VIETNAM ERA TWIN REGISTRY

Cooperative Studies Program Coordinating Center
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NATIONAL HEART, LUNG, AND BLOOD INSTITUTE
VIETNAM ERA TWIN STUDY

Twins offer a unique and valuable opportunity for scientific investigators to explore the effects of the environment and genetics on health. This questionnaire is part of a study being performed by the VIETNAM ERA TWIN REGISTRY and funded by the NATIONAL HEART, LUNG, AND BLOOD INSTITUTE to help advance scientific knowledge. Your cooperation in carefully completing and returning this questionnaire will greatly benefit this research endeavor.

Please be assured that all of the information you provide will be held in confidence. No individual will be identified in the published results of any study accessing data from the registry. This study has nothing to do with any compensation, claims or contacts you may have with the Department of Veterans Affairs. The information asked for in this survey is being collected under authority of Section 419 of the Public Health Service Act and Title 38, Chapter 73, Section 4101 of the Code of Federal Regulations.

Public reporting burden for this collection of information is estimated to average 30 minutes, including the time for reviewing instructions, gathering needed information and completing and reviewing the questionnaire. If you have comments regarding this burden please send them to Reports Clearance Officer, PHS, 721-H, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, Attention PRA; and to the Office of Management and Budget, Paperwork Reduction Project, Washington, D.C. 20503.

Mailing #

Instructions

BEFORE YOU BEGIN . . . PLEASE READ THESE INSTRUCTIONS

The questions in this survey ask you to follow instructions and use the answer categories provided. You will find instructions for responding included with each question, in CAPITAL LETTERS within parentheses. Below are examples of the different instructions you will see, and the correct way to answer each type of question.

INSTRUCTION 1 : (CIRCLE ONE)

1. What is the color of your eyes? (CIRCLE ONE)

1 BLUE
(2) BROWN
3 GREEN
4 ANOTHER COLOR

IF THE COLOR OF YOUR EYES IS BROWN, YOU WOULD CIRCLE THE NUMBER TO THE LEFT OF "BROWN".

INSTRUCTION 2 : (CIRCLE ALL THAT APPLY)

2. Last week, did you do any of the following? (CIRCLE ALL THAT APPLY)

(1) WORK FOR PAY
2 ATTEND CLASSES
(3) WATCH TV
4 VISIT FRIENDS
(5) EXERCISE

IF YOU WORKED FOR PAY, EXERCISED, AND WATCHED TV LAST WEEK, YOU WOULD CIRCLE THE NUMBER TO THE LEFT OF THE ITEMS, AS SHOWN.

INSTRUCTION 3 : (CIRCLE ONE FOR EACH LINE)

3. Do you plan to do any of the following next week? (CIRCLE ONE FOR EACH LINE)

	YES	NOT SURE	NO
a. Visit a relative	1	2	(3)
b. Go to a museum	1	(2)	3
c. Go to a library	(1)	2	3
d. Watch sports on TV	(1)	2	3

IF YOU DONT PLAN TO VISIT A RELATIVE NEXT WEEK, MAY GO TO A MUSEUM, DEFINITELY ARE GOING TO A LIBRARY, AND WILL WATCH SPORTS ON TV, YOU WOULD CIRCLE THE NUMBERS AS SHOWN.

INSTRUCTION 4 : (WRITE IN NUMBER, PUT A "0" IN ANY EXTRA BOXES ON THE LEFT)

4. How many cups of coffee do you drink each day, on average?
(WRITE IN NUMBER. PUT A "0" IN ANY EXTRA BOXES ON THE LEFT)

| 0 | 5 | CUPS OF COFFEE |

IF YOU DRINK 5 CUPS OF COFFEE DAILY, YOU WOULD WRITE IN THE NUMBER AS SHOWN.

Some items require you to skip over one or more questions depending upon your answers. You will be directed either by an arrow or by an arrow and boxed instructions.

INSTRUCTION 5 : DIRECTIONS TO SKIP AN ITEM

5. Have you ever been to a soccer game? (CIRCLE ONE)

1 YES
(2) NO → PROCEED TO QUESTION 7.

6. In what year did you last go to a soccer game? (WRITE IN YEAR)

| 1 | 9 | | | YEAR |

7. Do you plan to go to a soccer game in the next six months? (CIRCLE ONE)

(1) YES
2 NO

IF YOU HAD NEVER BEEN TO A SOCCER GAME, YOU WOULD HAVE CIRCLED THE CODE FOR "NO" AND ANSWERED QUESTION 7 NEXT. QUESTION 6 WOULD BE LEFT BLANK.

