guts
Growing Up Today Study

Complete Your Questionnaire Online
www.gutsweb.org

DIE-CUT WINDOW AREA

Has your address changed? Please make corrections and mail back with your survey.

Hello GUTS participant,

We would like to thank you for your dedication to the study. Your participation becomes more and more important each year. Now that we are seventeen years into GUTS, we are able to look at how the things that people did when they were younger affect their health right now. GUTS is one of the only teams in the world that can answer important questions about what life is like for young adults these days. And *you* make it possible.

TO COMPLETE YOUR QUESTIONNAIRE:

- Go to **www.gutsweb.org** and fill it out online. To log in, all you need is your birthdate and the ID listed with your name above.

OR

- Fill out this paper questionnaire and return it in the envelope provided (no postage necessary).

You may notice that this questionnaire is shorter than in years past. That's because from now on, thanks to your feedback, we will always send you one short questionnaire per year. We'll email you a link in January or mail you a paper copy in March.

We want to hear from you! Contact us any time:

- E-mail us at **guts@channing.harvard.edu**
- Like us on Facebook at **www.facebook.com/harvardguts**

Thanks again for your continued participation!

Stacey A. Missmer, ScD
GUTS Director

amazon.com

Everyone will receive a **$5 Amazon.com Gift Card*** for completing this survey. We couldn't do this research without you!

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IMPORTANT: Update Your Information!

Everyone will receive a $5 Amazon.com Gift Card for completing this questionnaire. Use your Amazon.com Gift Card to shop from a huge selection of books, electronics, music, DVDs, software, apparel, toys, and much more.

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GUTS staff will e-mail your Gift Card to the e-mail address you list within two weeks of receiving your completed questionnaire.

Make sure you give us your current contact information below in order to receive your Gift Card!

a) Please tell us your preferred e-mail address. If you have spam filtering software, please make sure you are able to accept e-mail from guts@channing.harvard.edu.

Primary E-mail:

Please print neatly and differentiate numbers and letters (e.g., 1 vs l or i, 0 vs O, 5 vs S)

☐ Check here to decline the $5 Amazon.com Gift Card and donate your $5 to GUTS research.

b) Is there another e-mail address that we can use to contact you if there is a problem with the first one?

Alternate E-mail:

Please print neatly and differentiate numbers and letters (e.g., 1 vs l or i, 0 vs O, 5 vs S)

c) Please enter your phone number. We do not routinely call participants, but in the event we lose contact with you, we may call to obtain your new information.

Cell Phone #: **Home Phone #:**

d) Please give us the name and address of someone at a different address (other than your mother) who we may contact in the event we lose contact with you (such as another relative or your best friend).

Back-up Contact:

Name: _____

Address: _____

_____

_____

Phone: _____

E-mail: _____

e) Has your name changed?

New last name:

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Federal regulations require us to include the following information:

There are no direct benefits to you from participation in this study. The risk of breach of confidentiality associated with participation in this study is very small. Your choice to participate in this study is completely voluntary and you may decline or withdraw at any time without penalty. Although complete information is important to the study, you may skip any question you do not wish to answer. If you have any questions regarding your rights as a research participant, you are encouraged to call a representative of the Human Subjects Committee at the Brigham and Women's Hospital (617-424-4100).

1. What is your current status? ◯ Never married ◯ Married ◯ Living with partner ◯ Separated ◯ Divorced ◯ Widowed

2. What is the zip code for where you live most of the time? ◯ I don't live in the U.S.

0	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9

3. Is this your correct date of birth?

◯ Yes
◯ No → If no, please write correct date. MONTH / DAY / YEAR

4. How much do you weigh? ☐☐☐ Pounds

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0	0	0	
1	1	1	4
2	2	2	5
3	3	3	
4	4	4	6
	5	5	
	6	6	
	7	7	
	8	8	7
	9	9	

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5. Who is completing this questionnaire?
◯ GUTS participant this was addressed to ◯ GUTS participant's parent ◯ Partner ◯ Sibling ◯ Other

6. Please describe your current work status: (Mark all that apply)
◯ Working full time ◯ Working part time ◯ Student ◯ Volunteering ◯ In the military
◯ Unemployed, laid off, or looking for work ◯ Staying at home with children/taking care of family
◯ On maternity or family leave from job ◯ Not working due to illness or disability

