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1) g\_dashboard

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2) pregq  
1 - sees current preg  
0 - does not see current preg

---

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3) YEAR of birth:

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survey start

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Thank you for your ongoing participation in GUTS!

This questionnaire should take about 30 minutes to complete.

You may notice that we've asked you some of these questions before. It is important for us to observe whether there are changes over time and how that may or may not impact your health.

If you need to pause in the middle of the questionnaire, your answers will be saved, and you can log in again at [www.gutslogin.org](http://www.gutslogin.org)

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#### Information for Research Participants

Your choice to participate in this study is completely voluntary, and you may withdraw at any time. You may skip any question you do not wish to answer. There are no direct benefits to you from participating in this study. You will not receive monetary compensation for participating. The risk of breach of confidentiality associated with participation in this study is very small. We have a Certificate of Confidentiality from the National Institutes of Health, which means we cannot be forced (for example by court order or subpoena) to disclose your health information or other identifying information from the research in any Federal, State or local civil, criminal, administrative, legislative, or other proceedings. If you have questions about this study, please contact [guts@channing.harvard.edu](mailto:guts@channing.harvard.edu). If you have any questions regarding your rights as a research participant, you may call the Mass General Brigham Human Research Committee (857-282-1900). By clicking "Next Page" you agree to participate in this research.

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In order to ensure that we ask the questions that are most relevant to you, please answer the following:

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What sex were you assigned at birth, such as on your original birth certificate? (required)

- Female  
 Male
- 

Which best describes your current gender identity?

- Woman  
 Man  
 Another gender (such as gender fluid, non-binary)
- 

In order to understand the biological basis of some chronic diseases, we may want to collect biological samples such as blood, urine, and stool.

Would you be willing to provide biological samples by mail if we sent you a convenient, pre-paid collection packet and instructions on how to collect them? (Answering this question does not obligate you to participate.)

- Yes  
 No
- 

What is your current status?

- Never married  
 Married  
 Divorced  
 Separated  
 Widowed  
 Domestic partnership
-

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What is your current living arrangement? (Check all that apply)

- Alone
- With spouse or partner
- With minor children
- With other adult family
- With other people
- With pets

---

What is the highest level of education you have completed?

- Some high school
- High school graduate or the equivalent (such as a GED)
- Trade/vocational school certificate/diploma
- Some college
- Associate degree (2-year college)
- Bachelor's degree (4-year college)
- Master's degree
- Doctoral degree
- Other

---

What is the highest level of education completed by your current spouse/partner?

- Some high school
- High school graduate or the equivalent (such as a GED)
- Trade/vocational school certificate/diploma
- Some college
- Associate degree (2-year college)
- Bachelor's degree (4-year college)
- Master's degree
- Doctoral degree
- Other

## Household Income

What is your total household income in US dollars?

- Less than \$10,000
- \$10,000 to \$49,999
- \$50,000 to \$69,999
- \$70,000 to \$99,999
- \$100,000 to \$149,999
- \$150,000 to \$199,000
- \$200,000 to \$249,000
- \$250,000 to \$299,000
- \$300,000 to \$349,000
- \$350,000 or more

## Hearing

In the PAST 12 MONTHS, have you had ringing, roaring, or buzzing in your ears or head?

- Never
- Once/month or less
- 2-3 times/month
- About once/week
- Several times/week
- Almost every day
- Every day

---

On the days you hear the sound, how long does it last?

- A few seconds
- Less than 5 minutes
- 5 minutes to an hour
- Several hours
- All the time

---

Does the sound affect your ability to do the following? Check all that apply.

- Sleep
- Work
- Concentrate
- Perform other activities
- None of these

---

At what age did this first begin?

- Younger than 20
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60+

---

Which best describes your hearing?

- Excellent
- Good
- A little hearing trouble
- Moderate hearing trouble
- A lot of hearing trouble
- Deaf

---

If your hearing is not as good as it used to be, at what age did you first notice a change?

- Younger than 20
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60+
- My hearing has not changed

---

Comments

**Pregnancy**

Please mark here if it is not possible for you to become pregnant now and in the future.  
(due to hysterectomy, tubal ligation, bilateral oophorectomy, etc.)

