modern lifestyle guts future health

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DIE-CUT WINDOW AREA

Has your address changed? Please make corrections and mail back with your survey.

Hello GUTS participant,

We would like to say thank you for your dedication to the study. Your participation becomes more and more important each year. Now that we are 14 years into GUTS, we are able to study how experiences early in life impact the health of young adults. GUTS is one of the only studies in the world that can answer important questions about what life is like for young adults these days. And *you* make it possible.

At the beginning of the study, your mother gave us permission to send you surveys. Now that you are an adult, it is important that you give us permission to continue communicating with you. As always, this survey is voluntary and all responses are confidential. The responses you give us will be used only for confidential research purposes. By returning this questionnaire, you are agreeing to let us continue to contact you about the project. If you choose not to respond *to this survey,* we will contact you in the future about other surveys. If you don't want to participate at all, which we hope is not the case, call Laura Anatale Tardiff, GUTS Project Director, at 617-525-0353 and let her know.

Based on your suggestions, you will find in this survey a lot about you, your work, your relationships, and your view of the world.

Please visit our website www.gutsblog.com or become a fan of GUTS on Facebook (www.facebook.com/harvardguts) to send us your comments. Thanks again for your continuing participation.

Everyone will receive a **$5 Amazon.com® Gift Card*** for returning this survey and may win one of ten prizes: **your choice of an eBook Reader, an iTouch, a Netbook, or a Wii!**

For this year's thank-you gift, we polled YOU to ask what YOU want! Thanks to all who responded to our e-mail and Facebook polls.

Turn over for details on this year's prizes, and thanks again. We couldn't do this research without you!

A. Lindsay Frazier, MD ScM

Rosalind J. Wright, MD MPH

Brigham & Women's Hospital BWH Harvard Medical School

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IMPORTANT: Update Your Information!

Everyone will receive a $5 Amazon.com Gift Card for returning this questionnaire. Use your Amazon.com Gift Card to shop from a huge selection of books, electronics, music, DVDs, software, apparel, toys, and much more.

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Ten lucky GUTS participants will also receive their choice of one of the following prizes: an eBook Reader, an iTouch, a Netbook, or a Wii!

GUTS staff will e-mail your Gift Card to the e-mail address below within two weeks of receiving your completed questionnaire.

Make sure you give us your current contact information below to receive your Gift Card!

a) Please tell us your most used e-mail address that will accept e-mail from the study. If you have spam filtering software, please make sure you are able to accept e-mail from: guts@channing.harvard.edu.

Primary E-mail:

Please print neatly and differentiate numbers and letters (e.g., 1 vs l or i, 0 vs O, 5 vs S)

☐ Check here to decline the $5 Amazon.com Gift Card and donate your $5 to GUTS research. You will still be entered into the raffle.

b) Is there another e-mail address that we can use to contact you if there is a problem with the first one?

Alternate E-mail:

Please print neatly and differentiate numbers and letters (e.g., 1 vs l or i, 0 vs O, 5 vs S)

c) Please enter your phone number. We do not routinely call participants, but in the event we lose contact with you, we may call to obtain your new information.

Cell Phone #: **Home Phone #:**

d) Please give us the name and address of someone at a different address (other than your mother) who we may contact in the event we lose contact with you (such as another relative or your best friend).

Back-up Contact:

Name: _____

Address: _____

_____

_____

Phone: _____

E-mail: _____

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Federal regulations require us to include the following information:

There are no direct benefits to you from participation in this study. The risk of breach of confidentiality associated with participation in this study is very small. Your choice to participate in this study is completely voluntary and you may decline or withdraw at any time without penalty. Although complete information is important to the study, you may skip any question you do not wish to answer. If you have any questions regarding your rights as a research participant, you are encouraged to call a representative of the Human Subjects Committee at the Brigham and Women's Hospital (617-525-3170).

Use a No. 2 pencil only.

G10

1. What is your current status?

○ Never married ○ Married ○ Living with partner
○ Separated ○ Divorced ○ Widowed

2. Who do you live with most of the time? (Mark all that apply)

○ I live alone ○ Other adults, including roommates
○ My spouse, partner, or significant other
○ My children or my spouse/partner's children
○ My parent(s) ○ Other

3. Do you have parenting responsibility for any children (biological, adopted, or step)?

○ Yes ○ No

4. Is this your correct date of birth?

○ Yes
○ No → **If no, please write correct date.** MONTH / DAY / YEAR

5. Are you CURRENTLY involved in an intimate relationship that has lasted three months or more?
(An intimate relationship includes a person you are married to, dating, or going out with.)

○ Yes ○ No →

Have you EVER BEEN involved in an intimate relationship that lasted 3 months or more?

○ Yes → *Think of your most recent intimate relationship that lasted three months or more...*
○ No

a) **Was your partner:** ○ Male ○ Female

b) **How long did this relationship last?**
○ 3–5 months ○ 6–11 months ○ 1 year ○ 2 years ○ 3+ years

c) **How old were you when this relationship ended?** ☐☐ years old

PLEASE PROCEED TO QUESTION 6

a) Is your partner in your current relationship:

○ Male ○ Female

b) How long have you been involved in this relationship?

○ 3–5 months ○ 6–11 months ○ 1 year ○ 2 years ○ 3+ years

c) Have you and your intimate partner: (Mark all that apply)

○ Gotten married
○ Registered as domestic partners
○ Had a commitment ceremony
○ None of these →

How likely is it that you will get married, register as domestic partners, or have a commitment ceremony with your intimate partner?

