacuuming, sweeping)
52 Major House Cleaning (scrubbing walls and windows, shampooing carpet)
53 Home Repair (painting, wallpaper)
54 Childcare (infants – age 6, dressing, feeding, bathing)
55 Caretaking (disabled/elderly, lifting, grooming,feeding)
56 Other

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DISC

Historical Leisure Activity Questionnaire

Correction ○

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ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Sequence #:** ☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)

Please list all activities identified on the previous page and then determine the average frequency and duration of each activity.

	Leisure Activity Code and Name (See Activity Code List on Page 1)	Historical: High School (HS) 14 - 17 years old (4 years total)			Historical: Post HS / College 18 - 21 years old (4 years total)			Past Year: Past 12 months		
		A. # of yr	B. mos/yr	C. hrs/wk	D. # of yr	E. mos/yr	F. hrs/wk	G. mos/ year	H. times/ mo	I. min/ time
1.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
2.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
3.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
4.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
5.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
6.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
7.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
8.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
9.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐
10.	☐☐ _____	☐	☐☐	☐☐.☐	☐	☐☐	☐☐.☐	☐☐	☐☐	☐☐☐

37001

DISC Staff Initials: _____

FAX to MMRI (410) 323 - 4729

DISC Certification Number: ☐ - ☐☐

DISC

Girls Follow-Up Study

16809

Date of Next Menses Questionnaire

Please Use Black Pen

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date of Visit:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

This questionnaire should be completed by clinic staff when the Participant's postcard arrives with the start date of her next period after her clinic visit. Complete the date below and fax this form to MMRI.

1. What is the start date of the participant's next menses after her clinic visit? ☐☐ / ☐☐ / ☐☐☐☐
mon day year

DISC Staff Initials: _____ DISC Certification Number ☐ - ☐☐

FAX to MMRI (410) 323 - 4729

DISC

Girls Follow-Up Study

21479

Repeat Visit Questionnaire

Please Use Black Pen

Correction ○

ID: [ ] - [IDN] - [ ]

Letter Code: [LETCODE]

Date: [FDATE] mon / day / year [CORRFIX]

This questionnaire should be administered by clinic staff at the start of a repeat clinic visit, before anything is asked or measurements are taken.

1. Are you currently pregnant?	○ Yes (1)	○ No (2)	○ Maybe (3)	D2401
2. Are you currently breastfeeding?	○ Yes	○ No		D2402
3. Results of urine pregnancy test?	○ Positive	○ Negative		D2403

If subject is pregnant or breastfeeding, skip to Staff Certification and do not complete the visit.

4. Did you bring your menstrual calendar? ○ Yes ○ No D2404

5. If you brought your menstrual calendar, what is the date you recorded for the start of your last period? If you do not have your calendar, what is the date your last period started?
(If less than one month from today, skip to Item 7)
[ ] mon / [ ] day / [ ] year D2405DT

6. If longer than one month, why have you not had a period in the past month? **(Choose only one)** D2406

Code
1 ○ Normally have long intervals between periods
2 ○ Irregular / skipped periods
3 ○ Pregnancy
4 ○ Hysterectomy (uterus removed) or ovaries removed
5 ○ Used birth control pills, patches, vaginal rings, or implants to skip periods
6 ○ Do not know
7 ○ Other (Specify) D2406SP

7. Are you currently taking any type of hormones for birth control, to regulate your periods, or for any aother reason? Please include hormones used in any form, including pills, patches, shots, implants or vaginal rings. D2407

○ Yes (1) ○ No (2) If **No**, skip to item 9.

8. What are you currently taking? **(Choose only one)**

A. Type of hormone: D2408A

1 ○ Birth control pills
2 ○ Contraceptive patch or hormone skin patch
3 ○ Vaginal ring
4 ○ Implants or shots such as Depo_Provera or Norplant
5 ○ Other (Specify) D2408ASP

B. Name of product: D2408B [ ] ○ Unknown D2408BU

C. # periods / year while taking: [ ] D2408C

DISC Staff Initials: _____ DISC Certification Number [ ] - [ ] STAFFID

FAX to MMRI (410) 323 - 4729

DISC

Girls Follow-Up Study

Repeat Visit Questionnaire

55445

IDN

Please Use Black Pen

Correction ○ CORRFIX

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ LETCODE **Date:** FDATE ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year)

9.A. Since your last visit, have you been pregnant? Please include live birth, still births, miscarriages, tubal, ectopic or molar pregnancies, and induced or elective abortions. D2409A ○ Yes ○ No

B. Month and year pregnancy ended? ☐☐ / ☐☐☐☐ (mon / year) D2409B — If **No**, skip to item 10.

C. Number of weeks pregnant? ☐☐ wks D2409C

D. Took pill or shot to dry up milk? ○ Yes ○ No ○ Unknown D2409D

E. Was outcome a live birth? ○ Yes ○ No — If **No**, skip to item 10. D2409E

F. If live birth, did you breastfeed? ○ Yes ○ No — If **No**, skip to item 10. D2409F

G. If breastfed, number of weeks? ☐☐ wks D2409G

10.A. Since your last visit, has a doctor told you that you have any medical conditions? ○ Yes ○ No D2410A — If **No**, skip to item 11.