I am unable to become pregnant

---

Are you currently pregnant? (required)

- No
- Yes
- Unsure

**Pregnancy**

Has your pregnancy been confirmed by a positive pregnancy test (include over-the-counter and clinic tests)?

- Yes
- No

How many weeks along is the pregnancy?

Please round down to the nearest whole number. If uncertain, please use your best estimate.

- 1 week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
- 28
- 29
- 30
- 31
- 32
- 33
- 34
- 35
- 36
- 37
- 38
- 39
- 40
- 41
- 42
- 43
- 44
- 45

What is this dating based on? Check all that apply

- Last menstrual period
- Early pregnancy ultrasound
- Other



---

Specify other

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---

Thinking back to when you got pregnant, which of the following best describes the timing of your pregnancy?

- I wanted to be pregnant at that time or sooner.
  - I wanted to be pregnant in the next 1-2 years, but not yet.
  - I wanted to be pregnant in 2+ years, but not yet.
  - I did not want to be pregnant then or at any time.
- 

Thinking back to before you got pregnant, how much did you want to become pregnant?

- 10 highly wanted
  - 9
  - 8
  - 7
  - 6
  - 5
  - 4
  - 3
  - 2
  - 1 not wanted at all
- 

Thinking back to before you got pregnant, how important was it to you to avoid becoming pregnant?

- 10 extremely important to avoid
  - 9
  - 8
  - 7
  - 6
  - 5
  - 4
  - 3
  - 2
  - 1 not important at all to avoid
- 

Thinking back to when you found out you were pregnant, how happy were you to find out you were pregnant?

- 10 extremely happy
- 9
- 8
- 7
- 6
- 5
- 4
- 3
- 2
- 1 not happy at all

---

Thinking back to when you found out you were pregnant, how acceptable was it to you to be pregnant at that time?

- 10 extremely acceptable
- 9
- 8
- 7
- 6
- 5
- 4
- 3
- 2
- 1 completely unacceptable

---

Were you actively trying to become pregnant?

- Yes
- No

---

How many months did you actively try to get pregnant?

- 1 month or less
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months
- 12 months
- 1 to 2 years
- 3 years or more

---

Did you use any form of medically assisted reproduction for help getting pregnant (such as intrauterine insemination, in vitro fertilization, etc.)?

- No
- Yes, my partner and I had difficulty getting pregnant
- Yes, I want to have a child on my own
- Yes, for same-sex couple reproduction
- Yes, other

---

Did you undergo any medical treatments or procedures to help you get pregnant?

Check all that apply:

- Fertility medications [such as clomiphene (Clomid), letrozole (Femara), metformin (Glucophage), gonadotropin injections (Pergonal, Metrodin, Follistim)]
- Intracervical insemination (ICI, i.e. inserting sperm into the vagina)
- Intrauterine insemination (IUI)
- In vitro fertilization (IVF)
- Intracytoplasmic sperm injection (ICSI)
- Gamete intrafallopian transfer (GIFT) or zygote intrafallopian transfer (ZIFT)
- Sperm donation (known or anonymous)
- Egg or embryo donation (known or anonymous)
- Other

---

Are you actively trying to become pregnant, or do you think that you may become pregnant at some point within the next year? (required)

- No  
 Yes, actively trying  
 Yes, may become pregnant within the next year
- 

For how many months have you been actively trying to get pregnant?

- 1 month or less  
 2 months  
 3 months  
 4 months  
 5 months  
 6 months  
 7 months  
 8 months  
 9 months  
 10 months  
 11 months  
 12 months  
 1 to 2 years  
 3 years or more
- 

Are you currently using any form of medically assisted reproduction for help getting pregnant (such as intrauterine insemination, in vitro fertilization, etc.)?