○ Very unlikely ○ Somewhat unlikely ○ Neither unlikely or likely
○ Somewhat likely ○ Very likely

d) The following questions are about your current intimate relationship.

	Not at all			Medium			Very much
How much do you feel you "give" to the relationship?	○	○	○	○	○	○	○
To what extent do you love your partner at this stage?	○	○	○	○	○	○	○
To what extent do you feel that things that happen to your partner also affect or are important to you?	○	○	○	○	○	○	○
How committed are you to this relationship?	○	○	○	○	○	○	○
How satisfied are you with this relationship?	○	○	○	○	○	○	○
How much do you need your partner at this stage?	○	○	○	○	○	○	○
How sexually intimate are you with your partner?	○	○	○	○	○	○	○
How much do you confide in your partner?	○	○	○	○	○	○	○
To what extent do you try to change things about your partner that bother you? (For instance, behaviors, attitudes, etc.)	○	○	○	○	○	○	○
How stressful is your relationship with your partner?	○	○	○	○	○	○	○
To what extent do you communicate negative feelings toward your partner? (For instance, anger, dissatisfaction, frustration, etc.)	○	○	○	○	○	○	○
How close do you feel to your partner?	○	○	○	○	○	○	○
How much do you feel angry or resentful towards your partner?	○	○	○	○	○	○	○
How much do you and your partner argue with one another?	○	○	○	○	○	○	○
	Not at all well			**Medium**			**Very well**
How well are things going between you and your partner?	○	○	○	○	○	○	○
	Not serious at all			**Medium**			**Very serious**
When you and your partner argue, how serious are the problems or arguments?	○	○	○	○	○	○	○

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6. How financially independent are you from your parents?

- ◯ Completely independent
- ◯ Mostly independent, but sometimes they help some
- ◯ 50% independent, 50% rely on my parents
- ◯ Mostly dependent, but I contribute some
- ◯ Completely dependent

7. Please describe your current work status (Mark all that apply):

- ◯ Working full time
- ◯ Working part time
- ◯ Student
- ◯ Volunteering
- ◯ In the military
- ◯ Unemployed, laid off, or looking for work
- ◯ Staying at home with children/taking care of family
- ◯ On maternity or family leave from job
- ◯ Not working due to illness or disability

8. What is the highest grade of school you have completed or the highest degree you have received?

- ◯ Some high school
- ◯ High school graduate or the equivalent (e.g., GED)
- ◯ Trade/vocational school certificate/diploma
- ◯ Some college
- ◯ Associate degree (2-year college)
- ◯ Bachelor's degree (4-year college)
- ◯ Master's degree
- ◯ Doctoral degree

9. What is the highest degree you INTEND to earn?

- ◯ I already have the highest degree I intend to earn
- ◯ High school graduate or the equivalent (e.g., GED)
- ◯ Trade/vocational school certificate/diploma
- ◯ Associate degree (2-year college)
- ◯ Bachelor's degree (4-year college)
- ◯ Master's degree
- ◯ Doctoral degree

10. In the past year, how often have you...

	Never	1 time	2–5 times	6–11 times	12+ times
Participated in a protest, demonstration, or march	◯	◯	◯	◯	◯
Donated time to a political group or political activity	◯	◯	◯	◯	◯
Donated time to a charity or non-profit organization	◯	◯	◯	◯	◯
Donated time to a community or neighborhood organization	◯	◯	◯	◯	◯
Donated time to a place of worship (e.g., church, synagogue, etc.)	◯	◯	◯	◯	◯

11. Are you currently registered to vote?

◯ Yes ◯ No

12. Did you vote in the 2008 U.S. Presidential election?

◯ Yes ◯ No

13. How much do you weigh? ☐☐☐ pounds

14. How do you describe yourself? (Mark one answer)

◯ Female ◯ Male ◯ Transgender
◯ Do not identify as female, male or transgender

15. How much do you agree with the following statements?

	Strongly agree	Agree	Disagree	Strongly disagree
I feel that I'm a person of worth, at least on an equal basis with others.	◯	◯	◯	◯
I feel that I have a number of good qualities.	◯	◯	◯	◯
All in all, I am inclined to feel that I'm a failure.	◯	◯	◯	◯
I am able to do things as well as most other people.	◯	◯	◯	◯
I feel I do not have much to be proud of.	◯	◯	◯	◯
I take a positive attitude toward myself.	◯	◯	◯	◯
On the whole, I am satisfied with myself.	◯	◯	◯	◯
I wish I could have more respect for myself.	◯	◯	◯	◯
I certainly feel useless at times.	◯	◯	◯	◯
At times I think that I am no good at all.	◯	◯	◯	◯

16. In general, how much do you do the following when you are under a lot of stress?

	Not at all	A little bit	Medium amount	A lot
I take time to figure out what I am really feeling.	◯	◯	◯	◯
I delve into my feelings to get a thorough understanding of them.	◯	◯	◯	◯
I realize that my feelings are valid and important.	◯	◯	◯	◯
I acknowledge my emotions.	◯	◯	◯	◯
I let my feelings come out freely.	◯	◯	◯	◯
I take time to express my emotions.	◯	◯	◯	◯
I allow myself to express my emotions.	◯	◯	◯	◯
I feel free to express my emotions.	◯	◯	◯	◯