B. List the conditions and describe them

	A. Condition	B. Description
1.	D2410B1A	D2410B1B
2.	D2410B2A	D2410B2B
3.	D2410B3A	D2410B3B

11.A. Since your last visit, have you had any type of surgery? Please include breast procedures, hysterectomy (uterus removed), ovarian surgery, and others. ○ Yes ○ No D2411A — If **No**, skip to item 12.

B. What were the surgeries?

A. Surgery	1 Yes	2 No	B. If Yes, description:
1. Breast surgery or procedure D2411B1A	○	○	D2411B1B
2. Hysterectomy D2411B2A	○	○	D2411B2B
3. Ovarian surgery D2411B3A	○	○	D2411B3B
4. Other D2411B4A	○	○	D2411B4B

DISC Staff Initials: _____ DISC Certification Number ☐ - ☐☐

FAX to MMRI (410) 323 - 4729

STAFFID2

DISC

Girls Follow-Up Study

Repeat Visit Questionnaire

33673 IDN

Please Use Black Pen

Correction ○ CORRFIX

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ LETCODE **Date:** ☐☐ / ☐☐ / ☐☐☐☐ FDATE
(mon / day / year)

12. A. Do you currently smoke cigarettes? D2412A ○ Yes (1) ○ No (2) **If No, skip to item 13.**

B. On average, how many cigarettes do you currently smoke? (*1 pack = 20 cigarettes*) D2412B

☐☐ # of cigarettes **Per** ○ Day (1) ○ Week (2) ○ Month (3) ○ Year (4) D2412BPR

13.A. Do you currently drink alcohol? Do not include sips of alcohol for religious or other reasons. D2413A ○ Yes ○ No **If No, skip to item 14.**

B. How often do you have drinks containing alcohol? Please record the number of occasions, not the number of drinks you consumed. D2413B

☐☐ # of occasions **Per** code ○ Day (1) ○ Week (2) ○ Month (3) ○ Year (4) D2413BPR

C. On the days you drink, how many drinks do you usually have per day? A drink is a 12 ounce can or glass of beer, a four ounce glass of wine, or one shot of liquor.

☐☐ # of drinks per day D2413C

14. Weight (kg) (weight must be measured in a hospital gown) ☐☐☐.☐ D2414

To be completed by clinic staff when informed by participant after the visit.

15. What is the start date of the participant's next menses after her clinic visit? ☐☐ / ☐☐ / ☐☐☐☐ (mon / day / year) D2415DT

For this item only:

DISC Staff Initials: _____ DISC Certification Number ☐ - ☐☐ D2415STF

STAFFID3

DISC Staff Initials: _____ DISC Certification Number ☐ - ☐☐

DISC

Girls Follow-Up Study

DISC 50
Rev 0
08/29/2006

5646

Anthropometry Form

Please Use Black Pen

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

1. Date of examination: ☐☐ / ☐☐ / ☐☐☐☐
mon day year

	A. First measurement	B. Second measurement	C. Third measurement
2. DISC Certification Number	☐ - ☐☐	☐ - ☐☐	☐ - ☐☐
3. Height (cm)	☐☐☐.☐	☐☐☐.☐	☐☐☐.☐
4. Weight (kg)	☐☐☐.☐	☐☐☐.☐	☐☐☐.☐
5. Waist (cm)	☐☐☐.☐	☐☐☐.☐	☐☐☐.☐

Third measurement *necessary* if second measurement differs from the first measurement by more than the following:

1. Both measurements made by the same observer.
   a. Height, 0.5 cm
   b. Weight, 0.2 kg
   c. Waist, 1.0 cm

2. The two measurements made by different observers.
   a. Height, 0.5 cm
   b. Weight, 0.2 kg
   c. Waist, 2.5 cm

DISC Staff Initials: _____ DISC Certification Number ☐ - ☐☐

FAX to MMRI (410) 323 - 4729

DISC

Girls Follow-Up Study

43151

Blood Pressure Measurement Form

Please Use Black Pen

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

Be sure that the participant is seated properly for at least 5 minutes before taking blood pressure, making sure that the feet are flat on the floor, the legs are not crossed, and the arm is well supported at heart level.

To check the monitor's settings: with the power off, press and hold the on/off (power) button for more than three seconds while holding the start button; F1 is displayed. Press the start button to cycle through the 3 settings and the deflation button to cycle through the options for each setting. Be sure F1 is set to 3, F2 is set to 5 and F3 is set to 1. After checking these settings, please record them in the space below. For a more detailed description of this procedure, please consult the blood pressure section of the procedures manual.