- No  
 Yes, my partner and I have had difficulty getting pregnant  
 Yes, I want to have a child on my own  
 Yes, for same-sex couple reproduction  
 Yes, other
- 

What medical treatments or procedures have you used to help you get pregnant?  
Check all that apply:

- Fertility medications [such as clomiphene (Clomid), letrozole (Femara), metformin (Glucophage), gonadotropin injections (Pergonal, Metrodin, Follistim)]  
 Intracervical insemination (ICI, i.e. inserting sperm into the vagina)  
 Intrauterine insemination (IUI)  
 In vitro fertilization (IVF)  
 Intracytoplasmic sperm injection (ICSI)  
 Gamete intrafallopian transfer (GIFT) or zygote intrafallopian transfer (ZIFT)  
 Sperm donation (known or anonymous)  
 Egg or embryo donation (known or anonymous)  
 Other

---

How much time has gone by since you stopped using any contraceptive/birth control?

- None, I have never used a contraceptive/birth control method.
- None, I am still using contraception/birth control.
- 1 month or less
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months
- 12 months
- 1 to 2 years
- 3 years or more

---

For how many months have you been having sexual intercourse without using any contraceptive method?

- None, I am using contraception
- 1 month or less
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months
- 12 months
- 1 to 2 years
- 3 years or more

---

How often do you have sexual intercourse without using any contraceptive method?

- Never, we always use contraception
- Once per MONTH or less often
- 2 to 3 times per MONTH
- Once per WEEK
- 2 to 3 times per WEEK
- 4 to 6 times per WEEK
- One or more times per DAY

---

Do you monitor your menstrual cycle for signs of ovulation?

- Yes
- No

---

How do you monitor your menstrual cycle? Check all that apply

- Keeping track of menstrual cycle length
- Basal body temperature monitoring
- Cervical mucus monitoring
- Ovulation prediction kits (such as Clearblue ovulation test)
- Fertility monitors that use urine samples (such as Clearblue Monitor)
- Fertility monitors that use saliva samples (such as OvaCue Monitor)
- Saliva ("ferning") microscopes (such as Fertile-Focus, Ovulens)
- Other

---

Do you increase the frequency of sexual intercourse around the time of ovulation predicted by your cycle monitoring method(s)?

- Yes
- No

---

Comments:

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Do you have a partner who is currently pregnant? (required)

- Yes
- No
- Unsure

---

Are you and a partner actively trying to become pregnant, or do you have a partner who may become pregnant within the next year? (required)

- No
- Yes, we are actively trying
- Yes, my partner may become pregnant within the next year

---

Are you the biological father?

- Yes
- No
- Unsure

---

Has the pregnancy been confirmed by a positive pregnancy test? (include over-the-counter and clinic tests)

- No
- Yes
- Unsure

---

How many weeks along is the pregnancy?

- 8 weeks or less
- 9-12 weeks
- 13-19 weeks
- 20-24 weeks
- 25-29 weeks
- 30-36 weeks
- 37-39 weeks
- 40-42 weeks
- 42+ weeks
- Unsure

---

Thinking back to when your partner got pregnant, which of the following best describes the timing of the pregnancy?

- I wanted my partner to be pregnant at that time or sooner.
- I wanted my partner to be pregnant in the next 1-2 years, but not yet.
- I wanted my partner to be pregnant in 2+ years, but not yet.
- I did not want my partner to be pregnant then or at any time.

---

Were you and your partner actively trying to become pregnant?

- Yes
- No

---

How many months did you and your partner actively try to get pregnant?

- 1 month or less
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months
- 12 months
- 1 to 2 years
- 3 years or more

---

For how many months have you and your partner been actively trying to get pregnant?

- 1 month or less
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months
- 12 months
- 1 to 2 years
- 3 years or more

---

How much time has gone by since you and your partner stopped using any contraceptive/birth control?

- None, we have never used a contraceptive/birth control method.
- None, we are still using contraception/birth control.
- 1 month or less
- 2 months
- 3 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months
- 12 months
- 1-2 years
- 3 years or more

---

How often do you have sexual intercourse without using any contraceptive method?

- Never, we always use contraception
- Once per MONTH or less often
- 2 to 3 times per MONTH
- Once per WEEK
- 2 to 3 times per WEEK
- 4 to 6 times per WEEK
- One or more times per DAY

---

For how many months have you been having sexual intercourse without using any contraceptive method?