17. In the PAST YEAR, how many times did you use a tanning bed?

◯ Never ◯ 1 time ◯ 2–9 times ◯ 10–19 times
◯ 20–29 times ◯ 30 or more times

18. In a typical 24-hour period, how many hours of sleep do you get?

◯ Less than 5 hours ◯ 5 ◯ 6 ◯ 7
◯ 8 ◯ 9 ◯ 10 ◯ 11 or more hours

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19. When was your last routine (preventive) physical exam or check-up? (19)

○ Past year ○ Past 1–2 years ○ More than 2 years ago

20. Do you have a primary care physician? (20)

○ Yes → **a) If yes, when was the last time you saw him/her?** (a)
- ○ In the past year
- ○ In the past 1–2 years
- ○ More than 2 years ago
- ○ Never

○ No

21. How often do you have headaches? (21)

○ Never (CONTINUE TO QUESTION 22)
○ 1–2 times/year ○ 3–6 times/year ○ 7–11 times/year
○ 12–24 times per year ○ 25+ times per year

a) What is/are the location(s) of your headaches? (Mark all that apply) (a)
- ○ Only on one side of head (i.e., left or right, but not both at the same time)
- ○ Both sides of the head (temples)
- ○ Front of the head ○ Back of the head
- ○ Band around the head
- ○ Around one eye ○ Around both eyes

b) Do you have any of the following symptoms when you have a typical headache? (Mark all that apply) (b)
- ○ Sensitive to noise or light (i.e., you want to be somewhere quiet or in a dark room)
- ○ Nausea or vomiting
- ○ Pulsating headache pain
- ○ Difficulty doing normal activities (bed rest necessary)
- ○ Pain gets worse when physically active
- ○ Pain prevents you from routine activities
- ○ None of the above

22. Below is a list of some of the ways you may have felt or behaved. Indicate how often you have felt this way during the PAST WEEK. (22)

	Rarely or none of the time	Some or a little of the time	Occasionally or a moderate amount of the time	All of the time
I was bothered by things that usually don't bother me.	○	○	○	○
I had trouble keeping my mind on what I was doing.	○	○	○	○
I felt depressed.	○	○	○	○
I felt that everything I did was an effort.	○	○	○	○
I felt hopeful about the future.	○	○	○	○
I felt fearful.	○	○	○	○
My sleep was restless.	○	○	○	○
I was happy.	○	○	○	○
I felt lonely.	○	○	○	○
I could not "get going."	○	○	○	○

23. Have you ever been told by a HEALTH CARE PROVIDER that you have any of the following illnesses? (23)

Leave blank for NO mark here for YES

	YEAR OF FIRST DIAGNOSIS				
	Before 1996	1996–1999	2000–2004	2005–2009	2010+
Fibrocystic/other benign breast disease (Y) → Confirmed by breast biopsy? ○ No ○ Yes	○	○	○	○	○
Melanoma (Y)	○	○	○	○	○
Other cancer (Y) → Type/location of cancer:	○	○	○	○	○
Blood clot (Pulmonary embolism, Deep vein thrombosis) (Y)	○	○	○	○	○
High blood sugar (Diabetes) (Y)	○	○	○	○	○
High cholesterol, triglycerides or lipids (Y)	○	○	○	○	○
High blood pressure (Hypertension) (Y)	○	○	○	○	○
Endometriosis (Y) → Confirmed by laparoscopy? ○ No ○ Yes	○	○	○	○	○
Kidney stones (Y)	○	○	○	○	○
Asthma (Y)	○	○	○	○	○
Thyroid disease: Hypothyroidism (Y)	○	○	○	○	○
Hyperthyroidism (Graves' Disease) (Y)	○	○	○	○	○
Polycystic ovarian syndrome (PCOS) (Y)	○	○	○	○	○
Seizure(s) (Y)	○	○	○	○	○
Mononucleosis (Mono) (Y) → Confirmed by blood test? ○ No ○ Yes	○	○	○	○	○
Psoriasis (Y)	○	○	○	○	○
Celiac disease (Y)	○	○	○	○	○
Food allergies (Y)	○	○	○	○	○
Other major illness or surgery in the last 10 years (e.g., multiple sclerosis, lupus, arthritis) (Y) → Please specify:	○	○	○	○	○

24. Have you ever received treatment or counseling for your use of alcohol, drugs, or tobacco/cigarettes? (Mark all that apply) (24)

○ Never received treatment
○ Alcohol use ○ Drug use ○ Tobacco/cigarette use

25. Have you smoked at least 100 cigarettes (5 packs) in your life? (25)

○ No ○ Yes

0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9

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26. In the PAST 12 MONTHS, have you smoked a cigarette? 26

○ Yes ○ No → **Please continue to Question 27**

a) How long ago did you smoke your last cigarette? a

○ In past week ○ In past month, but not in past week ○ 1–3 months ○ 4–6 months ○ 6+ months

b) How often do you smoke? b

○ Don't smoke ○ Less than once a month ○ Monthly, but not weekly ○ Weekly, but not daily ○ Daily

c) How many cigarettes do you smoke in one day? c

○ Don't smoke ○ 1 ○ 2–5 ○ 6–10 ○ 11–20 ○ 21 or more

d) Who do you usually smoke cigarettes with? (Mark all that apply) d

○ Spouse/Significant other ○ Other family members ○ Close friends ○ Acquaintances ○ I smoke alone

e) How many times in the PAST 12 MONTHS have you tried to quit smoking? e

○ Never ○ Once ○ 2–3 times ○ 4 or more times

f) In the PAST 12 MONTHS, have you quit smoking? f

○ Yes, and stayed quit

○ Yes, but restarted → **Do you intend to quit smoking in the next year?** ○ Yes ○ No