(IF YOU HAD BEEN TO A SOCCER GAME, QUESTIONS 5, 6, AND 7 WOULD BE ANSWERED.)

Daily habits and family history play an important role in determining risk factors associated with heart and lung disease. Your cooperation in answering each question as completely as possible will provide us with a vast amount of information which will aid in fighting these killing diseases.

Let's begin with some questions about your food habits . . .

FOOD HABITS

1. How often do you usually eat the following? (CIRCLE ONE FOR EACH LINE)

1/ 09

	Daily	3-6 times a week	1-2 times a week	1-3 times a month	Less than once a month	Never
a. Pork	1	2	3	4	5	6
b. Hot Dogs	1	2	3	4	5	6
c. Beef (roasts or steaks); Lamb	1	2	3	4	5	6
d. Poultry; Veal	1	2	3	4	5	6
e. Eggs	1	2	3	4	5	6
f. Cold water fish (mackerel, salmon, sardines, bluefish, tuna)	1	2	3	4	5	6
g. Shell fish (shrimp, lobster, crab)	1	2	3	4	5	6
h. Other fish	1	2	3	4	5	6
i. Dishes made of flour, cereal (dumplings, pancakes, spaghetti, macaroni, etc.)	1	2	3	4	5	6
j. Rice	1	2	3	4	5	6
k. Potatoes	1	2	3	4	5	6
l. Fruits and vegetables	1	2	3	4	5	6
m. Ice cream	1	2	3	4	5	6
n. Cheese	1	2	3	4	5	6

2. Estimate your daily consumption of the following:
(WRITE IN NUMBER PER DAY, IF ZERO, WRITE IN "00".)

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a. Glasses of skim or low fat milk ☐☐

b. Glasses of whole milk ☐☐

c. Glasses of buttermilk ☐☐

d. Cups of coffee ☐☐

e. Cups of tea ☐☐

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3. Do you routinely (3 or more times per week) supplement your diet with multivitamins? (CIRCLE ONE)

1/33

1 YES

2 NO

4. Other than a multivitamin do you routinely supplement your diet with any of the following: (CIRCLE ONE FOR EACH LINE)

	YES	NO
Vitamin A	1	2
Vitamin E	1	2
Fish Oil	1	2
Fiber	1	2
Calcium	1	2
Oat Bran	1	2
Zinc	1	2

5. How often do you take aspirin? (Do not include non aspirin products such as Tylenol, Motrin, Ibuprofen, etc.) (CIRCLE ONE)

1/41

1 Daily

2 3–6 times a week

3 1–2 times a week

4 1–3 times a month

5 Less than once a month

→ a. Why do you take aspirin: (CIRCLE ONE FOR EACH LINE)

	YES	NO
In response to a medical condition?	1	2
As a form of preventive medicine?	1	2

6 Never → PROCEED TO QUESTION 6.

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Now some questions about your cardiovascular system

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6. Has a doctor EVER told you that you have . . If "yes", answer 6i. (CIRCLE ONE FOR EACH LINE)	YES	NO	6i. At what age did you first have it? (WRITE IN AGE)
a. Angina pectoris?	1	2	☐☐ years old
b. Congestive heart failure?	1	2	☐☐ years old
c. Coronary heart disease?	1	2	☐☐ years old
d. Damaged heart valves?	1	2	☐☐ years old
e. Heart attack or myocardial infarction?	1	2	☐☐ years old
f. Heart murmur?	1	2	☐☐ years old
g. Phlebitis or thrombophlebitis?	1	2	☐☐ years old
h. Stroke or cerebrovascular accident?	1	2	☐☐ years old

