Has a doctor or nurse ever said that you have:

1. **No**  □  **Yes**  □  **Not Sure**  □  
   **E08HBP**
   **High blood pressure or hypertension?**  
   **E08HBPPR**
   □ No  □ Yes  FOR WOMEN: Was this during pregnancy only?
   **E08HBPPR**
   If yes, at what age were you first told this?
   **E08HBPAG**

2. **No**  □  **Yes**  □  **Not Sure**  □
   **E08HCHOL**
   **High blood cholesterol?**  
   **E08CHOAG**

3. **No**  □  **Yes**  □  **Not Sure**  □
   **E08HEART**
   **Heart problems?**
   **E08HEART**
   □ Heart attack  □ Angina  □ Rheumatic heart disease
   □ Mitral valve prolapse  □ Other: Please specify
   **E08HRTAK**  □  **E08ANGIN**  □  **E08RHD**  □  **E08MVP**  □
   **E08HRTAG**  □  **E08ANGAG**  □  **E08RHDAG**  □  **E08MVPAG**
   Age first told?
   **E08THHT**  □
   __________ years

4. **No**  □  **Yes**  □  **Not Sure**  □
   **E08DIAB**
   **Diabetes (high sugar in blood or urine)?**  
   **E08DIBAG**
   □ No  □ Yes  FOR WOMEN: Was this during pregnancy only?
   **E08GDM**
   If yes, at what age were you first told this?
Has a doctor or nurse ever said that you have:

5. **Kidney problems?**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What type?</th>
<th>Age first told?</th>
<th>Have you had this in the past year?</th>
</tr>
</thead>
<tbody>
<tr>
<td>urine infection from your kidney (pyelonephritis)</td>
<td>___ years</td>
<td>1 □ No 2 □ Yes</td>
</tr>
<tr>
<td>kidney stone(s)</td>
<td></td>
<td>1 □ No 2 □ Yes</td>
</tr>
<tr>
<td>other kidney problem such as nephritis or glomerulonephritis</td>
<td>___ years</td>
<td>1 □ No 2 □ Yes</td>
</tr>
<tr>
<td>other: Please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. **Liver disease?**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What type?</th>
<th>Age first told?</th>
<th>Have you had this in the past year?</th>
</tr>
</thead>
<tbody>
<tr>
<td>hepatitis?</td>
<td>___ years</td>
<td>1 □ No 2 □ Yes</td>
</tr>
<tr>
<td>cirrhosis?</td>
<td>___ years</td>
<td>1 □ No 2 □ Yes</td>
</tr>
<tr>
<td>other: Please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, at what age were you first told this? Have you had this in the past year?

7. **Gallstones or gallbladder disease?**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

| Gallstones or gallbladder disease? | ___ years | 1 □ No 2 □ Yes |

8. **Migraine headaches?**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

| Migraine headaches? | ___ years | 1 □ No 2 □ Yes |

9. **Peripheral vascular disease (problems with circulation to the legs)?**

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

| Peripheral vascular disease (problems with circulation to the legs)? | ___ years | 1 □ No 2 □ Yes |
Has a doctor or nurse ever said that you have:

10. Cancer or malignant tumor? E08CANCNCR

<table>
<thead>
<tr>
<th>Type</th>
<th>Age first told?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td>E08LUNAG</td>
</tr>
<tr>
<td>Breast</td>
<td>E08BRSAG</td>
</tr>
<tr>
<td>Cervical</td>
<td>E08CERAG</td>
</tr>
<tr>
<td>Blood/lymph glands</td>
<td>E08BLDSAG</td>
</tr>
<tr>
<td>Testes/scrotum</td>
<td>E08TESAG</td>
</tr>
<tr>
<td>Bone</td>
<td>E08BONAG</td>
</tr>
<tr>
<td>Melanoma</td>
<td>E08MELAG</td>
</tr>
<tr>
<td>Skin (not melanoma)</td>
<td>E08SKNAG</td>
</tr>
<tr>
<td>Brain</td>
<td>E08BRNAG</td>
</tr>
<tr>
<td>Stomach</td>
<td>E08STOAG</td>
</tr>
<tr>
<td>Colon</td>
<td>E08COLAG</td>
</tr>
<tr>
<td>Other: Please specify</td>
<td>E08OTCAG</td>
</tr>
</tbody>
</table>

11. Thyroid problem? E08THYRD

<table>
<thead>
<tr>
<th>Type</th>
<th>Age first told?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypothyroidism or underactive thyroid (low thyroid)</td>
<td>E08HOTAG</td>
</tr>
<tr>
<td>Hyperthyroidism or overactive thyroid (Grave’s disease)</td>
<td>E08HYTAG</td>
</tr>
<tr>
<td>Other: Please specify</td>
<td>E08OTTAG</td>
</tr>
</tbody>
</table>
Has a doctor or nurse ever said that you have:

12. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Digestive diseases? E08DIG

<table>
<thead>
<tr>
<th>What type?</th>
<th>Age first told?</th>
<th>Have you had this in the past year?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcer E08ULCER</td>
<td>___years</td>
<td>1 □ No 2 □ Yes</td>
</tr>
<tr>
<td>Other (such as Crohn's or ulcerative colitis) E08OTD</td>
<td>___years</td>
<td>1 □ No 2 □ Yes</td>
</tr>
<tr>
<td>Please specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, at what age were you first told this? Have you had this in the past year?

13. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Gout? ___years 1 □ No 2 □ Yes

14. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Asthma? ___years 1 □ No 2 □ Yes

15. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Epilepsy (seizures)? ___years 1 □ No 2 □ Yes

16. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Nervous, emotional or mental disorder? ___years 1 □ No 2 □ Yes

17. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Pneumonia? ___years 1 □ No 2 □ Yes

18. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Tuberculosis or a positive skin test for tuberculosis? ___years 1 □ No 2 □ Yes

19. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Emphysema? ___years

20. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Chronic bronchitis? ___years

21. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Stroke or TIA (Transient Ischemic Attack)? ___years

22. **No**  **Yes**  **Not Sure**

1  □  2  □  8  □  Multiple sclerosis? ___years
Has a doctor or nurse ever said that you have:

If yes, at what age were told this? ___________ years

Please specify: ____________________________

23. [ ] No [ ] Yes [ ] Not Sure

Any other major diseases or health problems? ______________

24. [ ] 1 [ ] 2 [ ] * 8 [ ]

Are you taking medications for high blood pressure?

25. [ ] 1 [ ] 2 [ ] * 8 [ ]

Are you taking medications to lower your blood cholesterol?

26. [ ] 1 [ ] 2 [ ] * 8 [ ]

Are you taking medications for asthma or any breathing problem?

27. [ ] 1 [ ] 2 [ ] * 8 [ ]

Are you currently taking any other prescription medications?
(FOR WOMEN, "excluding birth control pills")

28. [ ] 1 [ ] 2 [ ] * 8 [ ]

Are you currently taking aspirin at least three times a week (do not include Tylenol or Advil use)?

29. [ ] 1 [ ] 2 [ ] 8 [ ]

Have you ever had a headache that lasted more than 4 hours?

If "Yes", did the headache have any of the following characteristics?

1. [ ] No 2. [ ] Yes 1. It was on one side only.
   E081SIDE

2. [ ] No 2. [ ] Yes 2. It pulsated (throbbed).
   E08THROB

3. [ ] No 2. [ ] Yes 3. It kept you from doing your job or your usual activities.
   E08JOB

4. [ ] No 2. [ ] Yes 4. It was made worse by walking up stairs or by other physical activity.
   E08WALK

5. [ ] No 2. [ ] Yes 5. It was accompanied by sensitivity to light or sound.
   E08SENS

6. [ ] No 2. [ ] Yes 6. You were nauseated or vomited.
   E08VOMIT

7. How many times in your life did you have headaches with these characteristics?
   E08HEADX _______ times

*COMPLETE FOLLOW-UP FORMS*
30a. During the past three years, what is the most you weighed?

E083YMAX

30b. During the past three years, what is the least you weighed?

E083YMIN

31. During the past three years, have you been on a weight reducing diet? E083YWRD

1 □ No
2 □ Yes  E08NWRD

Are you on such a diet now?

1 □ No   2 □ Yes
If YES, what type of diet?

32. Do you have any medical problem(s) that interfered with your ability to exercise over the past twelve months? E08INTFR

1 □ No  ————> (GO TO QUESTION 33)
2 □ Yes  ————> If yes, specify: ______________________

b. How much did the medical problem(s) interfere with your ability to exercise? (CHECK THE BOX THAT BEST DESCRIBES THIS.) E08INMCH

A little  Very Much

1 □  2 □  3 □  4 □  5 □
Have you ever had the following tests?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Description</th>
<th>If yes, age last had?</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. 1 □ 2 □</td>
<td>E08TREAD</td>
<td>Graded exercise treadmill test, other than at a CARDIA exam?</td>
<td>E08TRDAG</td>
</tr>
<tr>
<td>34. 1 □ 2 □</td>
<td>E08ECHO</td>
<td>Echocardiogram, other than at a CARDIA exam?</td>
<td>E08ECHAG</td>
</tr>
<tr>
<td>35. 1 □ 2 □*</td>
<td>E08ANCTH</td>
<td>Coronary angiogram or heart catheterization (x-ray of heart vessels after injecting dye through your veins)?</td>
<td>E08ANCAG</td>
</tr>
<tr>
<td>36. 1 □ 2 □*</td>
<td>E08CAT</td>
<td>CT (or CAT) scan of brain?</td>
<td>E08CATAG</td>
</tr>
<tr>
<td>37. 1 □ 2 □*</td>
<td>E08MRI</td>
<td>MRI (magnetic resonance imaging) scan of brain?</td>
<td>E08MRIAG</td>
</tr>
</tbody>
</table>