○ No →

Think about your cigarette smoking during the PAST 12 MONTHS as you answer the following questions.

g) In the PAST 12 MONTHS. . . g	Not at all	A little bit	Somewhat	Quite a bit
Compared to when you first started smoking, did you need to smoke more in order to feel satisfied or get the same effect?	○	○	○	○
Over time, did you find you could smoke more without experiencing effects like nausea, lightheadedness, or dizziness?	○	○	○	○
How often did you smoke even though you promised yourself you wouldn't?	○	○	○	○
How often did you smoke more frequently or for more days in a row than you intended?	○	○	○	○
How often did you try to stop or cut down on your smoking but were unable to do so?	○	○	○	○
How often did you have periods of several days or more when you chain-smoked, that is, started another cigarette as soon as you finish one?	○	○	○	○
How often did you give up or greatly reduce important activities – like sports, school, work, or spending time with friends and family – so you could smoke?	○	○	○	○
How much did smoking cause you any physical problems like coughing, difficulty breathing, lung trouble, or problems with your heart or blood pressure?	○	○	○	○
Other than when stopping or cutting down, how much did smoking cause you any emotional problems like irritability, nervousness, restlessness, or depression?	○	○	○	○
How often did you continue to smoke even though you knew that smoking was causing physical or emotional problems or making them worse?	○	○	○	○

h) During the PAST 12 MONTHS, did you have times when you stopped, cut down, or simply went without smoking for a period of time, and then experienced the following: h	Not at all	A little bit	Somewhat	Quite a bit
A strong need or urge to have a cigarette	○	○	○	○
Feeling irritable, frustrated, or angry	○	○	○	○
Difficulty concentrating	○	○	○	○
Restlessness or impatience	○	○	○	○
Feeling tense or anxious	○	○	○	○
Difficulty sleeping	○	○	○	○
Increased appetite or weight gain	○	○	○	○
Feeling sad, blue or depressed	○	○	○	○
How often did you smoke to KEEP from feeling these ways?	○	○	○	○

27. In the past year, did you try to lose weight or keep from gaining weight? 27

○ No

○ Yes → **In the past year, did you do any of the following to lose weight or keep from gaining weight?**

	Never	Less than monthly	1–3 times a month	Once per week	2–6 times per week	Daily
Fast (not eat for at least a day)	○	○	○	○	○	○
Make yourself throw up	○	○	○	○	○	○
Take laxatives	○	○	○	○	○	○

28. Which of the following are you currently trying to do about your weight? 28

○ Nothing ○ Stay the same ○ Gain weight ○ Lose weight

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29. In the past year, how often did you go on a diet to lose weight or keep from gaining weight?

○ Never ○ A couple of times ○ Several times ○ Often ○ Always on a diet

30. How often do you eat. . .

	Almost never or never	Rarely	Sometimes	Often	Almost always or always
Because you're depressed or sad.	○	○	○	○	○
Because you feel worthless or inadequate.	○	○	○	○	○
As a way to help you cope.	○	○	○	○	○
As a way to comfort yourself.	○	○	○	○	○
As a way to avoid thinking about something unpleasant or to distract yourself.	○	○	○	○	○

31. Please answer the following questions as true or false:

True	False	
○	○	I usually eat too much at social occasions, like parties and picnics.
○	○	Sometimes things just taste so good that I keep on eating even when I am no longer hungry.
○	○	Since my weight goes up and down, I have gone on reducing diets more than once.
○	○	When I am with someone who is overeating, I usually overeat too.
○	○	Sometimes when I start eating, I just can't seem to stop.
○	○	It is difficult for me to leave something on my plate.
○	○	While on a diet, if I eat a food that is not allowed, I often then splurge and eat other high calorie foods.

32. Do you eat sensibly in front of others and splurge alone?

○ Never ○ Rarely ○ Often ○ Always

33. Do you go on eating binges though you are not hungry?

○ Never ○ Rarely ○ Sometimes ○ At least once a week

34. To what extent does this statement describe your eating behavior? "I start dieting in the morning, but because of any number of things that happen during the day, by evening I have given up and eat what I want, promising myself to start dieting again tomorrow."

○ Not like me ○ A little like me ○ Pretty good description of me ○ Describes me perfectly

35. Has anyone ever told you that they thought you had an eating disorder, such as anorexia nervosa or bulimia nervosa? (Mark all that apply)

○ No ○ Yes, a friend ○ Yes, a parent ○ Yes, a spouse/partner ○ Yes, a doctor, nurse, or other health care provider

36. Sometimes people will go on an "eating binge," when they eat an amount of food that most people, like their friends, would consider to be very large, in a short period of time. In the PAST YEAR, how often did you go on an eating binge?

