UNIVERSITY OF HAWAI'I CANCER CENTER

# The Multiethnic Cohort Study

## *Follow-Up Health Survey*

USC University of Southern California

**1** **Have you ever smoked tobacco cigarettes regularly (20 or more packs of cigarettes in your lifetime)?**
☐ No ☐ Yes, currently ☐ Yes, but not now

**If yes currently, how many cigarettes per day?** _____

**If yes but not now, in what year did you quit?** _____

**2** **On average during the last year, how many hours at night did you sleep?** _____ hours **and** _____ minutes

**3** **On average during the last year, how many hours in the daytime did you sleep?** ***(include naps)***
_____ hours **and** _____ minutes

**4** **In the past month, how often did you have trouble getting to sleep or staying asleep?**
☐ Not in the past month ☐ 1 - 2 times a week
☐ Less than once a week ☐ 3 or more times a week

**5** **If you had trouble sleeping during the past month, it was because you:** ***(mark all that apply)***
☐ Could not get to sleep within 30 minutes
☐ Woke up in the middle of the night or early morning
☐ Had to get up to use the bathroom
☐ Could not breathe comfortably
☐ Coughed or snored loudly
☐ Felt too cold or hot
☐ Had pain
☐ Other reasons (explain: _____)

**6** **In the past month, how often did you snore?** ***(mark only one)***
☐ Almost never ☐ Occasionally ☐ Most nights

**7** **In the past month, how would you rate your sleep quality overall?** ***(mark only one)***
☐ Very bad ☐ Fairly bad ☐ Fairly good ☐ Very good

***GO TO QUESTION 8***

**8** **Do you currently drink alcoholic beverages?**
☐ No ☐ Yes

**If yes, how many days in a week on average do you drink alcohol?**
☐ Less than one ☐ 1 - 3 days ☐ 4 - 6 days ☐ Daily

**If yes, how many cans/bottles/glasses do you consume on days that you drink alcohol?** _____ cans/bottles/glasses

**9** **How is your eyesight?** ***(include when using glasses or contact lens if you do)***
☐ Excellent ☐ Very good ☐ Fair ☐ Poor

**10** **How is your hearing?** ***(include when using a hearing aid if you do)***
☐ Excellent ☐ Very good ☐ Fair ☐ Poor

**11** **What is your sex?** ☐ Male ☐ Female

**12** **What is your date of birth?** _____ / _____ / 19_____
Month Day Year

**13** **How much do you currently weigh?** _____ pounds

**14** **What is your current marital status?** ***(mark only one)***
☐ Married or living as married ☐ Separated or divorced
☐ Single ☐ Widowed

**15** **Who do you live with?** ***(mark all that apply)***
☐ Live alone ☐ A spouse or partner ☐ Pet(s)
☐ Other family ☐ Other people

**16** **YOUR HOME PHONE NUMBER**
( ) –

**17** **YOUR CELL PHONE NUMBER**
( ) –

***GO TO QUESTION 18***

**18** **What is your email address?** ***(print legibly)***

**SURVEY ANSWERS SHOULD BE ONLY FOR THE PERSON NAMED BELOW**

**19** **If your name or address has changed, please provide the current information below:**

**Name**

**Address**

**City** **State** **Zip Code**

20 **How often do you participate in any social groups, such as religious meetings or services, self-help groups, charities, public services or community groups?**

☐ Never or almost never ☐ Less than once a month ☐ 1 - 3 times a month ☐ Once a week ☐ More than once a week

21 **How many relatives and friends do you have, whom you feel close to?**

☐ None ☐ 1 - 2 ☐ 3 - 5 ☐ 6 - 9 ☐ 10 or more

22 **Is there one special person you feel very close to, someone you feel you can share confidences and feelings with?**

☐ No ☐ Yes **If yes, how often do you see or talk to this person?**

☐ Daily ☐ Weekly ☐ Monthly ☐ Several times a year ☐ Once a year or less

23 **How often can you count on someone to provide you with emotional support (talking over problems or helping you make a difficult decision)?**

☐ None of the time ☐ A little of the time ☐ Some of the time ☐ Most of the time ☐ All of the time

24 **How many people can you count on to provide you with emotional support?** ☐ None ☐ 1 ☐ 2 ☐ 3 or more

25 **Was each of the following true for you much of the time in the past week:**

| | No | Yes |
|---|---|---|
| Did you feel depressed? | ☐ | ☐ |
| Did you feel sad? | ☐ | ☐ |
| Did you feel that everything you did was an effort? | ☐ | ☐ |
| Did you feel that you could not get going? | ☐ | ☐ |
| ***GO TO NEXT COLUMN*** | | |

| | No | Yes |
|---|---|---|
| Did you feel happy? | ☐ | ☐ |
| Did you feel lonely? | ☐ | ☐ |
| Did you enjoy life? | ☐ | ☐ |
| Did you feel that your sleep was restless? | ☐ | ☐ |