2/ 09

7. Do you get short of breath walking with other people at an ordinary pace on level ground? (CIRCLE ONE)

1 YES → a. Do you get short of breath walking at your own pace? (CIRCLE ONE)

1 YES

2 NO

2 NO

8. Have you EVER had any pain or discomfort in your chest? (CIRCLE ONE)

1 YES → a. When do you feel this pain or discomfort: (CIRCLE ONE FOR EACH LINE)

	YES	NO
When you are emotionally upset or excited?	1	2
When you walk fast or walk uphill?	1	2
When you walk at normal speed on level ground?	1	2
Under other conditions?	1	2

2 NO → PROCEED TO QUESTION 9.

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b. What do you do when you feel this pain or discomfort while you are walking? (CIRCLE ONE)

1 Stop walking or walk more slowly
2 Take medicine and continue walking at the same speed
3 Continue walking at the same speed without taking medication

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c. If you stop walking, regardless of whether you take medicine or not, how is the pain or discomfort then? (CIRCLE ONE)

1 The pain usually passes within ten minutes

2 The pain usually continues for more than ten minutes

d. Where are the pains or the discomfort located: (CIRCLE ONE FOR EACH LINE)

	YES	NO
In the middle of the chest?	1	2
In the left side of the chest?	1	2
In the left arm?	1	2
In some other place?	1	2

9. Have you EVER had a severe pain across the front of your chest lasting for a half hour or more? (CIRCLE ONE)

1 YES

2 NO

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10. Have you EVER been told by a doctor that you had hypertension or high blood pressure? (CIRCLE ONE)

1 YES ⟶ a. Age that you first had high blood pressure: (WRITE IN AGE) [|] years old

2 NO ⟶ PROCEED TO QUESTION 11.

7 DON'T KNOW

b. Has a doctor EVER prescribed medication for you for hypertension or high blood pressure? (CIRCLE ONE)

1 YES
2 NO
7 DON'T KNOW

c. Are you now taking medication for this condition? (CIRCLE ONE)

1 YES

2 NO

7 DON'T KNOW

2/ 2[illegible]

2/ 28

11. Have you EVER had a cardiac catheterization? (CIRCLE ONE)
If "yes", answer 11a.

1 YES → a. At what age? [ ][ ] years old

2 NO

12 Have you EVER had heart surgery? (CIRCLE ONE)
If "yes" answer 12f.

1 YES → Did you have . . .

2 NO ↓ PROCEED TO QUESTION 13.

Did you have . . .	YES	NO	12f. At what age did you have it?
a. Balloon angioplasty?	1	2	[ ][ ] years old
b. Coronary artery bypass surgery?	1	2	[ ][ ] years old
c. Valve repair?	1	2	[ ][ ] years old
d. Valve replacement?	1	2	[ ][ ] years old
e. Other? Specify: ______	1	2	[ ][ ] years old

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13. Has a doctor EVER told you that you have:
(CIRCLE ONE FOR EACH LINE)
If "yes", answer 13g.

	YES	NO	13g. At what age did you first have it?
a. Asthma?	1	2	[ ][ ] years old
b. Bronchitis or chronic bronchitis?	1	2	[ ][ ] years old
c. Chronic obstructive pulmonary disease (COPD)?	1	2	[ ][ ] years old
d. Emphysema?	1	2	[ ][ ] years old
e. Hay fever?	1	2	[ ][ ] years old
f. Pneumonia (include bronchopneumonia)?	1	2	[ ][ ] years old

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14. Do you have diabetes? (CIRCLE ONE) YEARS OLD

1 YES → a. At what age was your diabetes first diagnosed? [|]

2 NO → PROCEED TO QUESTION 15.

b. Is your diabetes currently controlled by diet alone? (CIRCLE ONE)
1 YES
2 NO

c. Is your diabetes currently treated with medication in pill form? (CIRCLE ONE)
1 YES
2 NO

d. Is your diabetes currently treated with insulin? (CIRCLE ONE)
1 YES
2 NO

e. Has your doctor EVER diagnosed diabetic ketoacidosis? (CIRCLE ONE)
1 YES
2 NO

f. Have you EVER been in a diabetic coma? (CIRCLE ONE)
1 YES
2 NO

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15. Have you EVER had a glucose tolerance test for diabetes? (CIRCLE ONE)

1 YES → a. Year of most recent test? [1|9| |]
2 NO
7 DONT KNOW

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16. Do you usually have a cough? (Count a cough when you first go out-of-doors or with your first tobacco product (if you smoke). Exclude clearing your throat). (CIRCLE ONE)