1. A. F1: ☐ B. F2: ☐ C. F3: ☐

2. Date of examination: ☐☐ / ☐☐ / ☐☐☐☐
mon day year

3. Is the blood pressure being taken in the right arm?
○ Yes
○ No, it is necessary to use the left arm
○ No, it is not possible to use either arm Skip to Certification #.

4. Is the participant experiencing any pain? ○ Yes ○ No

If Yes, please explain _____

5. Systolic (mmHg) ☐☐☐

6. Diastolic (mmHg) ☐☐☐

7. Pulse (BPM) ☐☐☐

8. Were there any problems or special occurances while taking blood pressure? ○ Yes ○ No

If Yes, please specify _____

DISC Staff Initials: _____ DISC Certification Number ☐ - ☐☐

FAX to MMRI (410) 323 - 4729

DISC

Girls Follow-Up Study

DISC 52
Rev 0
08/29/2006

60903

Venipuncture Form

Please Use Black Pen

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

1. Date of blood drawing: ☐☐ / ☐☐ / ☐☐☐☐
mon day year

2. Time of blood drawing: ☐☐ : ☐☐ ○ am ○ pm
hour minute

3. Has a blood specimen been obtained at this visit? ○ Yes ○ No **(If Yes, skip to item 4)**

A. If No, why not? ○ Participant refused
○ Technical problems
○ Other (please specify) _____

(If No, skip items 4 and 5)

4. When did the participant last have anything to eat or drink (except for water)?

Date: ☐☐ / ☐☐ / ☐☐☐☐
mon day year

Time: ☐☐ : ☐☐ ○ am ○ pm
hour minute

5. The number of vials that are needed for each color vacutainer is recorded below. Please note how many vials were collected for each type.

Blood Draw	# of vials needed	# of vials collected
A. 10ml Red-Top Tubes (no additive, glass 10 ml draw; BD 366430)	3	☐
B. 7ml Purple-Top Tubes (K3EDTA glass, 7 ml draw; BD 366450)	2	☐
C. 2ml Gray-Top Tubes (NaFL plastic, 2 ml draw; BD 367587)	1	☐

DISC Staff Initials: _____ DISC Certification Number ☐ - ☐☐

FAX to MMRI (410) 323 - 4729

DISC

GIRLS FOLLOW-UP STUDY

DISC 53
Rev 0
08/29/2006

23732

Participant Status Form

Please Use Black Pen

Correction ○

ID: ☐ - ☐☐☐☐ - ☐ **Letter Code:** ☐☐☐☐☐☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
mon day year

Please complete this form for the participants seen at your site and for any participant you attempted to contact but would not participate.

1. When was the participant's visit? ☐☐ / ☐☐ / ☐☐☐☐
mon day year

2. What is the status of the participant's visit? ○ Complete ○ Partial ○ None

If Complete, go to end

If None, skip to item 5

Partial Visit

3. If partial, indicate the components completed.

(Answer each item)	Complete	Not complete
A. Anthropometry	○	○
B. Blood Pressure	○	○
C. Blood Collection	○	○
D. Questionnaires	○	○
E. DXA	○	○
F. MRI	○	○
G. 3 24-hour recalls	○	○

4. If partial visit, indicate why

(Answer each item)	Yes	No
A. Pregnant or breastfeeding	○	○
B. Complete visit is too long	○	○
C. Unwilling to give blood	○	○
D. Concerned about radiation	○	○
E. Concerned about MRI	○	○
F. Claustrophobic	○	○
G. Other **(If Other, please explain)**	○	○

Go to end

No Visit

5. If no visit, please indicate why.

(Answer each item)	Yes	No
A. Unable to locate	○	○
B. Located, but unwilling to participate	○	○
C. Unable to get time off from work	○	○
D. Unable to get away from home	○	○
E. Not interested	○	○
F. Involves too much travel	○	○
G. Pregnant or breast feeding	○	○
H. Concerns about MRI, DXA, NDS-R	○	○
I. Other **(If Other, please specify)**	○	○

6. Steps taken to locate participant **(Answer each item)**

A. Telephone calls	○ Yes	○ No
(If Yes, number of calls) ☐☐		
B. Mail	○ Yes	○ No
C. Email	○ Yes	○ No
D. Contacted parents	○ Yes	○ No
E. Web	○ Yes	○ No
F. Other **(If Other, please specify)**	○ Yes	○ No

G. Date of last attempt to contact ☐☐ / ☐☐ / ☐☐☐☐
mon day year

DISC Staff Initials: _____ DISC Certification Number: ☐ - ☐☐

FAX to MMRI (410) 323 - 4729