- None, we are using contraception
- 1 month or less
- 2 months
- 4 months
- 5 months
- 6 months
- 7 months
- 8 months
- 9 months
- 10 months
- 11 months
- 12 months
- 1 to 2 years
- 3 years or more

---

Comments:

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The following questions are about the biological father/sperm donor of the child you are carrying.  
If you used a donor, please answer as best you can.

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The following questions are about the man who will be the biological father/sperm donor of your baby.  
If you are using a donor, please answer as best you can.

---

How old is the biological father/sperm donor?

- Don't know
- 18 or younger
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
- 28
- 29
- 30
- 31
- 32
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- 51
- 52
- 53
- 54
- 55
- 56
- 57
- 58
- 59
- 60
- 61
- 62
- 63
- 64
- 65 or older

---

How tall do you think the biological father/sperm donor is?

---

Feet

- 3 feet
- 4
- 5
- 6
- 7



---

Inches

- 0 inches
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11

---

How much do you think the biological father/sperm donor weighs (in pounds)?

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\_\_\_\_\_

---

Is the biological father/sperm donor Hispanic or Latino/a?

- No
- Yes
- Don't know

---

Which race do you consider the biological father/sperm donor to be? Check all that apply

- American Indian or Alaska Native
- Asian
- Black or African American
- Middle Eastern or North African
- Native Hawaiian or other Pacific Islander
- White
- Don't know
- Other

---

You are eligible to participate in our GUTS Pregnancy Health Sub-study. This sub-study investigates how diet, activity, and other factors influence pregnancy health and outcomes. If you agree to participate, we will contact you periodically to ask if you have become pregnant. When you become pregnant, you will be asked to provide additional information about your pregnancy.

Would you like to participate in the GUTS Pregnancy Health Sub-study?

- Yes
- Not at this time

---

You are eligible to participate in our GUTS Pregnancy Health Sub-study. This sub-study investigates how diet, activity, and other factors influence pregnancy health and outcomes. If you agree to participate, we will send you one questionnaire during your pregnancy and one after your pregnancy ends.

Would you like to participate in the GUTS Pregnancy Health Sub-study?

- Yes
- Not at this time

---

We would also like to ask the biological father/sperm donor of your baby to complete a one-time questionnaire. Participation will help investigate how diet, activity, and other factors prior to conception may influence pregnancy outcomes.

Would you like us to invite the biological father/sperm donor to participate?

- Yes, I think they would like to be invited.
- No, please do not contact them.
- Not applicable

---

We would also like to ask the person who will be the biological father/sperm donor of your baby to complete a one-time questionnaire. Participation will help investigate how diet, activity, and other factors prior to conception may influence pregnancy outcomes.

Would you like us to invite the biological father/sperm donor to participate?

- Yes, I think they would like to be invited.
- No, please do not contact them.
- Not applicable

---

Please provide the biological father/sperm donor's contact information.

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First Name:

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---

Email:

---

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The following questions are about your pregnant partner.

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The following questions are about your partner who may become pregnant.

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How old are they?

- Don't know
- 18 or younger
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
- 28
- 29
- 30
- 31
- 32
- 33
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- 56
- 57
- 58
- 59
- 60
- 61
- 62
- 63
- 64
- 65 or older

---

How tall do you think they are?

---

Feet

- 3 feet
- 4
- 5
- 6
- 7

---

Inches

- 0 inches  
 1  
 2  
 3  
 4  
 5  
 6  
 7  
 8  
 9  
 10  
 11

---

How much do you think they weigh (in pounds)?

---

\_\_\_\_\_

---

Are they Hispanic or Latino/a?

- No  
 Yes  
 Don't Know

---

Which race do you consider them to be? Check all that apply

- American Indian or Alaska Native  
 Asian  
 Black or African American  
 Middle Eastern or North African  
 Native Hawaiian or other Pacific Islander  
 White  
 Don't know  
 Other

---

You are invited to complete a one-time GUTS questionnaire that will help investigate diet, activity, and other factors that may influence pregnancy health and outcomes.

Would you like to participate ?

- Yes  
 No

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We would also like to ask your pregnant partner to complete a one-time questionnaire about diet, activity, and other factors that may influence pregnancy outcomes.

Would you like us to invite your partner to participate?