7. In the PAST 12 MONTHS, how often did you smoke cigarettes?
◯ Never ◯ Less than once a month ◯ Monthly, but not weekly ◯ Weekly, but not daily ◯ Daily

8. In the PAST 12 MONTHS, on average, how many cigarettes did you smoke in one day?
◯ I don't smoke ◯ 1 ◯ 2-5 ◯ 6-10 ◯ 11-20 ◯ 21 or more

9. In the PAST 12 MONTHS, on average, how often did you use marijuana?
◯ Never ◯ Once a month or less ◯ 2-3 times/month ◯ 1-2 times/week ◯ 3-5 times/week ◯ 6 or more times/week

10. In the PAST 12 MONTHS, on average, how often did you drink beer, wine, or liquor?
◯ Never ◯ Less than once a month ◯ Less than once a week ◯ 1-2 days/week ◯ 3-5 days/week ◯ Almost every day ◯ Daily

11. In the PAST 12 MONTHS, when you drank alcohol, how much did you usually drink at one time?
◯ I don't drink ◯ Less than 1 drink ◯ 1 drink ◯ 2 drinks ◯ 3 drinks ◯ 4 drinks ◯ 5 drinks ◯ 6 or more drinks

12. In the PAST 12 MONTHS, how many times did you drink 4 or more alcoholic drinks over a few hours?
◯ Never ◯ 1 time ◯ 2 times ◯ 3-5 times ◯ 6-8 times ◯ 9-11 times ◯ 12-15 times (about once/mo.)
◯ 16-24 times (about 2x/mo.) ◯ 25-36 times (about 3x/mo.) ◯ 37 or more times (average of more than 3x/mo.)

13. During the past year, did you try to lose weight or keep from gaining weight? ◯ No ◯ Yes

14. In the past year, did you do any of the following to lose weight or keep from gaining weight?
a) Go on a diet: ◯ Never ◯ A couple of times ◯ Several times ◯ Often ◯ Always on a diet
b) Use diet pills: ◯ Never ◯ Less than monthly ◯ 1-3 times per month ◯ Once a week ◯ More than once per week
c) Make yourself throw up: ◯ Never ◯ Less than monthly ◯ 1-3 times per month ◯ Once a week ◯ More than once per week
d) Take laxatives: ◯ Never ◯ Less than monthly ◯ 1-3 times per month ◯ Once a week ◯ More than once per week

15. Sometimes people will go on an "eating binge", when they eat an amount of food that most people, like their friends, would consider to be very large, in a short period of time. In the PAST YEAR, how often did you go on an eating binge?
◯ Never
◯ Less than monthly
◯ 1-3 times per month
◯ Once a week
◯ More than once a week

→ **a) Did you feel out of control, like you couldn't stop eating even if you wanted to stop?**
◯ No ◯ Yes

16. Do you have parenting responsibility for any children (biological, adopted, or step?) ◯ Yes ◯ No

17. In the PAST 12 MONTHS, how many times did you use a tanning bed?
◯ Never ◯ 1 time ◯ 2-9 times ◯ 10-19 times ◯ 20-29 times ◯ 30 or more times

18. Which one of the following best describes your feelings? (Mark one answer)
◯ Completely heterosexual *(attracted to persons of the opposite sex)* ◯ Mostly heterosexual ◯ Bisexual *(equally attracted to men and women)* ◯ Mostly homosexual ◯ Completely homosexual *(gay/lesbian, attracted to persons of the same sex)* ◯ Not sure

19. In the past year, the person(s) with whom you have had sexual contact *(however you define it)* is (are):
◯ I have not had sexual contact with anyone ◯ Female(s) ◯ Male(s) ◯ Female(s) and male(s)

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20. What is the usual average length of your menstrual cycle (interval from first day of period to first day of next period)?

◯ <21 days ◯ 21-25 ◯ 26-31 ◯ 32-39 ◯ 40-50 ◯ 51+ days or too irregular to estimate ◯ No periods/amenorrhea

21. How much pain do you usually have with your periods?

◯ No pain
◯ Mild cramps (medication seldom needed)
◯ Moderate cramps (medication usually needed)
◯ Severe cramps (medication and bed rest needed)

22. In the PAST 12 months, did you use birth control pills for any reason (e.g., birth control, acne, cramping, irregular periods)?