○ Never ○ Less than monthly ○ 1–3 times per month ○ Once a week ○ More than once a week

		No	Yes
a)	Did you feel out of control, like you couldn't stop even if you wanted to?	○	○
	Did you eat very fast or faster than you normally do?	○	○
	Did you eat until your stomach hurt or you felt sick to your stomach?	○	○
	Did you eat really large amounts of food when you didn't feel hungry?	○	○
	Did you eat by yourself because you did not want anyone to see how much you ate?	○	○
	Did you feel really bad about yourself or feel guilty after eating a lot of food?	○	○

b) IN THE PAST YEAR, was there a period of time when you went on eating binges frequently?

○ Never ○ Yes, for 1 month ○ Yes, for 2 months ○ Yes, for 3 months or more

1) During that period of time, how frequently did you go on an eating binge?

○ 1–3 times a month ○ Once a week ○ 2 or more times a week

2) During that period of time, did you do any of the following? (Mark all that apply)

○ Exercise a lot

○ Use laxatives to keep from gaining weight → ○ Monthly ○ Weekly ○ 2+ times/week

○ Make yourself throw up to keep from gaining weight → ○ Monthly ○ Weekly ○ 2+ times/week

37. A person's appearance, style, or dress may affect the way people think of them. On average, how do you think people would describe your appearance, style, or dress? (Mark one answer)

○ Very feminine ○ Mostly feminine ○ Somewhat feminine ○ Equally feminine and masculine ○ Somewhat masculine ○ Mostly masculine ○ Very masculine

38. A person's mannerisms (such as the way they walk or talk) may affect the way people think of them. On average, how do you think people would describe your mannerisms? (Mark one answer)

○ Very feminine ○ Mostly feminine ○ Somewhat feminine ○ Equally feminine and masculine ○ Somewhat masculine ○ Mostly masculine ○ Very masculine

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39. In the PAST 12 MONTHS, did you drink alcohol? 39

◯ Yes ◯ No → **Please continue to Question 40**

a) On average, in the PAST 12 MONTHS, how often did you drink beer, wine or liquor? a

◯ Less than once a month ◯ Less than once a week ◯ 1–2 days/week ◯ 3–5 days/week ◯ Almost every day ◯ Daily

b) When you drink alcohol, how much do you usually drink at one time? b

◯ Less than 1 drink ◯ 1 drink ◯ 2 drinks ◯ 3 drinks ◯ 4 drinks ◯ 5 drinks ◯ 6 or more drinks

c) In the PAST 12 MONTHS, how many times did you drink 4 or more alcoholic drinks over a few hours? c

◯ None ◯ 1 time ◯ 2 times ◯ 3–5 times ◯ 6–8 times ◯ 9–11 times ◯ 12–15 times (about once/month)
◯ 16–24 times (about 2x/month) ◯ 25–36 times (about 3x/month) ◯ 37 or more times (average of more than 3x/month)

Think about your use of alcohol during the PAST 12 MONTHS as you answer the following questions.

d) During the PAST 12 MONTHS. . .	Not at all	A little bit	Somewhat	Quite a bit	
How often did you spend a lot of time getting or drinking alcohol?	◯	◯	◯	◯	d
How often did you spend a lot of time getting over the effects of the alcohol you drank?	◯	◯	◯	◯	
Did you need to drink more alcohol than you used to in order to get the effect you wanted?	◯	◯	◯	◯	
Did you notice that drinking the same amount of alcohol had less effect on you than it used to?	◯	◯	◯	◯	
How often did you drink alcohol more frequently or in larger amounts than you intended?	◯	◯	◯	◯	
How often did you want to stop or cut down on your drinking but were unable to do so?	◯	◯	◯	◯	
How often did you give up or greatly reduce important activities – like hobbies, sports, school, work, or spending time with friends and family – because of your alcohol use?	◯	◯	◯	◯	
How much did you have problems with your emotions, nerves, or mental health that were probably caused or made worse by drinking alcohol?	◯	◯	◯	◯	
How much did you have any physical problems that were probably caused or made worse by drinking alcohol?	◯	◯	◯	◯	
How often did you continue to drink alcohol even though you thought drinking was causing you to have physical or emotional problems or making them worse?	◯	◯	◯	◯	
Did you have any problems with family or friends that were probably caused by your drinking?	◯	◯	◯	◯	
Did you regularly drink alcohol and then do something where being drunk might have put you in physical danger?	◯	◯	◯	◯	
Did drinking cause you to do things that got you in trouble with the law?	◯	◯	◯	◯	

e) During the PAST 12 MONTHS, did you have times when you stopped, cut down, or simply went without drinking for a period of time, and then experienced the following: e

	Not at all	A little bit	Somewhat	Quite a bit	
Having trouble sleeping	◯	◯	◯	◯	
Having your hands tremble	◯	◯	◯	◯	
Feeling anxious or nervous	◯	◯	◯	◯	
Vomiting or feeling nauseous	◯	◯	◯	◯	
Feeling like you couldn't sit still	◯	◯	◯	◯	
Sweating or feeling that your heart was beating fast	◯	◯	◯	◯	
Seeing, hearing, or feeling things that weren't really there	◯	◯	◯	◯	
Having seizures or fits	◯	◯	◯	◯	
How often did you drink to KEEP from feeling these ways?	◯	◯	◯	◯	
How often did you have 2 or more of these symptoms at the same time that lasted for longer than a day?	◯	◯	◯	◯	

f) During the PAST 12 MONTHS, did drinking alcohol cause you to have serious problems at work, school, or home — such as neglecting children, missing work or school, doing a poor job at work or school, or losing a job or dropping out of school? f

