



Baseline Survey

Million Veteran Program: A Partnership with Veterans

Please complete this survey and return it to study staff. By completing all or some of the questions, you are voluntarily consenting to participate in this survey.

The survey asks general information about you. Any information you provide about you or your family members will be kept confidential and secure according to VA policy. We will not attempt to contact your family members. The survey is labeled with a study code instead of your name to maintain confidentiality.

If you have any questions or wish to update your contact information, please speak with study staff or contact the **MVP Information Center** toll-free at **866-441-6075**.

Thank you for your participation!



Helpful hints in completing the MVP Baseline Survey

Please answer as many questions on the following pages as possible. You do not have to answer any question that makes you feel uncomfortable, but we appreciate you providing as much information as you can.

- Please place an “X” in only one answer box for each question unless it asks you to "Mark all that apply".

Please use blue or black pen to mark an “X” in the answer box.

Correct

Incorrect

EXAMPLES:



- Please print in the center of the box and avoid contact with the edge. The following is an example:

1	9	5	5
---	---	---	---

- It is best to use a dark blue or black pen to complete the survey. Please do not use a pencil, marker, or felt tip pen.
- If you are unsure about how to answer a question, please give the best answer you can.
- Answer each question unless you are asked to skip to another question.
- Please do not draw a line through any sections that are left blank or not applicable.

When you are finished, please place the survey in the enclosed postage-paid envelope and put it in the mail.

We thank you again for your participation!

Items 11-18b are from The Veterans RAND 12 Item Health Survey (VR-12), developed from the Veterans RAND 36 Item Health Survey (VR-36) which was developed from the MOS RAND SF-36 Version 1.0. The SF-36® is a registered trademark of the Medical Outcomes Trust.

Section A: Demographics

1. What is today's date?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
mm			dd			yyyy			

2. What is your date of birth?

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
mm			dd			yyyy			

3. What is your gender?

- Male
 Female

4. Are you Spanish, Hispanic, or Latino?

- No, not Spanish, Hispanic, Latino
 Yes, Mexican, Mexican American, Chicano
 Yes, Puerto Rican
 Yes, Cuban
 Yes, other Spanish, Hispanic, Latino

5. What is your race? (Mark all that apply)

- White
 Black / African-American
 American Indian / Alaska Native
 Chinese
 Japanese
 Asian Indian
 Other Asian
 Filipino
 Pacific Islander
 Other

6. Where are your ancestors originally from? (Mark all that apply)

- Africa
 East Asia / Pacific Ocean region
 Middle East
 North America
 Northern Europe
 Southern Europe
 South America
 Southwest Asia

7. What is the highest degree or level of school you have completed?

- Less than high school
 High school diploma / GED
 Some college credit, but no degree
 Associate's degree (e.g., AA, AS)
 Bachelor's degree (e.g., BA, BS)
 Master's degree (e.g., MA, MS, MBA)
 Professional or Doctorate degree

8. What is your current marital status?

- Married
 Civil commitment
 Cohabiting
 Separated
 Divorced
 Widowed
 Never married

9. Including yourself, how many people currently live in your household?

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9+ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. Which income category represents the total income of your household from all sources (before taxes and deductions) during the last 12 months?

- Less than \$10,000
 \$10,000 - \$19,999
 \$20,000 - \$29,999
 \$30,000 - \$39,999
 \$40,000 - \$49,999
 \$50,000 - \$59,999
 \$60,000 - \$74,999
 \$75,000 - \$99,999
 \$100,000 - \$149,999
 \$150,000 or more
 Prefer not to answer

Section B: Physical Features

11. Are you right or left handed?

- Right
- Left
- Both right and left (ambidextrous)

12. What is your:

Height feet inches

Weight pounds

13. What best describes the color of your skin without tanning?

- Very fair
- Fair
- Light olive
- Dark olive
- Brown
- Black

14. What best describes your natural hair color (if grey, please indicate color before going grey)?

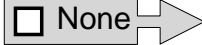
- Black
- Dark brown
- Light brown
- Blonde
- Red

15. What is the natural color of your eyes?

- Blue
- Green
- Hazel
- Light brown
- Dark brown
- Other

Section C: Uniformed Services Experience

16. In which branch of the service did you serve? (Mark all that apply)

- Army
- Navy
- Air Force
- Marine Corps
- Coast Guard
- National Guard
- Merchant Marines
- NOAA
- Public Health Service
- None  **Skip to Q27 on Page 3**

17. Please indicate whether your service was:

- Active Duty
- Reserves only
- Not applicable (not in the military)

18. When did you serve? (Mark all that apply)

- September 2001 or later
- August 1990 to August 2001 (includes Gulf War)
- May 1975 to July 1990
- August 1964 to April 1975 (Vietnam era)
- February 1955 to July 1964
- July 1950 to January 1955 (Korean War)
- January 1947 to June 1950
- December 1941 to December 1946 (WWII)
- November 1941 or earlier

19. Did you serve outside the United States?

- Yes
- No

20. Where were you stationed? (Mark all that apply)

- Africa
- Asia / South Pacific
- Caribbean
- Eastern Europe
- Mexico
- Middle East
- Northern / Central Europe
- Southern Europe / Mediterranean Basin
- South / Central America
- USA / Canada
- Other