◯ Yes → **a) What brand did you use (e.g., Seasonale, Yasmin)?** *Write in box the pill brand used longest:* [ ]

b) How did you take your pills each month and how did it affect your period?

◯ I use a "regular"-type pill (e.g., Yaz, Loestrin, Ortho tri-cyclen) so I SHOULD get my period every month.
◯ I use a "regular"-type pill, but take the "active" pills continuously so I SHOULD NOT get my period every month.
◯ I use an "Extended Cycle" pill (e.g., Seasonale, Seasonique, Lybrel) so I SHOULD NOT get my period every month.
◯ Other

◯ No

23. In the PAST 12 months, did you use any of these other methods of birth control for any reason? (Mark all that apply)

◯ None ◯ Male condom ◯ Vaginal ring (NuvaRing) ◯ Shots (Depo Provera, Lunelle) ◯ Withdrawal
◯ Patch (Ortho-Evra) ◯ Female condom ◯ Diaphragm/Cervical cap ◯ Spermicide/Jelly/Sponge ◯ Natural family planning
◯ Implant (Implanon) ◯ ParaGard IUD ◯ Mirena IUD ◯ Emergency contraception ◯ Rhythm ◯ Other

24. Since 2010, have you tried to become pregnant for 12 consecutive months without becoming pregnant (even if you ultimately became pregnant)?

◯ Yes → **a) Did a doctor find a reason why you had difficulty getting pregnant? (Mark all that apply)**

◯ I did not visit a doctor for diagnosis/treatment
◯ Tubal blockage or damage
◯ Polycystic ovary syndrome (PCOS)
◯ Other ovulatory disorder (e.g. high prolactin, thyroid)
◯ Endometriosis
◯ Spouse/male partner factor
◯ Not found
◯ Other [ ]

◯ No

25. Are you currently pregnant?

◯ Yes → **a) Regarding this pregnancy, were you actively trying to become pregnant?**

◯ Yes
◯ No → **If no, what was your feeling regarding this pregnancy?**

◯ I was not actively trying, but I was glad to become pregnant.
◯ I wanted to be pregnant someday, but not now.
◯ I did not want to be pregnant now or at any time in the future.

◯ No

26. Please answer each section below for <u>each</u> of your pregnancies that <u>ended</u> in the previous year. If you had twins or triplets, please count them as one pregnancy and mark more than one circle (if necessary) for gender. *If you have not been pregnant in the past year, please skip to #27. Need more room? Please make copies or download from gutsweb.org/forms.*

	Outcome of this pregnancy? (Mark one answer)	Were you trying to become pregnant?	How long did this pregnancy last?	For pregnancies lasting 20+ weeks: Did you have any of these complications?	Birth weight and gender	Type of delivery (Mark all that apply)
1st pregnancy	**FIRST PREGNANCY** ◯ Single live birth ◯ Twins/Triplets+ ◯ Miscarriage or Stillbirth ◯ Induced abortion ◯ Tubal or ectopic	◯ Yes ◯ No **How many months did it take you?** ◯ <2 ◯ 3-5 ◯ 6-8 ◯ 9-11 ◯ 12+	◯ <8 weeks ◯ 8-19 weeks ◯ 20-36 weeks ◯ 37-39 weeks ◯ 40-42 weeks ◯ 43+ weeks	◯ Gestational diabetes ◯ Pregnancy-related high blood pressure ◯ Pre-eclampsia/ toxemia	[ ][ ] lbs. [ ][ ] oz. ◯ Girl ◯ Boy	◯ Spontaneous labor* ◯ Induced labor** ◯ C-section ◯ Vaginal birth
2nd pregnancy	**SECOND PREGNANCY** ◯ Single live birth ◯ Twins/Triplets+ ◯ Miscarriage or Stillbirth ◯ Induced abortion ◯ Tubal or ectopic	◯ Yes ◯ No **How many months did it take you?** ◯ <2 ◯ 3-5 ◯ 6-8 ◯ 9-11 ◯ 12+	◯ <8 weeks ◯ 8-19 weeks ◯ 20-36 weeks ◯ 37-39 weeks ◯ 40-42 weeks ◯ 43+ weeks	◯ Gestational diabetes ◯ Pregnancy-related high blood pressure ◯ Pre-eclampsia/ toxemia	[ ][ ] lbs. [ ][ ] oz. ◯ Girl ◯ Boy	◯ Spontaneous labor* ◯ Induced labor** ◯ C-section ◯ Vaginal birth

*Spontaneous (contractions started ON THEIR OWN)
**Induced (contractions AFTER receiving a medication by mouth or IV, having gel applied on cervix or membranes broken by clinician)

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27. Since 2006, have you ever been told by a HEALTH CARE PROVIDER that you had any of the following illnesses?

