The following are some questions about your medical history. Please answer to the best of your knowledge.

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

2. How would you say your health currently compares with other persons of your age?
   - ☐ Better
   - ☐ Same
   - ☐ Worse

---

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

3. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
   - Yes, limited a lot ☐
   - Yes, limited a little ☐
   - No, not limited at all ☐

4. Climbing SEVERAL flights of stairs
   - Yes, limited a lot ☐
   - Yes, limited a little ☐
   - No, not limited at all ☐

---

During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

5. ACCOMPLISHED LESS than you would like
   - Yes ☐
   - No ☐

6. Were limited in the KIND of work or other activities
   - Yes ☐
   - No ☐

---

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

7. ACCOMPLISHED LESS than you would like
   - Yes ☐
   - No ☐

8. Didn’t do work or other activities as CAREFULLY as usual
   - Yes ☐
   - No ☐

---

9. 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 ☐
The next three questions are about how you feel and how things have been 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 -

10. Have you felt calm and peaceful?  
   - All of the time  
   - Most of the time  
   - A good bit of the time  
   - Some of the time  
   - A little of the time  
   - None of the time

11. Did you have a lot of energy?  
   - All of the time  
   - Most of the time  
   - A good bit of the time  
   - Some of the time  
   - A little of the time  
   - None of the time

12. Have you felt downhearted and blue?  
   - All of the time  
   - Most of the time  
   - A good bit of the time  
   - Some of the time  
   - A little of the time  
   - None of the time

13. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?  
   - All of the time  
   - Most of the time  
   - A good bit of the time  
   - Some of the time  
   - A little of the time  
   - None of the time

14. Are you unable to walk due to a condition other than shortness of breath?  
   - Yes  
   - No
   
   What is the nature of the condition?  
   (skip to question 19)

15. Do you get short of breath when hurrying on level ground or walking up a slight hill?  
   - Yes  
   - No  
   - Don’t know

16. Do you walk slower than people of the same age on level ground because of breathlessness or have to stop for breath when walking at your own pace on level ground?  
   - Yes  
   - No  
   - Don’t know

17. Do you stop for breath after walking about 100 yards or after a few minutes on level ground?  
   - Yes  
   - No  
   - Don’t know

18. Are you too breathless to leave the house or breathless when dressing?  
   - Yes  
   - No  
   - Don’t know

19. Are you taking aspirin on a regular basis?  
   - Yes  
   - No  
   - Don’t know

If Yes  
   a. How many days a week?
20. Do you usually have a cough on most days for 3 or more months during the year?
   - Yes
   - No
   
   For how many years have you had this cough?
   
   years

21. Do you usually bring up phlegm from your chest on most days for 3 or more months during the year?
   - Yes
   - No
   
   For how many years have you brought up phlegm from your chest like this?
   
   years

22. In the last 12 months, have you had wheezing or whistling in your chest?
   - Yes
   - No
   
   Skip to Q23

   a. In the last 12 months, how often have you had this wheezing or whistling? *(Read the options)*
      - most days or nights
      - a few days or nights a month
      - a few days or nights a week
      - a few days or nights a year

   b. In the last 12 months, have you had an attack of wheezing or whistling in the chest that has made you feel short of breath?
      - Yes
      - No

Has a doctor ever told you that you have any of the following conditions?

*Note: Skip any of 23-30 if previously reported*

23. Diabetes?
   - Yes
   - No
   - Don’t know

If Yes
   
   a. Are you currently taking medicine for your diabetes?
      - Yes
      - No
      - Unsure

      What kind of medicine are you taking for your diabetes?
      - Pills
      - Insulin and pills
      - Insulin
      - Other injections
Has a doctor ever told you that you have any of the following conditions?  
*Note: Skip any of 23-30 if previously reported*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. High blood pressure?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>25. High cholesterol?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>26. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>27. Asthma?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

**If Yes**  

a. For some people, asthma symptoms completely go away as they grow older. Later in life, however, asthma may recur. At approximately what ages did you experience each of the following events?

<table>
<thead>
<tr>
<th>Event</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age developed first asthma symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age doctor first diagnosed asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at start of 10 year (or more) period without asthma symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at first recurrence of asthma symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**28. Atrial Fibrillation?**  

- Yes  
- No  
- Don’t know

**29. Kidney disease?**

- Yes  
- No  
- Don’t know

If Yes  

a. Did you have kidney failure, requiring dialysis or transplantation?