- Yes, I think they would like to be invited.  
 No, please do not contact them.

---

First Name:

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\_\_\_\_\_

---

Email:

---

\_\_\_\_\_

## Menstruation

What is the current usual length of your menstrual cycle (interval from the first day of period to the first day of next period)? Exclude the 6 months after pregnancy or while breastfeeding.

- Less than 21 days
- 21 to 25 days
- 26 to 31 days
- 32 to 39 days
- 40 to 50 days
- More than 50 days or too irregular to count
- No periods/Amenorrhea
- Unsure (for example using hormonal contraception, breastfeeding)

What is the current usual pattern of your menstrual cycles? Exclude the 6 months after pregnancy or while breastfeeding.

- Very regular (+ or - 3 days)
- Regular (within 5-7 days)
- Usually irregular
- Always irregular
- No periods/Amenorrhea
- Unsure (for example using hormonal contraception, breastfeeding)

**Pain with Periods**

The following questions ask about pelvic/lower abdominal pain WITH YOUR PERIODS (including irregular bleeding or bleeding while on hormonal treatments, but not spotting).

By "pelvic/lower abdominal pain" we mean any type of pain (cramping, shooting, stabbing, etc.) in the lower part of your belly (the shaded area in the picture below).

Has there been a time in your life when you typically had pelvic/lower abdominal pain during your periods?

- No pain
- Yes, mild cramps (medication never or rarely needed)
- Yes, moderate cramps (medication usually needed)
- Yes, severe cramps (medication and bed rest needed)

When did you start having pain with your periods?

- With my very first period
- Within 2 years of my first period
- More than 2 years after my first period

Did you EVER have to lie down for any part of the day because of your period pain?

- Yes
- No

In the PAST 12 MONTHS, have you had a menstrual period?

- Yes
- No

In the PAST 12 MONTHS, how much pelvic/lower abdominal pain did you typically have during your period?

- No pain
- Mild cramps (medication never or rarely needed)
- Moderate cramps (medication usually needed)
- Severe cramps (medication and bed rest needed)

In the PAST 12 MONTHS, did your period pain prevent you from going to school, work or carrying out your daily activities (even if taking painkillers)?

- Never
- Occasionally (less than a quarter of my periods)
- Often (a quarter to half of my periods)
- Usually (more than half of my periods)
- Always (every period)

In the PAST 12 MONTHS, did your period pain prevent you from doing recreational or social activities (even if taking painkillers)?

- Never
- Occasionally (less than a quarter of my periods)
- Often (a quarter to half of my periods)
- Usually (more than half of my periods)
- Always (every period)

## Pain Not Related to Periods

The following questions ask about pelvic/lower abdominal pain UNRELATED TO YOUR MENSTRUAL PERIOD.

By "pelvic/lower abdominal pain unrelated to your menstrual period" we mean any type of pain (cramping, shooting, stabbing, etc.) in the lower part of your belly (the shaded area in the picture below) that is not related to your periods, intercourse, pregnancy or childbirth, surgery, sports-related or other injury, food poisoning, or stomach flu.

Have you ever experienced pelvic/lower abdominal pain unrelated to your menstrual period?

- Yes
- No

When you had pelvic/lower abdominal pain unrelated to your menstrual period, how much did it typically hurt?

- 0 - No Pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 - Extreme pain

In the PAST 12 MONTHS, how often have you had pelvic/lower abdominal pain unrelated to your period?

- Never
- 1-2 times in past year
- 3-11 times in past year
- Monthly, but not weekly
- Weekly, but not daily
- Daily

In the PAST 12 MONTHS, did your pelvic/lower abdominal pain unrelated to your period prevent you from going to school, work or carrying out your daily activities (even if taking painkillers)?

- Never
- Occasionally (every few months)
- Often (about once per month)
- Usually (about once per week)
- Always (more than once per week)

In the PAST 12 MONTHS, did your pelvic/lower abdominal pain unrelated to your period prevent you from doing recreational or social activities (even if taking painkillers)?

- Never
- Occasionally (every few months)
- Often (about once per month)
- Usually (about once per week)
- Always (more than once per week)

**Pain with Intercourse**

Have you EVER had vaginal intercourse/penetration?