Leave blank for NO, mark here for YES	YEAR OF FIRST DIAGNOSIS: Before 2006	2006–2008	2009–2011	2012+
Fibrocystic or other benign breast disease (Y)				
Confirmed by breast biopsy? No Yes				
Melanoma (Y)				
Other cancer (Y)				
Location/type of cancer:				
Diabetes (High blood sugar) (Y)				
Hypertension (High blood pressure) (Y)				
High cholesterol, triglycerides, or lipids (Y)				
Endometriosis (Y)				
Confirmed by laparoscopy? No Yes				
Chlamydia, HPV, genital warts, or any STD (Y)				
Asthma (Y)				
Psoriasis (Y)				
Eating Disorder				
Anorexia nervosa (Y)				
Bulimia nervosa (Y)				
Binge eating disorder (Y)				
Other eating disorder (Y)				
Polycystic Ovary Syndrome (PCOS) (Y)				
ACL tear (Y)				
Stress fracture (Y)				
Gallstones (Y)				
Kidney stones (Y)				
Rheumatoid arthritis (Y)				
Anxiety disorder (Y)				
Depression (Y)				
Mononucleosis (Mono) (Y)				
Confirmed by blood test? No Yes Don't know				
Irritable bowel syndrome (Y)				
Ulcerative Colitis/Crohn's Disease (Y)				
Gout (Y)				
Hypothyroidism (Y)				
Bacterial meningitis (Y)				
Concussion or other head injury (Y)				
Other major illness or surgery since 2006 (e.g., multiple sclerosis, bariatric surgery) (Y)				
Please specify:				

28. When was your last routine (preventive) physical exam?

○ 0-12 months ago ○ 13-24 months ago ○ 2+ years ago

E 0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9
N 0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9

29. Are you covered by any kind of health insurance or some other kind of health care plan?

○ Yes ○ No

30. Have you ever been treated for an eating disorder by a doctor, nurse, or other health care provider?

○ No ○ Yes, in the past ○ Yes, currently

a) Type of eating disorder

○ anorexia nervosa ○ bulimia nervosa
○ binge eating disorder ○ ED-NOS
○ compulsive eating ○ other

b) Type of treatment (Mark all that apply)

○ medications ○ inpatient/residential
○ nutritional counseling ○ weight loss counseling
○ psychological or behavioral counseling ○ other

c) Age when treated (Mark all that apply)

○ 9-12 ○ 13-15 ○ 16-18 ○ 19-22 ○ 23-27 ○ 28 or older

31. Please mark if you used any of the following medications regularly over the past 12 months.

- ○ ADHD Medication (e.g., Adderall, Concerta, Ritalin, Strattera, etc.)
- ○ Anti-migraine medication (e.g., Imitrex, Maxalt, Zomig)
- ○ Acetaminophen (e.g., Tylenol, Anacin 3, Excedrin Free)
  - Days/week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
  - Total tablets/week: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+
- ○ Aspirin or aspirin-containing products
  - Days/week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
  - Total tablets/week: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+
- ○ Ibuprofen (e.g., Advil, Motrin, Nuprin)
  - Days/week: ○ 1 ○ 2-3 ○ 4-5 ○ 6+ days
  - Total tablets/week: ○ 1-2 ○ 3-5 ○ 6-14 ○ 15+
- ○ Other anti-inflammatory analgesics (e.g., Aleve)
- ○ Painkillers (e.g., Percocet, Oxycontin, codeine, morphine)
- ○ Steroids taken orally (e.g., Prednisone)
- ○ Thiazide diuretic (e.g., HCTZ, Diuril)
- ○ Calcium blocker (e.g., Calan, Procardia)
- ○ Beta-blocker (e.g., Inderal, Lopressor)
- ○ ACE Inhibitors (e.g., Capoten, Vasotec)
- ○ Other anti-hypertensive
- ○ Statins (cholesterol-lowering drugs) (e.g., Mevacor, Crestor, Lipitor)
- ○ Other cholesterol-lowering drug (e.g., niacin)
- ○ Asthma meds (e.g., albuterol, Flovent)
- ○ Allergy meds (e.g., Allegra, Claritin, Zyrtec)
- ○ Insulin
- ○ Oral hypoglycemic medication (e.g., metformin)
- ○ Thyroid hormone (e.g., Synthroid, Levothroid)
- ○ SSRIs anti-depressant (e.g., Prozac, Zoloft)
- ○ Other antidepressants (e.g., Elavil, Tofranil)
- ○ Minor tranquilizers (e.g., Valium, Xanax)
- ○ GnRH agonists (e.g., Lupron)
- ○ Retinoids (e.g., RetinA, Differin, Accutane)
- ○ Other medication (no need to specify)