26 **Have you had your gallbladder removed?** ☐ No ☐ Yes

27 **Have you had cataract surgery?** ☐ No ☐ Yes

28 **Has your doctor ever told you that you had any of the following conditions?**

| | No | Yes |
|---|---|---|
| High blood pressure | ☐ | ☐ |
| Congestive heart failure | ☐ | ☐ |
| Angina (chest pain due to exertion) | ☐ | ☐ |
| Heart attack | ☐ | ☐ |
| Atrial fibrillation | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Diabetes (not including pre-diabetes) | ☐ | ☐ |
| Skin cancer (not melanoma) | ☐ | ☐ |
| Alzheimer's disease | ☐ | ☐ |
| Other dementia, senility or any other serious memory impairments | ☐ | ☐ |
| Polyp(s) of the intestines | ☐ | ☐ |
| Crohn's disease | ☐ | ☐ |
| ***GO TO NEXT COLUMN*** | | |

| | No | Yes |
|---|---|---|
| Ulcerative colitis | ☐ | ☐ |
| Osteoporosis (brittle bones) | ☐ | ☐ |
| Ulcer (stomach or duodenal) | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ |
| Other arthritis | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Parkinson's disease | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Chronic lung disease (such as chronic bronchitis or emphysema) | ☐ | ☐ |
| Fatty liver disease | ☐ | ☐ |
| Cirrhosis of the liver | ☐ | ☐ |
| Chronic hepatitis (B or C) | ☐ | ☐ |
| ***(men only)*** Enlarged prostate | ☐ | ☐ |

**29 Have you had any of the following tests?**

| | No | Yes | | IF YES, MARK EVERY YEAR YOU HAD THE TEST: Before 2015 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gastroscopy of the stomach | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colonoscopy or sigmoidoscopy of the colon | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *(men only)* PSA blood test for the prostate | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *(women only)* Mammogram | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| *(women only)* Pap smear | ☐ | ☐ | → | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**30 In the past two years, have you had PERSISTENT or TROUBLESOME problems such as:**

Shortness of breath while awake? ☐ No ☐ Yes

Persistent dizziness or lightheadedness? ☐ No ☐ Yes

Severe fatigue or exhaustion? ☐ No ☐ Yes

Falling down? ☐ No ☐ Yes
If yes, how many times did you need medical treatment? ☐ None ☐ 1 - 3 ☐ 4 - 6 ☐ 7 or more

**31 Do you usually need assistance with walking?** ☐ No ☐ Yes
If yes, *(mark all that apply)* ☐ Cane ☐ Walker ☐ Wheelchair/scooter

**32 Have you had difficulty with any of these activities because of a health or memory problem?**
*(do not include difficulties that you have had for less than three months)*

| | MARK ONLY ONE: None | Some difficulty | Can't do | Don't do |
|---|---|---|---|---|
| Walking one block | ☐ | ☐ | ☐ | ☐ |
| Sitting for about two hours | ☐ | ☐ | ☐ | ☐ |
| Getting up from a chair after sitting for long periods | ☐ | ☐ | ☐ | ☐ |
| Climbing one flight of stairs without resting | ☐ | ☐ | ☐ | ☐ |
| Lifting or carrying weights over 10 pounds, such as a heavy bag of groceries | ☐ | ☐ | ☐ | ☐ |
| Getting in or out of bed | ☐ | ☐ | ☐ | ☐ |
| Dressing, including putting on shoes and socks | ☐ | ☐ | ☐ | ☐ |
| Preparing a hot meal | ☐ | ☐ | ☐ | ☐ |
| Taking medications | ☐ | ☐ | ☐ | ☐ |
| Using a map to figure out how to get around | ☐ | ☐ | ☐ | ☐ |
| Picking up a dime from a table | ☐ | ☐ | ☐ | ☐ |

***GO TO NEXT COLUMN***

| | MARK ONLY ONE: None | Some difficulty | Can't do | Don't do |
|---|---|---|---|---|
| Walking across a room | ☐ | ☐ | ☐ | ☐ |
| Using the toilet, including getting up and down | ☐ | ☐ | ☐ | ☐ |
| Reaching or extending your arms above shoulder level | ☐ | ☐ | ☐ | ☐ |
| Stooping, kneeling or crouching | ☐ | ☐ | ☐ | ☐ |
| Pulling or pushing large objects, such as a living room chair | ☐ | ☐ | ☐ | ☐ |
| Bathing or showering | ☐ | ☐ | ☐ | ☐ |
| Shopping for groceries | ☐ | ☐ | ☐ | ☐ |
| Eating, including having to cut your food or feed yourself | ☐ | ☐ | ☐ | ☐ |
| Making phone calls | ☐ | ☐ | ☐ | ☐ |
| Managing your money, such as paying your bills and keeping track of expenses | ☐ | ☐ | ☐ | ☐ |
| Driving a car | ☐ | ☐ | ☐ | ☐ |
| Traveling by train, bus or taxi | ☐ | ☐ | ☐ | ☐ |

33 *(women only)* **Are you currently taking estrogen (female hormones) by pill, injection, or patch?** ☐ No ☐ Yes

34 *(women only)* **Are you currently taking progesterone (such as Provera)?** ☐ No ☐ Yes