◯ Not at all ◯ A little bit ◯ Somewhat ◯ Quite a bit

40. Have you ever used marijuana? 40

◯ Yes → **a) How old were you the first time you used marijuana?** ☐☐ years old a
◯ No

b) In the PAST 12 MONTHS, have you used marijuana? b

◯ Yes → **c) How often in the PAST 12 MONTHS?** c
◯ No

◯ Once a month or less ◯ 2–3 times a month ◯ 1–2 times a week
◯ 3–5 times a week ◯ 6 or more times a week

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41. Have you EVER used:

	Not in past 12 months	1 time	2–5 times	6–10 times	11–15 times	16 or more times
	If yes, number of times in the PAST 12 MONTHS					
Cocaine or crack (coke, rock) ○ No ○ Yes →	○	○	○	○	○	○
Heroin (dope, H) ○ No ○ Yes →	○	○	○	○	○	○
Ecstasy (E, X) ○ No ○ Yes →	○	○	○	○	○	○
LSD (acid), **mushrooms** (shrooms) **or any other hallucinogen** ○ No ○ Yes →	○	○	○	○	○	○
Crystal meth (methamphetamine, crank, tweak) ○ No ○ Yes →	○	○	○	○	○	○
Other amphetamines (uppers, speed) ○ No ○ Yes →	○	○	○	○	○	○

42. Have you EVER used any of these drugs without a doctor's prescription:

	Not in past 12 months	1 time	2–5 times	6–10 times	11–15 times	16 or more times
	If yes, number of times in the PAST 12 MONTHS					
Tranquilizers (e.g., Valium, Diazapam, Xanax, Ativan, Librium, Klonopin) ○ No ○ Yes →	○	○	○	○	○	○
Pain killers (e.g., Percocet, Percodan, Oxycontin, Oxycodone, codeine, morphine) ○ No ○ Yes →	○	○	○	○	○	○
Sleeping pills (e.g., Rohypnol, downers, roofies) ○ No ○ Yes →	○	○	○	○	○	○
Stimulants (e.g., Ritalin, Adderall, Dexedrine, Concerta, etc.) ○ No ○ Yes →	○	○	○	○	○	○

43. During the PAST 12 MONTHS, did you use any illegal drug (e.g., marijuana, cocaine, ecstasy) and/or prescription drug (e.g., pain killers, stimulants, etc.) without a doctor's prescription?

○ Yes ○ No → **Please continue to Question 44**

Think of your use of illegal drugs and/or prescription drugs that were NOT prescribed to you or that you used only for the experience or feeling caused during the PAST 12 MONTHS as you answer the following questions. Do NOT count tobacco or alcohol.

a) During the PAST 12 MONTHS. . .	Not at all	A little bit	Somewhat	Quite a bit
How often did you spend a lot of time getting or using the drug(s)?	○	○	○	○
How often did you spend a lot of time getting over the effects of the drug(s) you used?	○	○	○	○
Did you need to use more of the drug(s) than you used to in order to get the effect you wanted?	○	○	○	○
Did you notice that using the same amount of the drug(s) had less effect on you than it used to?	○	○	○	○
How often did you use the drug(s) more frequently or in larger amounts than you intended?	○	○	○	○
How often did you want to stop or cut down on your use of the drug(s) but were unable to do so?	○	○	○	○
How often did you give up or greatly reduce important activities – like hobbies, sports, school, work, or spending time with friends and family – because of your use of the drug(s)?	○	○	○	○
How much did you have problems with your emotions, nerves, or mental health that were probably caused or made worse by your use of the drug(s)?	○	○	○	○
How much did you have any physical problems that were probably caused or made worse by your use of the drug(s)?	○	○	○	○
How often did you continue to use the drug(s) even though you thought it was causing physical or emotional problems or making them worse?	○	○	○	○
Did you regularly use the drug(s) and then do something where using them might have put you in physical danger?	○	○	○	○
Did using the drug(s) cause you to do things that got you in trouble with the law?	○	○	○	○
Did you have any problems with family or friends that were probably caused by your use of the drug(s)?	○	○	○	○

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b) **During the PAST 12 MONTHS, did you have times when you stopped, cut down, or simply went without using the drug(s) for a period of time and then experienced withdrawal symptoms such as fatigue, exhaustion, muscle aches or cramps, sweating, hunger, vomiting or nausea, diarrhea, depression, sadness, bad dreams or trouble sleeping?**

- ○ Never cut down
- ○ Not at all
- ○ A little bit
- ○ Somewhat
- ○ Quite a bit

→ **During the PAST 12 MONTHS, how often did you have 2 or more withdrawal symptoms at the same time that lasted for longer than a day?**

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit

c) **During the PAST 12 MONTHS, how often did you use the drug(s) to keep from having withdrawal symptoms?**

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit

d) **During the PAST 12 MONTHS, did using the drug(s) cause you to have serious problems at work, school, or home — such as neglecting children, missing work or school, doing a poor job at work or school, or losing a job or dropping out of school?**

○ Not at all ○ A little bit ○ Somewhat ○ Quite a bit

44. **Which one of the following best describes your feelings? (Mark one answer)**

○ Completely heterosexual *(attracted to persons of the opposite sex)* ○ Mostly heterosexual ○ Bisexual *(equally attracted to men and women)* ○ Mostly homosexual ○ Completely homosexual *(gay/lesbian, attracted to persons of the same sex)* ○ Not sure