- Yes  
- No
Has a doctor ever told you that you have any of the following conditions?  
*Note: Skip any of 23-30 if previously reported*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Has your doctor or health care provider ever told you that you had a kidney stone?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td><strong>If Yes</strong></td>
<td>a. How old were you during your first stone episode?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. How many kidney stones have you had in the past?</td>
<td>O None</td>
<td>O 1</td>
<td>O 2-5</td>
</tr>
<tr>
<td><strong>If No</strong></td>
<td>go to Question 32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Did you pass a kidney stone since your last MESA visit?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td><strong>If Yes</strong></td>
<td>a. How many kidney stones did you pass?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>O 1</td>
<td>O 2-5</td>
<td>O More than 5</td>
</tr>
<tr>
<td>32. Have any first degree relatives (i.e. mother, father, siblings, children) ever had a kidney stone?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>33. Has a dentist every told you that you had periodontitis, or that you had bone loss around your teeth?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>34. Has a dentist every told you that you had gum disease?</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

35. *For participants with history of pacemaker or implanted cardioverter defibrillator based on prior event investigation (skip if answered at FU18):*

a. Based on your prior MESA interviews, I see that you have had a [pacemaker or other device type from investigation] implanted on Month/Day/Year [CC inserts date of insertion based on event investigation]. Is that right? Do you still have an implanted device?  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

*For participants without history of device:*

b. Do you have an implanted cardiac pacemaker or an implanted cardioverter-defibrillator (ICD)?  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
If yes to a or b:

c. Is it a cardiac pacemaker or a cardioverter-defibrillator?

- [ ] cardiac pacemaker
- [ ] cardioverter-defibrillator

d. What doctor do you see for regular evaluation of that device?

Name: ___________________________ City, state: ___________________________

Reproductive History (WOMEN ONLY -- MEN are finished with this questionnaire.)

36. Between the ages of 16 and 40, about how long was your average menstrual cycle (time from first day of one period to the first day of the next period)?

- [ ] Less than 25 days
- [ ] 25-43 days
- [ ] 35-60 days
- [ ] More than 60 days
- [ ] Totally variable

37. Have you ever had hot flashes or night sweats related to menopause?

If Yes —

[a. At what age did the hot flashes or night sweats start?]

[b. At what age did the hot flashes or night sweats end?]

[c. Were the symptoms:

- [ ] Mild (symptom did not interfere with usual activities)
- [ ] Moderate (symptom interfered somewhat with usual activities)
- [ ] Severe (symptom was so bothersome that usual activities could not be performed)

38. At what age did you go through menopause (change of life)? (skip if previously reported)

39. Did you go through menopause naturally, or as a result of surgery (hysterectomy or removal of both ovaries)?

- [ ] Naturally
- [ ] As a result of surgery
- [ ] Don’t know
40. Have you had surgery to remove your ovaries?
   - Yes
   - No
   - Don’t know

   a. At what age?  
      - Don’t know

   b. How many ovaries were removed?
      - 1
      - 2

   c. What was the reason for removing your ovaries? (Select all that apply)
      - Ovarian cyst
      - Ovarian cancer
      - Non-cancerous tumor
      - Family history of ovarian cancer or breast cancer
      - Removed at the time of a hysterectomy
      - Removed at the time of a tubal ligation to prevent pregnancy
      - Endometriosis
      - Don’t know
      - Other, please specify:

   d. Were you still having menstrual periods at the time of the surgery?
      - Yes
      - No
      - Don’t know

If participant has previously reported removal of both ovaries -- skip to question 40c

41. Have you had a hysterectomy (surgery to remove your uterus/womb)?
   - Yes
   - No
   - Don’t know

   a. At what age?  
      - Don’t know

   b. What was the reason for removing your uterus? (Select all that apply)
      - Fibroids
      - Endometrial (uterine) cancer
      - Heavy bleeding
      - Pregnancy/delivery complication
      - Cervical cancer
      - Prolapse
      - Endometriosis
      - Family history of ovarian cancer or endometrial cancer
      - Don’t know
      - Other, please specify:

   c. Were you still having menstrual periods at the time of the surgery?
      - Yes
      - No
      - Don’t know

If No  
   How long before surgery did your periods stop?
      - months
      - years
      - Don’t know

If participant has previously reported hysterectomy -- skip to question 41b
42. Have you ever used birth control pills?
   - Yes → At what age did you stop taking birth control pills? [ ]
   - No

43. Since your last MESA visit, have you taken hormone replacement therapy?
   - No → Questionnaire Completed
   - Yes → a. Are you currently using hormone replacement therapy?
     - Yes → At what age did you begin? [ ]
     - No → At what ages did you take hormones?
       - Age started [ ]
       - Age stopped [ ]

   b. Which type of therapy were you on?
     - Estrogen alone (like Premarin or Estratab)
     - Estrogen with progestin (like Prempro)
     - Other types of hormone replacement therapy
       Specify: [ ]
     - Don’t know