1 YES → a. Do you usually cough as much as 4 to 6 times a day, for 4 or more days per week? (CIRCLE ONE)
1 YES
2 NO

2 NO → PROCEED TO QUESTION 17.

b. Do you usually cough at all on getting up or first thing in the morning? (CIRCLE ONE)
1 YES
2 NO

c. Do you usually cough at all during the rest of the day or at night? (CIRCLE ONE)
1 YES
2 NO

d. Do you usually cough like this on most days for 3 consecutive months or more during the year? (CIRCLE ONE)
1 YES
2 NO

e. For how many years have you had this cough? (WRITE IN YEARS. PUT A "0" IN ANY EXTRA BOXES ON THE LEFT.)

[|] years

7 DONT KNOW

3/ 09

3/ 1

3/ 17

17. Do you usually bring up phlegm from your chest? Count phlegm on first going out of doors or with your first tobacco product (if you smoke). Exclude phlegm from your nose. Count swallowed phlegm. (CIRCLE ONE)

1 YES → a. Do you usually bring up phlegm like this as much as twice a day, 4 or more days per week? (CIRCLE ONE)

1 YES
2 NO

2 NO

PROCEED TO QUESTION 18.

b. Do you usually bring up phlegm at all on getting up, or first thing in the morning? (CIRCLE ONE)

1 YES
2 NO

c. Do you usually bring up phlegm at all during the rest of the day or at night? (CIRCLE ONE)

1 YES
2 NO

d. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year? (CIRCLE ONE)

1 YES
2 NO

e. For how many years have you had trouble with phlegm? (WRITE IN YEARS. PUT A "0" IN ANY BOXES ON THE LEFT.)

[|] years

7 DON'T KNOW

3/ 25

18. Has a doctor EVER told you that you have cataracts? (CIRCLE ONE)

1 No
2 Left eye only
3 Right eye only
4 Both eyes

→ a. Have you undergone cataract surgery? (CIRCLE ONE)

1 No
2 Left eye only
3 Right eye only
4 Both eyes

19. Has a doctor EVER told you that you have glaucoma? (CIRCLE ONE)

1 No
2 Left eye only
3 Right eye only
4 Both eyes

→ a. Have you undergone glaucoma surgery? (CIRCLE ONE)

1 No
2 Left eye only
3 Right eye only
4 Both eyes

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PROCEED TO QUESTION 20.

And, a few questions about your smoking habits . . .

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20. Have you smoked at least 100 cigarettes in your life? (CIRCLE ONE)

1 YES
2 NO → PROCEED TO QUESTION 23.

21. Do you smoke cigarettes now? (CIRCLE ONE)

1 YES → a. How many cigarettes do you usually smoke per day? (WRITE IN NUMBER. PUT A "0" IN ANY BOXES ON THE LEFT)

[| |] cigarettes per day

2 NO → PROCEED TO QUESTION 22.

b. How old were you when you started smoking cigarettes regularly? (WRITE IN AGE)

[|] years old

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c. How much do you inhale when smoking cigarettes? (CIRCLE ONE)

1 Do not inhale
2 Inhale slightly
3 Inhale moderately
4 Inhale deeply

d. What type of cigarettes do you usually smoke? (CIRCLE ONE)

1 Regular cigarettes
2 Low tar/Low nicotine cigarettes

e. Do you smoke filter tip cigarettes? (CIRCLE ONE)

1 YES
2 NO
→ PROCEED TO QUESTION 23.

3/ :

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22. If you do NOT smoke cigarettes now, did you ever smoke cigarettes regularly? (CIRCLE ONE)

1 YES → a. How old were you when you started smoking cigarettes regularly? (WRITE IN AGE)

[|] years old

2 NO ↓ PROCEED TO QUESTION 23.

b. How many cigarettes did you usually smoke per day? (WRITE IN NUMBER. PUT A "0" IN ANY BOXES ON THE LEFT.)