45. **During your life, have you EVER identified yourself as "mostly heterosexual," bisexual, or lesbian or gay?**

○ Yes → a) **If yes, how old were you when you FIRST identified as "mostly heterosexual," bisexual, or lesbian or gay? (If you do not remember your exact age, please fill in your best guess.)** ☐☐ years old

○ No

46. **During your LIFETIME, have you EVER been sexually attracted to MALES?**

○ Yes → a) **How old were you when you FIRST realized you were sexually attracted to MALES? (Think about your first crush or the first time you recognized feeling sexually attracted to someone.) If you do not remember your exact age, please fill in your best guess.** ☐☐ years old

○ No

47. **During your LIFETIME, have you EVER had sexual contact with a MALE?**

○ Yes → a) **During your LIFETIME, how many different MALES have you had sexual contact with?**

○ 1 ○ 2 ○ 3–5 ○ 6–10 ○ 11–14 ○ 15–24 ○ 25–34 ○ 35 or more

b) **How old were you when you FIRST had sexual contact with a MALE? (If you do not remember your exact age, please fill in your best guess.)** ☐☐ years old

○ No

48. **Many GUTS participants have told us they have felt sexually attracted to other females. During your LIFETIME, have you EVER been sexually attracted to FEMALES?**

○ Yes → a) **How old were you when you FIRST realized you were sexually attracted to FEMALES? (Think about your first crush or the first time you recognized feeling sexually attracted to someone.) If you do not remember your exact age, please fill in your best guess.** ☐☐ years old

b) **Have you ever told another person that you are sexually attracted to FEMALES?**

○ Yes → c) **How old were you when you FIRST told another person you were sexually attracted to FEMALES? (If you do not remember your exact age, please fill in your best guess.)** ☐☐ years old

○ No

○ No

49. **During your LIFETIME, have you EVER had sexual contact with a FEMALE?**

○ Yes → a) **During your LIFETIME, how many different FEMALES have you had sexual contact with?**

○ 1 ○ 2 ○ 3–5 ○ 6–10 ○ 11–14 ○ 15–24 ○ 25–34 ○ 35 or more

b) **How old were you when you FIRST had sexual contact with a FEMALE? (If you do not remember your exact age, please fill in your best guess.)** ☐☐ years old

○ No

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50. Have you ever been pregnant?

○ Yes ○ No → **Please continue to Question 53**

51. Are you currently pregnant?

○ Yes →
○ No

a) How many weeks has it been since the start of your last menstrual period? (e.g., 22 weeks)

☐☐ weeks (Between 1 and 44 weeks)

b) Regarding this pregnancy, were you actively trying to become pregnant?

○ Yes → **How many months did it take you to get pregnant?**

1 month or less	2 mo	3 mo	4 mo	5 mo	6 mo	7 mo	8 mo	9 mo	10 mo	11 mo	12+ months
○	○	○	○	○	○	○	○	○	○	○	○

○ No →

If you were not trying to become pregnant, what was your feeling regarding this pregnancy?

○ I was not actively trying, but I was glad to become pregnant.
○ I wanted to be pregnant someday, but not now.
○ I did not want to be pregnant now or at any time in the future.

52. Please complete one row of the chart for each of your past pregnancies, including miscarriages and induced abortions. If you had twins or triplets, please count them as one pregnancy, fill in the largest weight, and mark more than one circle (if necessary) for gender. (If currently pregnant, don't include your current pregnancy.)

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	Calendar year in which pregnancy ended?	How many months did it take you to get pregnant?	How long did this pregnancy last?	For pregnancies lasting 20+ weeks. . . Did you have any of these complications related to pregnancy or lactation?	Birth weight and gender	Type of delivery* (Mark all that apply)
1st Pregnancy	Please print neatly **Year** ☐☐☐☐ ○ Single live birth ○ Twins/Triplets+ ○ Miscarriage/Stillbirth ○ Induced abortion ○ Tubal or ectopic	○ I wasn't trying ○ 1 or less ○ 2 ○ 3 ○ 4 ○ 5–6 ○ 7–8 ○ 9–11 ○ 12 or more	○ <8 weeks ○ 8–11 weeks ○ 12–19 weeks ○ 20–27 weeks ○ 28–31 weeks ○ 32–36 weeks ○ 37–39 weeks ○ 40–42 weeks ○ 43+ weeks	○ Gestational diabetes ○ Pregnancy-related high blood pressure ○ Pre-eclampsia/ Toxemia ○ Mastitis/Breast Infection	☐☐ lbs. ☐☐ oz. ○ Girl ○ Boy	○ Spontaneous labor* ○ Induced labor** ○ No labor*** ○ C-section ○ Vaginal birth
2nd Pregnancy	Please print neatly **Year** ☐☐☐☐ ○ Single live birth ○ Twins/Triplets+ ○ Miscarriage/Stillbirth ○ Induced abortion ○ Tubal or ectopic	○ I wasn't trying ○ 1 or less ○ 2 ○ 3 ○ 4 ○ 5–6 ○ 7–8 ○ 9–11 ○ 12 or more	○ <8 weeks ○ 8–11 weeks ○ 12–19 weeks ○ 20–27 weeks ○ 28–31 weeks ○ 32–36 weeks ○ 37–39 weeks ○ 40–42 weeks ○ 43+ weeks	○ Gestational diabetes ○ Pregnancy-related high blood pressure ○ Pre-eclampsia/ Toxemia ○ Mastitis/Breast Infection	☐☐ lbs. ☐☐ oz. ○ Girl ○ Boy	○ Spontaneous labor* ○ Induced labor** ○ No labor*** ○ C-section ○ Vaginal birth
3rd Pregnancy	Please print neatly **Year** ☐☐☐☐ ○ Single live birth ○ Twins/Triplets+ ○ Miscarriage/Stillbirth ○ Induced abortion ○ Tubal or ectopic	○ I wasn't trying ○ 1 or less ○ 2 ○ 3 ○ 4 ○ 5–6 ○ 7–8 ○ 9–11 ○ 12 or more	○ <8 weeks ○ 8–11 weeks ○ 12–19 weeks ○ 20–27 weeks ○ 28–31 weeks ○ 32–36 weeks ○ 37–39 weeks ○ 40–42 weeks ○ 43+ weeks	○ Gestational diabetes ○ Pregnancy-related high blood pressure ○ Pre-eclampsia/ Toxemia ○ Mastitis/Breast Infection	☐☐ lbs. ☐☐ oz. ○ Girl ○ Boy	○ Spontaneous labor* ○ Induced labor** ○ No labor*** ○ C-section ○ Vaginal birth