32. Are you biologically related to your mother who participates in the Nurses' Health Study?

○ No ○ Yes ○ Not sure

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33. Were you hospitalized over the past 12 months?

○ Yes → **a) If yes, what was the reason?** *Write in box:*

○ No

Which of these statements best describes your own health state today?

34. Mobility
- ○ I have no problems in walking about
- ○ I have slight problems in walking about
- ○ I have moderate problems in walking about
- ○ I have severe problems in walking about
- ○ I am unable to walk about

35. Self-care
- ○ I have no problems washing or dressing myself
- ○ I have slight problems washing or dressing myself
- ○ I have moderate problems washing or dressing myself
- ○ I have severe problems washing or dressing myself
- ○ I am unable to wash or dress myself

36. Usual Activities (e.g., work, study, housework, family, or leisure activities)
- ○ I have no problems doing my usual activities
- ○ I have slight problems doing my usual activities
- ○ I have moderate problems doing my usual activities
- ○ I have severe problems doing my usual activities
- ○ I am unable to perform my usual activities

37. Pain/Discomfort
- ○ I have no pain or discomfort
- ○ I have slight pain or discomfort
- ○ I have moderate pain or discomfort
- ○ I have severe pain or discomfort
- ○ I have extreme pain or discomfort

38. Anxiety/Depression
- ○ I am not anxious or depressed
- ○ I am slightly anxious or depressed
- ○ I am moderately anxious or depressed
- ○ I am severely anxious or depressed
- ○ I am extremely anxious or depressed

39. Have you ever had doctor-diagnosed . . . (Mark all that apply)

○ Food allergies ○ Hayfever ○ Eczema (atopic dermatitis) ○ Eosinophilic esophagitis ○ None of these

→ **a) What type?** ○ Peanut ○ Tree nuts* ○ Shellfish ○ Milk ○ Egg

*Tree nuts include walnuts, macadamia nuts, almonds, pistachios, cashews, pecans, hazelnuts, and Brazil nuts.

40. Have you ever regularly had heartburn/acid reflux 1 or more times a week?

○ Yes → **a) How long ago did these symptoms begin?** ○ <1 year ○ 1-2 years ○ 3-5 years ○ 6-10 years ○ 10+ years

○ No

b) Do you take any drugs to treat acid reflux?

○ No ○ Yes →

If yes, what type of drugs do you take?
- ○ Antacids (e.g., TUMS)
- ○ H2 blockers (e.g., Pepcid, Zantac)
- ○ Proton Pump Inhibitors (e.g., Prilosec, Nexium, Prevacid)

How would you describe your use of medications for heartburn/acid reflux?
- ○ Use occasionally, as needed
- ○ Use regularly, symptoms well-controlled
- ○ Use regularly, but symptoms not well-controlled

In the past year, how often did you have symptoms of heartburn/acid reflux?
- ○ Never in the past year
- ○ Less than once a month
- ○ About once a month
- ○ About once a week
- ○ Several times a week
- ○ Daily

41. Which best describes your hearing?
- ○ Excellent
- ○ Good
- ○ A little hearing trouble
- ○ Moderate hearing trouble
- ○ A lot of hearing trouble
- ○ Deaf

→ **a) If your hearing is not as good as it used to be, at what age did you first notice a change?**

○ Less than 12 years old ○ 12-17 years old ○ 18-22 years old ○ 23-28 years ○ 29+

○ Hearing problem since birth ○ Hearing has not changed

42. Please estimate how many hours per week in your lifetime <u>you</u> spent in <u>very noisy</u> activities or settings without ear protection. Very noisy means you would need to shout to be heard by someone standing <u>3 feet away</u> from you - see examples below. We realize this is a difficult task, but please provide your best guess.