**WOMEN:** GO TO QUESTION 39 ON PAGE 8.

**MEN:** GO TO QUESTION 38.

38. No Yes Not Sure

| 1 □ 2 □ 8 □ | E08VASSEC   | Have you had a vasectomy?                                                  | E08VASAG             |

**MEN:** END OF QUESTIONNAIRE
WOMEN ONLY:

39. [Box] No [Box] Yes [Box] Not Sure
   [Box] 1  [Box] 2  [Box] 8
   E08TUBAL
   Have you had a tubal ligation (had your tubes tied)?

40. [Box] 1  [Box] 2  [Box] 8
   E08HYSTR
   Have you had a hysterectomy?

41. [Box] 1  [Box] 2  [Box] 8
   E08OVRM
   Has either of your ovaries been removed?
   
   41a. Was one ovary removed or both?
       E08NOVRM
       One  Two  Not sure
       [Box] 1  [Box] 2  [Box] 8

42. [Box] 1  [Box] 2  [Box] 8
   E08BRTHC
   Have you ever taken birth control pills?

43. [Box] 1  [Box] 2  [Box] 8
   E08OTHBC
   Have you ever used any other kind of birth control, for example barrier methods such as condoms, diaphragms or cervical caps, medications such as Norplant or injectables, an IUD, or any other type of birth control?

44. [Box] 1  [Box] 2  [Box] 8
   E08HMNOW
   Are you currently taking hormones other than birth control pills?

45. [Box] 1  [Box] 2  [Box] 8
   E08PPREG
   Have you ever been pregnant?
   
   45a. Are you currently pregnant? E08PREG
       No  Yes  Not Sure
       [Box] 1  [Box] 2  [Box] 8

   45b. Are you currently breast feeding? E08BRSPD
       No  Yes
       [Box] 1  [Box] 2  (GO TO NEXT PAGE)

END OF QUESTIONNAIRE

*COMPLETE A FOLLOW-UP FORM
E08IVID
   ___ ___ ___ INTERVIEWER ID
45c. How many pregnancies of at least 20 weeks have you had?

**E08TOTPG** pregnancies

Please record the amount of weight gained during each pregnancy of at least 20 weeks:

**Pregnancy # 1:** Delivery date **E08PDAT1**
Weight gain **E08WGN1** pounds

Did you return to pre-pregnancy weight within one year?
1 □ No ➔ **E08RET1** If no, how much of the weight did you lose within one year? **E08WLS1** pounds
2 □ Yes

**Pregnancy # 2:** Delivery date **E08PDAT2**
Weight gain **E08WGN2** pounds

Did you return to pre-pregnancy weight within one year?
1 □ No ➔ **E08RET2** If no, how much of the weight did you lose within one year? **E08WLS2** pounds
2 □ Yes

**Pregnancy # 3:** Delivery date **E08PDAT3**
Weight gain **E08WGN3** pounds

Did you return to pre-pregnancy weight within one year?
1 □ No ➔ **E08RET3** If no, how much of the weight did you lose within one year? **E08WLS3** pounds
2 □ Yes

**Pregnancy # 4:** Delivery date **E08PDAT4**
Weight gain **E08WGN4** pounds

Did you return to pre-pregnancy weight within one year?
1 □ No ➔ **E08RET4** If no, how much of the weight did you lose within one year? **E08WLS4** pounds
2 □ Yes
45c. (cont.) Please record the amount of weight gained during each pregnancy of at least 20 weeks:

**Pregnancy # 5:** Delivery date __/__/ E08PDAT5
Weight gain ____E08WGN5___ pounds

Did you return to pre-pregnancy weight within one year?
1 □ No   ----> If no, how much of the weight did you lose within one year? ____E08WLS5 pounds
2 □ Yes

**Pregnancy # 6:** Delivery date __/__/ E08PDAT6
Weight gain ____E08WGN6___ pounds

Did you return to pre-pregnancy weight within one year?
1 □ No   ----> If no, how much of the weight did you lose within one year? ____E08WLS6 pounds
2 □ Yes

**Pregnancy # 7:** Delivery date __/__/ E08PDAT7
Weight gain ____E08WGN7___ pounds

Did you return to pre-pregnancy weight within one year?
1 □ No   ----> If no, how much of the weight did you lose within one year? ____E08WLS7 pounds
2 □ Yes

**Pregnancy # 8:** Delivery date __/__/ E08PDAT8
Weight gain ____E08WGN8___ pounds

Did you return to pre-pregnancy weight within one year?
1 □ No   ----> If no, how much of the weight did you lose within one year? ____E08WLS8 pounds
2 □ Yes

E08IVID
___ ___ ___ INTERVIEWER ID