*Spontaneous (contractions started ON THEIR OWN)
**Induced (contractions AFTER receiving a medication by mouth or IV, having gel applied on cervix or membranes broken by clinician)
***No labor (C-Section without contractions)

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53. Are you actively trying to become pregnant or do you think that you may become pregnant within the next year? 53

○ No ○ Yes, actively trying to get pregnant ○ Yes, may become pregnant within the next year

54. Have you ever tried to become pregnant FOR 12 CONSECUTIVE MONTHS without becoming pregnant (even if you ultimately became pregnant? 54

○ Yes → ○ No

a) How old were you when this first happened? a

☐☐ years old

b) Did a doctor find a reason why you had difficulty getting pregnant? (Mark all that apply) b

- ○ I did not visit a doctor for diagnosis/treatment
- ○ Tubal blockage or damage
- ○ Polycystic ovary syndrome (PCOS)
- ○ Other ovulatory disorder (e.g., high prolactin, thyroid problems, early menopause)
- ○ Endometriosis
- ○ Mass or abnormality of the uterus (e.g., fibroids)
- ○ Spouse/male partner factor
- ○ Not found
- ○ Other _____

55. Do you use birth control pills for any reason (acne, bad cramping, irregular periods, birth control)? 55

○ Yes → ○ No

a) What brand of birth control pill do you use (i.e., Seasonale, Yasmin)? *Write in below:* a

b) How do you take your pills each month and how does it affect your period? b

- ○ I use a "regular"-type pill (e.g., Yaz, Loestrin, Ortho tri-cyclen) and **GET** my period every month.
- ○ I use a "regular"-type pill, but take the "active" pills continuously so that I **DO NOT** get my period every month.
- ○ I use the "Extended Cycle" pill (e.g., Seasonale, Seasonique, Lybrel, Quasense) and **DO NOT** get my period every month.
- ○ Other

c) Do you currently use any of these other methods of birth control for any reason? (Mark all that apply) c

- ○ None
- ○ Natural family planning/Rhythm
- ○ Male condom
- ○ Female condom
- ○ Shots (Depo Provera)
- ○ Mirena IUD
- ○ ParaGard IUD
- ○ Implant (Implanon)
- ○ Diaphragm/Cervical cap
- ○ Vaginal ring (NuvaRing)
- ○ Spermicide/Jelly/Sponge
- ○ Patch (Orth-Evra)
- ○ Other

56. During the PAST WEEK, how often have you felt the ways described below? 56

	None of the time	Rarely	Sometimes	Often	Very often	All of the time
I get nervous when things do not go the right way for me.	○	○	○	○	○	○
I worry a lot of the time.	○	○	○	○	○	○
I am afraid of a lot of things.	○	○	○	○	○	○
I worry about what other people think about me.	○	○	○	○	○	○
My feelings are easily hurt.	○	○	○	○	○	○
I worry about what is going to happen.	○	○	○	○	○	○
I worry when I go to bed at night.	○	○	○	○	○	○
I am nervous.	○	○	○	○	○	○
I often worry about something bad happening to me.	○	○	○	○	○	○

57. During the PAST MONTH, how much of the time: 57

	None of the time	Rarely	Sometimes	Often	Very often	All of the time
Have you felt happy, satisfied, or pleased with your personal life?	○	○	○	○	○	○
Have you felt that the future looks hopeful and promising?	○	○	○	○	○	○
Has your daily life been full of things that were interesting to you?	○	○	○	○	○	○
Did you feel relaxed and free of tension?	○	○	○	○	○	○
Have you generally enjoyed the things you do?	○	○	○	○	○	○
When you got up in the morning about how often did you expect to have an interesting day?	○	○	○	○	○	○
Have you felt calm and peaceful?	○	○	○	○	○	○
Has living been a wonderful adventure for you?	○	○	○	○	○	○
Have you felt cheerful, lighthearted?	○	○	○	○	○	○
Were you a happy person?	○	○	○	○	○	○
How often have you been waking up feeling fresh and rested?	○	○	○	○	○	○

Thank you!

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