	HOURS PER WEEK IN A NOISY SETTING							
When you were AGE:	0	0.5	1-2	3-10	11-20	21-40	41+	N/A
5-11	○	○	○	○	○	○	○	○
12-17	○	○	○	○	○	○	○	○
18-22	○	○	○	○	○	○	○	○
23+	○	○	○	○	○	○	○	○

EXAMPLES
- Rock concerts, bars, clubs
- Gyms, amusement parks, sports events
- Playing musical instruments
- Public transportation
- Motorcycle riding
- Using a lawn mower, weed whacker, leaf blower

43. For each age range below, please estimate how many hours per week you used headphones or earbuds with the volume set at 60% of maximum (~2/3) or higher:

	HOURS PER WEEK							
AGE	0	0.5	1-2	3-10	11-20	21-40	41+	N/A
5-11	○	○	○	○	○	○	○	○
12-17	○	○	○	○	○	○	○	○
18-22	○	○	○	○	○	○	○	○
23+	○	○	○	○	○	○	○	○

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44. Do you experience any of the following symptoms most months of the year for at least several days before your menstrual period begins?

	Usual Severity			
	Not at all	Mild	Moderate	Severe
Abdominal bloating	○	○	○	○
Breast tenderness	○	○	○	○
Dizziness	○	○	○	○
Headache	○	○	○	○
Hot flashes/night sweats	○	○	○	○
Nausea	○	○	○	○
Swelling in extremities	○	○	○	○
Acne	○	○	○	○
Diarrhea/constipation	○	○	○	○
Food cravings	○	○	○	○
Palpitations	○	○	○	○
Anxiety/nervousness	○	○	○	○
Increased appetite	○	○	○	○
Decreased appetite	○	○	○	○
Irritability	○	○	○	○
Hypersensitivity	○	○	○	○
Fatigue	○	○	○	○
Mood swings	○	○	○	○
Crying easily	○	○	○	○
Insomnia	○	○	○	○
Angry outbursts	○	○	○	○
Desire to be alone	○	○	○	○
Depression	○	○	○	○
Confusion	○	○	○	○
Forgetfulness	○	○	○	○
Abdominal cramping	○	○	○	○
Lower back pain	○	○	○	○
	Minimal	Mild	Moderate	Severe
Severity of all symptoms together	○	○	○	○

If you marked "not at all" for all symptoms, please skip to question 52.

45. How many days before the first day of your period do your symptoms usually begin?

○ 1-3 days ○ 4-7 days ○ 7-14 days ○ >14 days

46. How many days do your symptoms last after your period begins?

○ 1-3 days ○ 4-7 days ○ 7-14 days ○ >14 days

47. In the week after your period has stopped, which of the following statements best describes your symptoms?

○ My symptoms are completely absent
○ My symptoms are still present but are less severe than before my period
○ My symptoms are present and are as severe as before my period

48. At what age did your symptoms generally begin?

○ Always since my first period
○ In my teens
○ In my 20s
○ In my 30s

49. Do you experience any of the following because of your menstrual symptoms?

	How severe is the problem?				
	Not at all	Mild	Moderate	Severe	N/A
Relationship problems with family or partner	○	○	○	○	○
Difficulties in parenting	○	○	○	○	○
Problems at work or in school	○	○	○	○	○
Increased desire to be alone	○	○	○	○	○

50. Have you seen a health care provider because of these symptoms?

○ No ○ Yes

51. Do you take any of the following to treat your symptoms? (Mark all that apply)

○ Pain relievers (any type, including Midol)
○ Oral contraceptives
○ Anti-depressants (e.g., Prozac, Zoloft)
○ B Vitamins
○ Calcium
○ Other dietary supplements

52. Have you ever been diagnosed by a health care provider with Premenstrual Syndrome (PMS)?

○ No ○ Yes

a) If yes, did the clinician have you keep a prospective record of your symptoms for at least one menstrual cycle (i.e., a chart, calendar, or daily record)?