[| |] cigarettes per day

c. How old were you when you stopped smoking cigarettes? (WRITE IN AGE)

[|] years old

d. Did you stop smoking cigarettes because: (CIRCLE ONE FOR EACH LINE)

	YES	NO
A doctor told you to?	1	2
You were feeling ill?	1	2
You thought it was unhealthy?	1	2
You were urged to by others?	1	2

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23. Have you smoked at least 10 cigars in your life? (CIRCLE ONE)

1 YES

2 NO → PROCEED TO QUESTION 26.

24. Do you smoke cigars now? (CIRCLE ONE)

1 YES → a. How many cigars do you usually smoke per week? (WRITE IN NUMBER. PUT A "0" IN ANY BOXES ON THE LEFT.)

[|] cigars per week

2 NO ↓ PROCEED TO QUESTION 25.

b. How old were you when you started smoking cigars regularly? (WRITE IN AGE)

[|] years old

c. How much do you inhale when smoking cigars? (CIRCLE ONE)

1 Do not inhale
2 Inhale slightly
3 Inhale moderately
4 Inhale deeply

→ PROCEED TO QUESTION 26.

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25. If you do NOT smoke cigars now, did you ever smoke cigars regularly? (CIRCLE ONE) 3/ 5

1 YES

2 NO

26. Have you smoked at least 10 pipefuls of tobacco in your life? (CIRCLE ONE)

1 YES

2 NO → PROCEED TO QUESTION 29.

27. Do you smoke a pipe now? (CIRCLE ONE)

1 YES → a. How many pipefuls of tobacco do you usually smoke per week? (WRITE IN NUMBER. PUT A "0" IN ANY BOXES ON LEFT.)

[ ][ ] pipefuls per week

b. How old were you when you started smoking a pipe regularly? (WRITE IN AGE)

[ ][ ] years old

c. How much do you inhale when smoking a pipe? (CIRCLE ONE)

1 Do not inhale

2 Inhale slightly

3 Inhale moderately

4 Inhale deeply

→ PROCEED TO QUESTION 29. 3/

2 NO → PROCEED TO QUESTION 28.

28. If you do NOT smoke a pipe now, did you ever smoke a pipe regularly? (CIRCLE ONE)

1 YES

2 NO

29. Do you chew tobacco or use snuff? (CIRCLE ONE)

1 YES

2 NO

3/

. . . And about your consumption of alcoholic beverages . .

30. Have you had more than 20 alcoholic drinks in your entire life? (CIRCLE ONE)

1 YES

2 NO → PROCEED TO QUESTION 34.

31. During the past 2 weeks, how many days did you drink any beer? (WRITE IN DAYS or CIRCLE "00".)

☐☐ days → a. On the day(s) when you drank beer, about how many beers did you drink a day? (WRITE IN NUMBER, PUT A "0" IN ANY BOXES ON THE LEFT)

☐☐ beers a day

or

00 None → PROCEED TO QUESTION 32.

4/ 13

32. During the past 2 weeks, on how many days did you drink any wine? (WRITE IN DAYS or CIRCLE "00".)

☐☐ days → a. On the day(s) when you drank wine, about how many glasses of wine did you drink a day? (WRITE IN NUMBER, PUT A "0" IN ANY BOXES ON THE LEFT)

☐☐ glasses a day

or

00 None → PROCEED TO QUESTION 33.

4/ 17

4/ 18

33. During the past 2 weeks, on how many days did you drink any hard liquor, such as whiskey, rum, gin, or vodka?
(WRITE IN DAYS or CIRCLE "00".)

[ ][ ] days → a. On the day(s) when you drank hard liquor, about how many drinks did you have a day?
(WRITE IN NUMBER, PUT A ZERO IN ANY BOXES ON THE LEFT.)

[ ][ ] drinks of hard liquor per day

or

00 None

PROCEED TO QUESTION 34.

34. During the past month, on how many DAYS did you have 9 or more drinks of ANY alcoholic beverage?
(WRITE IN DAYS or CIRCLE "00".)

[ ][ ] days

or

00 None

4/ 23

35. During the past month, on how many DAYS did you have 5 or more drinks of ANY alcoholic beverage?
(WRITE IN DAYS or CIRCLE "0".)