- Yes  
 No

When you had vaginal intercourse/penetration, did you have pelvic pain either during or in the 24 hours following?

- No  
 Yes, during intercourse/penetration  
 Yes, in the 24 hours following intercourse/penetration  
 Yes, both during intercourse/penetration and in the 24 hours following

Did you ever INTERRUPT vaginal intercourse/penetration because of pelvic pain?

- Yes  
 No

In the PAST 12 MONTHS, did you INTERRUPT vaginal intercourse/penetration because of pelvic pain?

- Yes  
 No

Did you ever AVOID vaginal intercourse/penetration because of pelvic pain?

- Yes  
 No

In the PAST 12 MONTHS, did you AVOID vaginal intercourse/penetration because of pelvic pain?

- Yes  
 No

Comments:



## Acne & Body Hair

In the past 3 months, have you had acne on your face?

- No pimples, pustules or nodules in the past 3 months  
 Yes, 1 to 4 pimples, pustules, or nodules on the face (except nose) during the past 3 months  
 Yes, 5 or more pimples, pustules, or nodules on the face (except nose) during the past 3 months

Which of these medications have you ever used for acne treatment? Check all that apply.

- Hormonal contraception  
 Non-prescription skin creams/gels (such as Clearasil)  
 Cleocin-T gel or cream  
 Tretinoin (Retin-A)  
 Antibiotic pills (such as tetracycline, doxycycline, minocycline, erythromycin)  
 Spironolactone (Aldactone)  
 Adapalene (Differin)  
 Isotretinoin (Accutane)  
 Laser or light treatment  
 Other  
 None

Have you ever had a procedure (such as electrolysis or laser removal) to permanently remove excess hair from your face, chest, or abdomen?

Do not include procedures done to remove hair in other areas such as arms, legs, armpits, or pubic area.

- No  
 Yes

Do you regularly shave, wax, bleach, or use other similar methods to remove or make less evident excess hair on your face, chest, or abdomen?

Do not include procedures done to remove hair in other areas such as arms, legs, armpits, or pubic area.

- No  
 Yes

Use the figures and descriptions to rate how much body hair you have before any type of technique or procedure to remove or make body hair less evident.

Only consider body hair that is dark and coarse.

How would you describe the amount of hair on your upper lip before any type of technique or procedure to remove or make body hair less evident?

Only consider body hair that is dark and coarse.

- 0: No hair  
 1: A few hairs at outer lip margin  
 2: A small mustache at outer lip margin  
 3: A mustache extending halfway from the outer margin  
 4: A mustache extending to the midline

---

How would you describe the amount of hair on your chin before any type of technique or procedure to remove or make body hair less evident?

Only consider body hair that is dark and coarse.

- 
- 0: No hairs  
 1: A few scattered hairs  
 2: Scattered hairs with small concentrations  
 3: Complete cover, light  
 4: Complete cover, heavy

---

How would you describe the amount of hair on your chest before any type of technique or procedure to remove or make body hair less evident?

Only consider body hair that is dark and coarse.

- 
- 0: No hair  
 1: Hair around the areolas  
 2: Hair around the areolas and in the middle of the chest  
 3: Hair around the areolas extending to the middle, partial cover  
 4: Complete cover

---

How would you describe the amount of hair on your upper abdomen (above the navel) before any type of technique or procedure to remove or make body hair less evident?

Only consider body hair that is dark and coarse.

- 
- 0: No hair  
 1: A few midline hairs  
 2: Midline streak of hair  
 3: Hair extends beyond midline, partial cover  
 4: Hair extends beyond midline, complete cover

---

How would you describe the amount of hair on your lower abdomen (below the navel) before any type of technique or procedure to remove or make body hair less evident?

Only consider body hair that is dark and coarse.

- 
- 0: No hair  
 1: A few midline hairs  
 2: Midline streak of hair  
 3: Midline band of hair  
 4: Inverted V-shape growth of pubic hair in addition

---

How would you describe the amount of hair on your thighs before any type of technique or procedure to remove or make body hair less evident?

Only consider body hair that is dark and coarse.