21. Did you deploy in support of the 1990-91 Gulf War?

- Yes
- No

22. Did you deploy in support of Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF)?

- Yes
- No

23. Were you ever exposed to Agent Orange?

- Yes
- No
- Not sure

24. Were you ever exposed to chemical or biological warfare agents?

- Yes
- No
- Not sure

25. Were you ever given the Anthrax vaccine?

- Yes
- No
- Not sure

26. Have you ever taken pyridostigmine bromide (anti-nerve agent pills)?

- Yes
- No
- Not sure

Section D: Activities and Habits

27. How would you rate your current physical fitness status?

- Very good
- Fairly good
- Satisfactory
- Fairly poor
- Very poor


28. How physically strenuous is your work / job (paid and unpaid)?

- Very light (mainly sitting)
- Light (mainly walking)
- Medium (lifting, carrying light loads)
- Heavy manual work (climbing, carrying heavy loads)

29. How often do you exercise vigorously enough to work up a sweat?

- Daily
- 5 - 6 times a week
- 2 - 4 times a week
- Once a week
- 1 - 3 times a month
- Rarely / Never

30. How often do you have a drink containing alcohol?

- Never  Skip to Q33 on Page 4
- 1 - 3 days per month
- 1 day per week
- 2 - 3 days per week
- 4 - 5 days per week
- 6+ days per week

31. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

32. How often do you have six or more drinks on one occasion?

- Never
- Less than monthly
- Monthly
- 2 - 3 times per week
- 4+ times a week

33. In your lifetime, have you smoked a total of at least 100 cigarettes, cigars, or pipes?

No

Yes

33a. Have you ever smoked daily or almost every day for at least 1 year?

Yes

No

33b. Do you smoke now?

Yes, daily

Yes, occasionally

Not at all

36. 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?

a. Accomplished less than you would like:

None of the time

A little of the time

Some of the time

Most of the time

All of the time

b. Were limited in the kind of work or other activities:

None of the time

A little of the time

Some of the time

Most of the time

All of the time

37. 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)?

a. Accomplished less than you would like:

None of the time

A little of the time

Some of the time

Most of the time

All of the time

b. Did not do work or other activities as carefully as usual:

None of the time

A little of the time

Some of the time

Most of the time

All of the time

Section E: Health Status

34. In general, would you say your health is:

Excellent

Very good

Good

Fair

Poor

The following question is about activities you might do during a typical day.

35. Does your health now limit you in these activities? If so, how much?

a. 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

b. Climbing several flights of stairs:

Yes, limited a lot

Yes, limited a little

No, not limited at all

38. 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 following 3 questions are about how you feel and how things have been with you. For each question, please give the one answer that comes closest to the way you have been feeling.

39. How much of the time during the **PAST 4 WEEKS**...

a. **Have you felt calm and peaceful?**

- All of the time
- Most of the time
- Good bit of the time
- Some of the time
- A little bit of the time
- None of the time

b. **Did you have a lot of energy?**

- All of the time
- Most of the time
- Good bit of the time
- Some of the time
- A little bit of the time
- None of the time

c. **Have you felt downhearted and blue?**

- All of the time
- Most of the time
- Good bit of the time
- Some of the time
- A little bit of the time
- None of the time

40. 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
- Some of the time
- A little of the time
- None of the time

41. **COMPARED TO ONE YEAR AGO**, how would you rate your:

a. **Physical health in general now?**

- Much better
- Somewhat better
- About the same
- Somewhat worse
- Much worse

b. **Emotional health in general now?**

- Much better
- Somewhat better
- About the same
- Somewhat worse
- Much worse

c. **Cognitive (memory and thinking) health in general now?**

- Much better
- Somewhat better
- About the same
- Somewhat worse
- Much worse

42. On a scale of 0-10, where 0 means no pain and 10 means pain as bad as you can imagine, please rate your overall amount of pain in the **PAST WEEK**:

- 0 1 2 3 4 5 6 7 8 9 10
-

No
Pain

Pain as bad
as you can
imagine

Section F: Medical History and Health Care Usage

43. Please tell us if you have been diagnosed with the following conditions. Check the appropriate box and indicate the year of diagnosis and whether you currently take any medication(s) ("TAKE MEDS") for that condition. (Mark all that apply)

Circulatory System Problems				Mental Health Disorders			
	YES	YEAR DIAGNOSED	TAKE MEDS		YES	YEAR DIAGNOSED	TAKE MEDS
High blood pressure (Hypertension)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Anxiety reaction / Panic disorder	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Attention deficit hyper-activity disorder (ADHD)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Transient ischemic attack (TIA)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Bipolar disorder	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Post-traumatic stress disorder (PTSD)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Coronary artery / Coronary heart disease (includes angina)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Peripheral vascular disease	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Personality disorder	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Pulmonary embolism or deep vein thrombosis (DVT)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Congestive heart failure	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Social phobia	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other circulatory system problem	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Other mental health disorder	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Skeletal / Muscular Problems				Hearing / Vision			
	YES	YEAR DIAGNOSED	TAKE MEDS		YES	YEAR DIAGNOSED	TAKE MEDS
Osteoarthritis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other arthritis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Blindness, all causes	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Tinnitus or ringing in the ears	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>
Other skeletal / muscular problem	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Severe hearing loss or partial deafness in one or both ears	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>