35 **Are you currently taking any pills or shots for osteoporosis or brittle bones (such as Fosamax, Actonel, Boniva, Prolia, Reclast, Forteo or OTHER)?** ☐ No ☐ Yes

36 **Have you ever taken any of the following medications at least two times per week for one month or longer?**

| | |
|---|---|
| **LOW DOSE ASPIRIN** (Baby Aspirin) | ☐ No ☐ Yes |
| **ASPIRIN** (Anacin, Bufferin, Bayer, Excedrin, Ecotrin or OTHER) | ☐ No ☐ Yes |
| **ACETAMINOPHEN** (Aspirin-Free Anacin, Tylenol or OTHER) | ☐ No ☐ Yes |
| **OTHER PAIN RELIEF MEDICATION** (Motrin, Ibuprofen, Advil, Aleve, Naproxen, Indocin or OTHER) | ☐ No ☐ Yes |
| **CELEBREX** (Celecoxib), **VIOXX** (Rofecoxib), **OR BEXTRA** (Valdecoxib) | ☐ No ☐ Yes |
| **WATER PILLS FOR HIGH BLOOD PRESSURE OR OTHER REASONS** (Hydrochlorothiazide, Lasix, Maxzide, Spironolactone or OTHER) | ☐ No ☐ Yes |
| **OTHER HIGH BLOOD PRESSURE MEDICATION** (Cozaar, Losartan, Lisinopril, Norvasc, Amlodipine, Nifedipine, Metoprolol, Coreg, Atenolol or OTHER) | ☐ No ☐ Yes |
| **HIGH CHOLESTEROL MEDICATION** (Statins such as Lipitor, Pravachol, Crestor, Zocor, Lovastatin, Zetia, Lopid or OTHER) | ☐ No ☐ Yes |
| **PEPTIC ULCER MEDICATION** (Zantac, Pepcid, Protonix, Prilosec, Nexium or OTHER) | ☐ No ☐ Yes |
| ***GO TO NEXT COLUMN*** | |

| | |
|---|---|
| **ASTHMA MEDICATION PILLS OR INHALERS** (Albuterol, Azmacort, Proventil, Theophylline or OTHER) | ☐ No ☐ Yes |
| **ALLERGY PILLS OR SHOTS** (Claritin, Allegra, Zyrtec, Benadryl or OTHER) | ☐ No ☐ Yes |
| **EVISTA** (Raloxifene) | ☐ No ☐ Yes |
| **INSULIN SHOTS FOR DIABETES** (Lantus, Novolog, Levemir, Basaglar, Toujeo, Tresiba, Humalog Kwikpen or OTHER) | ☐ No ☐ Yes |
| **METFORMIN PILLS FOR DIABETES OR OTHER REASONS** (Glucophage, Avandamet, Glucovance, Janumet or OTHER) | ☐ No ☐ Yes |
| **OTHER PILLS OR NON-INSULIN SHOTS FOR DIABETES** (Glyburide, Glipizide, Januvia, Victoza, Trulicity, Byetta, Bydureon or OTHER) | ☐ No ☐ Yes |
| **SLEEPING PILLS WITH PRESCRIPTION** (Ambien, Trazodone, Lunesta or OTHER) | ☐ No ☐ Yes |
| **OVER-THE-COUNTER SLEEP AIDS** (Nytol, Unisom, Melatonin or OTHER) | ☐ No ☐ Yes |
| **ANTI-DEPRESSANTS** (Prozac, Celexa, Lexapro, Zoloft, Cymbalta or OTHER) | ☐ No ☐ Yes |

37 **Have you ever used marijuana for medical reasons?** ☐ No ☐ Yes, currently ☐ Yes, but not now

38 **Have you ever experienced discrimination, been treated poorly, been prevented from doing something, or been hassled or made to feel inferior in any of the following five situations because of:**

**Your race or ethnicity?**

| | No | Rarely | Occasionally | Often |
|---|---|---|---|---|
| Getting a job | ☐ | ☐ | ☐ | ☐ |
| Getting housing | ☐ | ☐ | ☐ | ☐ |
| At work | ☐ | ☐ | ☐ | ☐ |
| Getting medical care | ☐ | ☐ | ☐ | ☐ |
| On the street or in a public setting | ☐ | ☐ | ☐ | ☐ |

***GO TO NEXT COLUMN***

**Your social or economic situation (because of how much money or education you have)?**

| | No | Rarely | Occasionally | Often |
|---|---|---|---|---|
| Getting a job | ☐ | ☐ | ☐ | ☐ |
| Getting housing | ☐ | ☐ | ☐ | ☐ |
| At work | ☐ | ☐ | ☐ | ☐ |
| Getting medical care | ☐ | ☐ | ☐ | ☐ |
| On the street or in a public setting | ☐ | ☐ | ☐ | ☐ |

39 **Did you get assistance from another person to fill in this questionnaire, such as your spouse or child?** ☐ No ☐ Yes

***THANK YOU SO MUCH FOR YOUR TIME AND COOPERATION!***