- 
- 0: No hair  
 1: Sparse growth covering less than one quarter of the thigh  
 2: Sparse growth covering more than one quarter of the thigh  
 3: Thigh completely covered, light  
 4: Thigh completely covered, heavy

## Personal Care Products

Please indicate if you have used any of the following products in the past 3 months.

- Deodorant
- Shampoo
- Conditioner/crème rinse
- Hair gel/spray
- Other hair care products (such as mousse, hair bleach, relaxer, perm)
- Toothpaste
- Mouthwash
- Dental floss
- Perfume/ Cologne
- Bar soap
- Hand sanitizer
- Hand/body lotion
- Face lotion/moisturizer
- Face oil
- Body oil/lotion
- Shaving cream
- Colored cosmetics (such as hair dye, foundation, blush, eyeshadow, eyeliner, lipstick)
- Body sunscreen
- Face sunscreen
- Nail polish
- Nail polish remover

For the past 3 months, how many times PER WEEK have you used deodorant?

- Never or less than once a week   
 1 time per week   
 2   
 3   
 4   
 5   
 6  
 7   
 8   
 9   
 10   
 11   
 12   
 13   
 14   
 15   
 16   
 17   
 18  
 19   
 20   
 21+ times per week

For the past 3 months, how many times PER WEEK have you used shampoo?

- Never or less than once a week  
 1  
 2  
 3  
 4  
 5  
 6  
 7  
 8  
 9  
 10  
 11  
 12  
 13  
 14  
 15  
 16  
 17  
 18  
 19  
 20  
 21+

---

For the past 3 months, how many times PER WEEK have you used conditioner/crème rinse?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used hair gel/spray?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used other hair care products (such as mousse, hair bleach, relaxer, perm)?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used toothpaste?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used mouthwash?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used dental floss?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used perfume/cologne?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used bar soap?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used hand sanitizer?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used hand lotion?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week



---

For the past 3 months, how many times PER WEEK have you used face lotion/moisturizer?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used face oil?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used body oil/lotion?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used shaving cream?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used colored cosmetics (such as hair dye, foundation, blush, eye shadow, eyeliner, lipstick)?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used body sunscreen?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used face sunscreen?

- Never or less than once a week
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+

---

For the past 3 months, how many times PER WEEK have you used nail polish?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used nail polish remover?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

## Household Products

Please indicate if you have used any of the following products in the past 3 months.

- Furniture polish
- Floor wax
- Fabric softener
- Laundry detergent
- Laundry starch

---

For the past 3 months, how many times PER WEEK have you used furniture polish?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used floor wax?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used fabric softener?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used laundry detergent?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

For the past 3 months, how many times PER WEEK have you used laundry starch?

- Never or less than once a week
- 1 time per week
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21+ times per week

---

In general, do you use fragrance-free products?

- Always
- Sometimes
- Rarely



For the past 3 months, how many times PER WEEK have you eaten or drunk anything stored in a plastic container?

- Never or less than once a week
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
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- 30
- 31
- 32
- 33
- 34
- 35
- 36
- 37
- 38
- 39
- 40
- 41
- 42
- 43
- 44
- 45
- 46
- 47
- 48
- 49
- 50+

For the past 3 months, how many times PER WEEK have you eaten or drunk anything heated in a plastic container?

- Never or less than once a week
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
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- 31
- 32
- 33
- 34
- 35
- 36
- 37
- 38
- 39
- 40
- 41
- 42
- 43
- 44
- 45
- 46
- 47
- 48
- 49
- 50+

**Covid-19**

Have you ever had a COVID-19 infection (presumed or confirmed)?

- Yes  
 No

How many times have you had COVID-19?

- 1 time  
 2  
 3  
 4  
 5+

When was your first COVID-19 infection (presumed or confirmed)?

Month:

- January  
 February  
 March  
 April  
 May  
 June  
 July  
 August  
 September  
 October  
 November  
 December

Year:

- 2020  
 2021  
 2022  
 2023  
 2024

Was your first COVID-19 infection confirmed by a positive test?

- Yes, Rapid test  
 Yes, PCR test  
 Yes, Other  
 No

When was your second COVID-19 infection (presumed or confirmed)?