Infectious Diseases			
	YES	YEAR DIAGNOSED	TAKE MEDS
Tuberculosis	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Other infectious disease	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

Cancer			
	YES	YEAR DIAGNOSED	TAKE MEDS
Breast cancer	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Colon cancer / Rectal cancer	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Lung cancer	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Other cancer	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

Kidney Disease			
	YES	YEAR DIAGNOSED	TAKE MEDS
Kidney disease without dialysis	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Kidney disease with dialysis	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Acute kidney disease with no current dialysis	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

Nervous System Problems

	YES	YEAR DIAGNOSED	TAKE MEDS
Migraine headaches	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Other headaches	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Memory loss or impairment	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Dementia (includes Alzheimer's, vascular, etc.)	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Concussion or loss of consciousness	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Traumatic brain injury	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Spinal cord injury or impairment	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Epilepsy / Seizure	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Amyotrophic lateral sclerosis (Lou Gehring's disease)	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Other nervous system problem	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

Digestive System Problems			
	YES	YEAR DIAGNOSED	TAKE MEDS
Acid reflux / GERD	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Peptic ulcers	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Bowel obstruction	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Colon polyps	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Irritable bowel syndrome (IBS)	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Ulcerative colitis	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Celiac disease / Sprue	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Other digestive system disorder	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

Other Conditions

	YES	YEAR DIAGNOSED	TAKE MEDS
Asthma	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Chronic lung disease (COPD, Emphysema or Bronchitis)	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Diabetes / "sugar"	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Enlarged prostate (Benign prostatic hyperplasia)	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Liver condition (e.g., Cirrhosis)	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Skin condition (e.g., Eczema, Psoriasis)	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
Other disease / disorder	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

45. In the **PAST YEAR**, how many times were you a patient in a hospital overnight or longer?

	VA Healthcare Facility	Non-VA Healthcare Facility
None	<input type="checkbox"/>	<input type="checkbox"/>
1 - 3	<input type="checkbox"/>	<input type="checkbox"/>
4 - 6	<input type="checkbox"/>	<input type="checkbox"/>
7 - 9	<input type="checkbox"/>	<input type="checkbox"/>
10 or more	<input type="checkbox"/>	<input type="checkbox"/>

46. How many **prescription** medications do you currently receive from:

	VA Pharmacy	Non-VA Pharmacy
None	<input type="checkbox"/>	<input type="checkbox"/>
1 - 3	<input type="checkbox"/>	<input type="checkbox"/>
4 - 6	<input type="checkbox"/>	<input type="checkbox"/>
7 - 9	<input type="checkbox"/>	<input type="checkbox"/>
10 or more	<input type="checkbox"/>	<input type="checkbox"/>

47. How many **non-prescription** medications do you currently receive from:

	VA Pharmacy	Non-VA Pharmacy
None	<input type="checkbox"/>	<input type="checkbox"/>
1 - 3	<input type="checkbox"/>	<input type="checkbox"/>
4 - 6	<input type="checkbox"/>	<input type="checkbox"/>
7 - 9	<input type="checkbox"/>	<input type="checkbox"/>
10 or more	<input type="checkbox"/>	<input type="checkbox"/>

Section G: Healthcare Utilization

44. In the **PAST YEAR**, about how much of your health care did you get at a VA facility (e.g., doctor's visits, hospitalizations, urgent care visits, or counseling)?

- None
- 1 - 25%
- 26 - 50%
- 51 - 75%
- 76 - 99%
- 100%

Section H: Family History

48. Were you adopted as a child?

- Yes
- No

49. Are you a twin, triplet, or other multiple birth?

- Yes
- No

50. Please answer the following questions about your **biological** family, if known.

	YEAR OF BIRTH	LIVING?		YEAR OF DEATH
		YES	NO	
Mother	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Father	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

51. Do you have any of the following?

	NO	YES	HOW MANY?
Daughters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Sons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Brothers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>

52. Please answer some questions about your **biological** siblings, beginning with the eldest.

	BROTHER OR SISTER?	YEAR OF BIRTH	LIVING?	YEAR OF DEATH
1	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
6	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
7	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
8	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
9	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
10	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
11	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
12	<input type="checkbox"/> Brother <input type="checkbox"/> Sister	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

53. Please tell us if any of YOUR BIOLOGICAL FAMILY MEMBERS have been diagnosed with the following conditions. If you do not have information regarding any of your family members listed, please leave those sections blank.

	MOTHER	FATHER	SIBLING	GRANDPARENTS ON MOTHER'S SIDE	GRANDPARENTS ON FATHER'S SIDE
Alzheimer's / Other dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, prostate	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, all others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic lung disease (COPD, Emphysema or Bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery / Coronary heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes / "sugar"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / Transient ischemic attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

54. Did anyone help you complete this survey?

- Yes
- No

Thank you for completing this survey.