[ ][ ] days

or

00 None

4/ 25

. . . And now about your physical activity

4/ 26

36. Do you usually participate in any of the following activities? (CIRCLE ONE FOR EACH LINE)

	YES	NO
a. Climbing stairs instead of taking the elevator	1	2
b. Walking instead of driving short distances	1	2
c. Parking away from your destination so you have to walk more	1	2
d. Walking on your lunch break or after dinner	1	2
e. Getting off at a bus stop before your destination and walking	1	2
f. Other extra walking or stair climbing for exercise	1	2

37. For at least the last three (3) months, which of the following activities have you performed regularly? (CIRCLE ONE FOR EACH LINE)

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	YES	NO
a. Jog or run at least 10 miles per week	1	2
b. Play strenuous racquet sports (singles tennis, paddle ball, etc.) at least 5 hours per week	1	2
c. Play other strenuous sports (basketball, soccer, etc.)	1	2
d. Ride a bicycle at least 50 miles per week	1	2
e. Swim at least 2 miles per week	1	2

38. Are you presently employed? (CIRCLE ONE)

1 YES, Full-time (at least 35 hours a week)

2 YES, Part-time (less than 35 hours a week)

3 NO ———▶ PROCEED DIRECTLY TO QUESTION 44.

39. In a typical day, how much time do you spend sitting when you work? (CIRCLE ONE)

1 Practically all the time

2 More than 1/2 the time

3 1/2 the time

4 Less than 1/2 the time

5 Almost never

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40. In a typical day, how much time on the job do you spend walking? (CIRCLE ONE) 4/39

1 Practically all the time
2 More than 1/2 the time
3 1/2 the time
4 Less than 1/2 the time
5 Almost never

41. In a typical day, how far do you walk getting to and from your job? (WRITE IN NUMBER. IF ZERO, PUT IN "000".) (Let 1 mile = 12 city blocks)

[ ][ ][ ] city blocks

42. What is the main type of transportation you usually use to get to and from your job? (CIRCLE ONE)

1 Public transportation
2 Car
3 Bicycle
4 Walk

43. How often do you have to lift heavy weights or carry heavy things (Greater than 50 lbs.) on the job? (CIRCLE ONE)

1 Frequently
2 Sometimes
3 Very infrequently or never

4/44

And now a few questions about your daily walking patterns (include both leisure and on the job activity).

44. How many flights of stairs do you climb each day? (WRITE IN NUMBER. IF ZERO, PUT IN "00".) (Let 10 steps = 1 flight)

[ ][ ] flights of stairs

45. How many city blocks or their equivalent do you walk each day? (WRITE IN NUMBER. IF ZERO, PUT IN "000".) (Let 1 mile = 12 city blocks)

[ ][ ][ ] city blocks

46. On average do you: (CIRCLE ONE)

1 Stroll at an easy pace
2 Walk at a normal pace
3 Walk fairly briskly
4 Walk fast (4 or more miles an hour)

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. . . And about your sleep patterns

47. In the past month, how often did you: (CIRCLE ONE FOR EACH LINE)

	Not at All	1-3 Days	4-7 Days	8-14 Days	15-21 Days	22-31 Days
a. Have trouble falling asleep?	0	1	2	3	4	5
b. Wake up several times per night?	0	1	2	3	4	5
c. Have trouble staying asleep (including waking far too early)?	0	1	2	3	4	5
d. Wake up after your usual amount of sleep feeling tired and worn out?	0	1	2	3	4	5

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And some questions concerning you and your family

48. In the past five years, how frequently have you and your twin gotten together? (CIRCLE ONE)

1 Almost daily
2 One to four times per week
3 One to three times per month
4 Occasionally during the year
5 Less than once per year
6 Not applicable, twin deceased

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49. In the past five years, how frequently have you and your twin talked on the telephone or written to one another? (CIRCLE ONE)

1 Almost daily
2 One to four times per week
3 One to three times per month
4 Occasionally during the year
5 Less than once per year
6. Not applicable, twin deceased

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50. What is your current marital status? (CIRCLE ONE)