---

Month:

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

---

Year:

- 2020
- 2021
- 2022
- 2023
- 2024

---

Was your second COVID-19 infection confirmed by a positive test?

- Yes, Rapid test
- Yes, PCR test
- Yes, Other
- No

---

When was your third COVID-19 infection (presumed or confirmed)?

---

Month:

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

---

Year:

- 2020
- 2021
- 2022
- 2023
- 2024

---

Was your third COVID-19 infection confirmed by a positive test?

- Yes, Rapid test
- Yes, PCR test
- Yes, Other
- No

---

When was your fourth COVID-19 infection (presumed or confirmed)?

Month:

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

---

Year:

- 2020
- 2021
- 2022
- 2023
- 2024

---

Was your fourth COVID-19 infection confirmed by a positive test?

- Yes, Rapid test
- Yes, PCR test
- Yes, Other
- No

---

When was your fifth COVID-19 infection (presumed or confirmed)?

Month:

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

---

Year:

- 2020
- 2021
- 2022
- 2023
- 2024

---

Was your fifth COVID-19 infection confirmed by a positive test?

- Yes, Rapid test
- Yes, PCR test
- Yes, Other
- No

---

When you had COVID-19, did you EVER have any of the following symptoms?

- Persistent cough
- Shortness of breath or difficulty breathing
- Fever
- Headache
- Sore throat
- Runny nose
- Sneezing
- Muscle aches
- Vomiting or diarrhea
- Loss of taste
- Loss of smell
- Fatigue
- Confusion, disorientation, "brain fog"
- Rash, blisters or welts anywhere on body
- Mouth or tongue ulcers
- Other symptoms
- I did not have symptoms

---

When you had COVID-19, what was the sickest you EVER felt?

- Severely sick
- Moderately sick
- Mildly sick
- I didn't feel sick at all

---

Were you EVER hospitalized because of COVID-19?

- Yes
- No

---

Have you EVER experienced any long-term COVID-19 symptoms (lasting for more than 4 weeks)?

- Yes
- No

---

Which of the following long-term COVID-19 symptoms have you EVER experienced? Check all that apply.

- Fatigue
- Shortness of breath or difficulty breathing
- Persistent cough
- Muscle, joint or chest pain
- Smell and taste problems
- Confusion, disorientation, "brain fog"
- Memory issues
- Depression, anxiety, changes in mood
- Headache
- Intermittent fever
- Heart palpitations (fast-beating or pounding heart)
- Rash, blisters or welts anywhere on body
- Mouth or tongue ulcers
- Tinnitus
- Other

---

What is the longest time ANY of your symptoms lasted?

- Less than 2 months
- 2-3 months
- 4-5 months
- 6 or more months

---

Are any of these long-term symptoms ongoing?

- Yes
- No

---

Have you received at least one dose of a COVID-19 vaccine?

- Yes
- No, but I plan to get it
- No, I do not plan to get it
- No, I'm not sure if I will get it

---

How many COVID-19 vaccine doses have you received? (include boosters)

- 1
- 2
- 3
- 4+

---

When was your first vaccine dose? (If you don't recall, make your best guess.)

---

Month:

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

---

Year:

- 2020
- 2021
- 2022
- 2023
- 2024

---

When was your most recent dose/booster? (If you don't recall, make your best guess.)

---

Month:

- January
- February
- March
- April
- May
- June
- July
- August
- September
- October
- November
- December

---

Year:

- 2020
- 2021
- 2022
- 2023
- 2024

---

Which vaccine/booster did you receive? Check all that apply.

- Pfizer
- Moderna
- Johnson and Johnson/Janssen
- Novavax
- AstraZeneca
- Other
- Not sure

---

Comment



---

Please include any final comments below; we review these comments to improve future questionnaires.

---

Comment:

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survey start

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Thank you for being an active GUTS participant! We will email you when your next GUTS questionnaire becomes available.

[Click here to return to your GUTS dashboard.](#)

You can contact [guts@channing.harvard.edu](mailto:guts@channing.harvard.edu) with any questions or comments.

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You can contact [guts@channing.harvard.edu](mailto:guts@channing.harvard.edu) with any questions or comments.