○ No ○ Yes

53. Do you currently have acne? Please choose only one of the following:

○ No, no pimples, pustules, or nodules in the last 3 months
○ Yes, 1 to 4 pimples, pustules, or nodules on the face (except nose) during the last 3 months
○ Yes, 5 or more pimples, pustules, or nodules on the face (except nose) during the last 3 months

54. Do you use any method to remove or make less evident excess hair on your face, chest, or abdomen? (Answer NO if used to remove hair in other areas including arms, legs, armpits, or pubic area.) Please choose only one:

○ No
○ Yes, I use non-permanent methods (e.g., shaving, waxing, bleaching)
○ Yes, I have used a permanent hair removal method (e.g., electrolysis or laser)

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55. Below is a list of some of the ways you may have felt or behaved. Indicate how often you have felt this way during the PAST WEEK.

	Rarely or none of the time	Some or a little of the time	Occasionally or a moderate amount of time	All of the time
I was bothered by things that usually don't bother me.	○	○	○	○
I had trouble keeping my mind on what I was doing.	○	○	○	○
I felt depressed.	○	○	○	○
I felt that everything I did was an effort.	○	○	○	○
I felt hopeful about the future.	○	○	○	○
I felt fearful.	○	○	○	○
My sleep was restless.	○	○	○	○
I was happy.	○	○	○	○
I felt lonely.	○	○	○	○
I could not "get going."	○	○	○	○

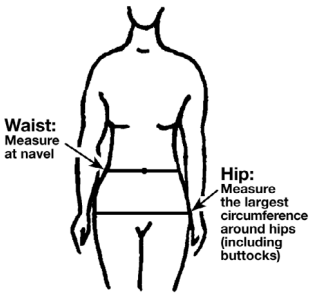
56. Question 56, which should only be answered if a tape measure is available, asks about body measurements. This information will be more accurate if you follow these suggestions.

- **Make measurements while standing**
- **Avoid measuring over bulky clothing**
- **Try to record answers to the nearest 1/4 (do not estimate)**

If a tape measure is not available, please leave blank.

WAIST

Inches		Fraction
0	0	0
1	1	1/4
2	2	2/4
3	3	3/4
4	4	
5	5	
6	6	
	7	
	8	
	9	



HIP

Inches		Fraction
0	0	0
1	1	1/4
2	2	2/4
3	3	3/4
4	4	
5	5	
6	6	
	7	
	8	
	9	

57. Please choose the appropriate response for each item. Think of your neighborhood as the area about 1 mile around your home.

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
There is a lot of trash and litter on the street in my neighborhood.	○	○	○	○	○
There is a lot of noise in my neighborhood.	○	○	○	○	○
In my neighborhood the buildings and homes are well-maintained.	○	○	○	○	○
The buildings and houses in my neighborhood are interesting.	○	○	○	○	○
My neighborhood is attractive.	○	○	○	○	○
There are interesting things to do in my neighborhood.	○	○	○	○	○
My neighborhood offers many opportunities to be physically active.	○	○	○	○	○
Sports and recreational facilities in my neighborhood offer many opportunities to get exercise.	○	○	○	○	○
It is pleasant to walk in my neighborhood.	○	○	○	○	○
The trees in my neighborhood provide enough shade.	○	○	○	○	○
I often see other people walking in my neighborhood.	○	○	○	○	○
I often see other people exercising (e.g., jogging, bicycling, playing sports) in my neighborhood.	○	○	○	○	○
My neighborhood has heavy traffic.	○	○	○	○	○
There are busy roads to cross when out for walks in my neighborhood.	○	○	○	○	○
In my neighborhood it is easy to walk places.	○	○	○	○	○
A large selection of fresh fruits and vegetables is available in my neighborhood.	○	○	○	○	○
The fresh fruits and vegetables in my neighborhood are of high quality.	○	○	○	○	○
A large selection of low-fat products is available in my neighborhood.	○	○	○	○	○
There are many opportunities to purchase fast foods in my neighborhood.	○	○	○	○	○
I feel safe walking in my neighborhood, day or night.	○	○	○	○	○
Violence is not a problem in my neighborhood.	○	○	○	○	○
My neighborhood is safe from crime.	○	○	○	○	○

Thank you! Please return the completed questionnaire in the enclosed postage-paid envelope to: GUTS, Channing Laboratory, 181 Longwood Avenue, Boston, MA 02115
Questions/comments? Email us: guts@channing.harvard.edu

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