1 Never married

2 Married once and married at present

3 Married once and terminated by death

4 Married once and terminated by divorce

5 Multiple marriage, married at present

6 Multiple marriage, not married at present

7 Separated

51. Do you regularly (2 or more times per month) participate in a church or religious group? (CIRCLE ONE)

1 YES

2 NO

52. Are you an active member of a club, association, or organized activity in your community? (CIRCLE ONE)

1 YES

2 NO

	None	1 or 2	3 to 5	6 to 9	10 or more
53. Not counting your wife and other relatives, how many close friends do you have? (Friends that you feel at ease with, can talk to about personal matters, and can call on for help.) (CIRCLE ONE)	0	1	2	3	4
54. How many relatives, including your wife, do you feel close to? (Relatives that you feel comfortable with, can talk to about personal matters, and can call on for help.) (CIRCLE ONE)	0	1	2	3	4
55. How many of these close friends and close relatives, not counting your wife, do you see, write letters to, or talk to on the the telephone at least once a month? (CIRCLE ONE)	0	1	2	3	4

4/63

56. Below are several traits or qualities that describe people. Please respond whether each trait describes you very well, fairly well, somewhat, or not at all. (CIRCLE ONE FOR EACH LINE)

	Very Well	Fairly Well	Somewhat Well	Not at All
a. Having a strong need to excel (be best in most things)	0	1	2	3
b. Being bossy or dominating	0	1	2	3
c. Usually feeling pressed for time	0	1	2	3
d. Being hard driving and competitive	0	1	2	3
e. Eating too quickly	0	1	2	3
f. Waiting for something gets you quite upset	0	1	2	3

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57. Now we want to know how you have generally felt at the end of an average day in your regular line of work. If you currently are retired or unemployed please answer the following questions in reference to your last job.

a. Have you often felt very pressed for time? (CIRCLE ONE)

1 YES

2 NO

b. Has your work often stayed with you so that you were thinking about it after working hours? (CIRCLE ONE)

1 YES

2 NO

c. Has your work often stretched you to the very limits of your energy and capacity? (CIRCLE ONE)

1 YES

2 NO

d. Have you often felt uncertain, uncomfortable, or dissatisfied with how well you were doing in your regular line of work? (CIRCLE ONE)

1 YES

2 NO

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5/ 09

58. What is your height (without shoes)? (WRITE IN HEIGHT. IF ZERO INCHES, WRITE "00".)
    [ ] feet [ ][ ] inches

59. What is your weight (without shoes or clothes)? (WRITE IN NUMBER)
    [ ][ ][ ] pounds

60. What is your current waist size? (WRITE IN NUMBER)
    [ ][ ] inches

61. What was your usual weight at age 25? (WRITE IN NUMBER)
    [ ][ ][ ] pounds

62. What was your maximum weight ever? (WRITE IN NUMBER)
    [ ][ ][ ] pounds

    How old were you when at maximum weight? (WRITE IN AGE)
    [ ][ ] years old

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63. Which of the following groups best describes your national origin or ancestry? (If you are of mixed racial and/or national origin, select the category with which you most closely identify yourself.) (CIRCLE ONE)

    1 Alaskan Native or American Indian
    2 Asian or Pacific Islander
    3 Black, not of Hispanic origin
    4 Hispanic
    5 White, not of Hispanic origin

64. What was your age on your last birthday? (WRITE IN AGE)

    [ ][ ] years old

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65. **FAMILY HISTORY**

Please tell us a little about your family's health history. Respond to the questions below for each of the specified people. When age is requested please give the age to the best of your knowledge. Include information for BLOOD RELATIVES ONLY, that is, not step parents, adoptive parents, etc. When cause of death is requested please be specific, that is, if cancer tell us what type of cancer: lung, liver, etc.

YOUR FAMILY MEMBERS

5/28

	Alive? YES	Alive? NO	Age at last birthday, or age at death, if dead.	If dead, cause of death:
Your Mother	1	2	☐☐	______
Your Father	1	2	☐☐	______
Your Mother's Mother	1	2	☐☐	______
Your Mother's Father	1	2	☐☐	______
Your Father's Mother	1	2	☐☐	______
Your Father's Father	1	2	☐☐	______

How many brothers did you have? (INCLUDE YOUR TWIN) ☐☐ brothers

How many sisters did you have? (IF NONE, ENTER ZEROS) ☐☐ sisters

Are all of your brothers and sisters alive? (CIRCLE ONE)
1 YES
2 NO → How many are dead? (ENTER NUMBER) ☐☐ deceased brothers and sisters

YOUR FAMILY'S HEALTH PROBLEMS

Listed below are a variety of illnesses. Please report all known treated or diagnosed illnesses for each of your family members listed. Answer YES/NO as to their having had the condition, give the age (to the best of your knowledge) at the time of the diagnoses or first treatment whichever came first. Again, report on BLOOD RELATIVES ONLY.

Health Problem	Your Mother: Had this illness? YES	NO	→ Age	Your Father: Had this illness? YES	NO	→ Age	Your Mother's Mother: Had this illness? YES	NO	→ Age	Your Mother's Father: Had this illness? YES	NO	→ Age	Your Father's Mother: Had this illness? YES	NO	→ Age	Your Father's Father: Had this illness? YES	NO	→ Age
6/09 Congestive Heart Failure	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐
Heart Attack	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐
Angina (Heart Pains)	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐
7/09 High Blood Pressure (Hypertension)	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐
Diabetes	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐	1	2	☐☐

. . . and now tell us about these general health conditions

66. Has a doctor EVER told you that you had: If "yes", answer 67. (CIRCLE ONE FOR EACH LINE)	YES	NO	67. At what age did you first have it?
a. Abdominal Hernia	1	2	☐☐ years old
b. Alcoholic Hepatitis	1	2	☐☐ years old
c. Ankylosing Spondylitis	1	2	☐☐ years old
d. Cancer	1	2	☐☐ years old
e. Cirrhosis of the Liver	1	2	☐☐ years old
f. Crohn's Disease	1	2	☐☐ years old
g. Depression	1	2	☐☐ years old
h. Epilepsy	1	2	☐☐ years old
i. Gallstones	1	2	☐☐ years old
j. Gout	1	2	☐☐ years old
k. Hemorrhoids or Piles	1	2	☐☐ years old
l. Hiatal Hernia	1	2	☐☐ years old
m. Infectious Hepatitis	1	2	☐☐ years old
n. Kidney Disease	1	2	☐☐ years old
o. Kidney Stones	1	2	☐☐ years old
p. Migraine Headaches	1	2	☐☐ years old
q. Multiple Sclerosis	1	2	☐☐ years old
r. Osteoarthritis	1	2	☐☐ years old
s. Periodontal (Gum) Disease	1	2	☐☐ years old
t. Rectal Polyps	1	2	☐☐ years old
u. Reiter's Disease	1	2	☐☐ years old
v. Rheumatoid Arthritis	1	2	☐☐ years old
w. Schizophrenia	1	2	☐☐ years old
x. Thyroid Disease	1	2	☐☐ years old
y. Ulcerative Colitis	1	2	☐☐ years old
z. Ulcers (duodenal, peptic, or stomach)	1	2	☐☐ years old

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7/

8/

8

ADDRESS UPDATING INFORMATION

The last set of questions will help us make sure that we have the correct address for both you and your twin brother, in case we need to contact you in future years for additional health surveys. The information on this page will be kept separate from the other information you have provided.

1. Please print your name, address, and telephone number (where you can be reached in the coming year).

Name: ______________________ ______________________
First Name & Middle Initial — Last Name

Number & Street Address ______________________

City ______________ State ________ Zip Code ________

Telephone Number ________ - ________ - ________
(Area Code)

In whose name is the phone listed? ______________________ ______________________
First Name & Middle Initial — Last Name

2. If your twin brother is alive, please print his name, current address and telephone number.

Your Twin's Name: ______________________ ______________________
First Name & Middle Initial — Last Name

Number & Street Address ______________________

City ______________ State ________ Zip Code ________

Telephone Number ________ - ________ - ________
(Area Code)

3. A. If your brother is dead, in what year did he die?

1	9		

B. In what city, state, and country did he die?

City ______________ State ________ Country ________

(OVER)

4. Since we may need to contact you again at some time, please give us the name, address and telephone number of a person other than your twin who will always know where you can be reached.

Name: ______________________________ ______________________________
First Name & Middle Initial Last Name

Number & Street Address ______________________________

City ______________________ State ____________ Zip Code ____________

Telephone Number ____________ - ____________ - ____________
(Area Code)

In whose name is the phone listed? ______________________________ ______________________________
First Name & Middle Initial Last Name

THANK YOU FOR YOUR ASSISTANCE AND CONTINUED SUPPORT OF THE VET REGISTRY

Your responses will be kept confidential. Please return this questionnaire to us in the envelope provided.