

Thank you for participating in the UMass Vitamin D Study!

Please provide the requested information. Please write clearly and fill in the bubbles completely. If you have questions please ask the study staff for assistance.

NOTE: All responses will be kept completely confidential, and your name will not be associated with the information you provide in this questionnaire.

1. What is your date of birth?

Month: Day: Year:

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2. Do you consider yourself to be Spanish/Hispanic/Latina? Yes No

3. Which category(s) best describes your race?
(Mark one or more as appropriate)

- white
- black or African American
- Asian
- American Indian/Native American
- Native Hawaiian or Pacific Islander
- other

4. What is your highest level of education?

- some high school
- high school diploma
- some college/currently enrolled in college
- college degree
- some graduate school
- graduate degree



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(For Office Use Only)

5. Which of the following best describes your **father/guardian's** occupation when you were in middle/high school?

- lawyer, medical doctor, scientist, engineer, college professor or teacher
- executive, manager or administrator
- sales or clerical work
- mechanic, electrician, repairer or craft worker (e.g., carpenter)
- service worker (e.g., janitor, guard)
- laborer, handler, equipment cleaner or helper
- farming
- military
- homemaker, stay at home parent
- did not work
- don't know/not in contact with father

other →

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6. Which of the following best describes your **mother/guardian's** occupation when you were in middle/high school?

- lawyer, medical doctor, scientist, engineer, college professor or teacher
- executive, manager or administrator
- sales or clerical work
- mechanic, electrician, repairer or craft worker (e.g., carpenter)
- service worker (e.g., janitor, guard)
- laborer, handler, equipment cleaner or helper
- farming
- military
- homemaker, stay at home parent
- did not work
- don't know/not in contact with mother

other →

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7. What time did you go to bed last night? Hour Minutes

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 AM PM

8. What time did you get out of bed this morning? Hour Minutes

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9. Have you had anything to eat today, not counting water or coffee? yes no

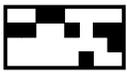
10. When did you last eat? Hour Minutes

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 AM PM



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(For Office Use Only)

19. For each symptom listed below, please indicate whether you experience it most months of the year, for at least several days before your menstrual period begins. Don't include symptoms that you experience throughout your entire menstrual cycle, or symptoms that start when your period starts. For symptoms you do experience, please indicate the usual severity of each (i.e., mild, moderate or severe).

	Not at all	Mild	Moderate	Severe
Abdominal bloating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast tenderness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hot flashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swelling in extremities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acne	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea/constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food cravings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety/nervousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased/decreased appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional hypersensitivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood swings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tendency to cry easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insomnia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angry outbursts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Desire to be alone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forgetfulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal cramping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other:

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Other:

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Severity of "other" symptom(s):

If you do not experience any of these symptoms (i.e., you marked "not at all" for each) skip to question 27 on page 6. →



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20. How would you describe the overall severity of your symptoms together?
- minimal (no effect on my normal activities)
 - mild (noticeable, but not troublesome)
 - moderate (interferes with my normal activities)
 - severe (intolerable, prevents my normal activities)

21. How many days **before the first day of your period** do your symptoms usually begin?

Please write in number of days (ex. 05):

22. How many days do your symptoms last **after your period begins**?

Please write in number of days (ex. 05):

23. **In the week after your menstrual period had stopped**, which of the following statements best described your symptoms?

- My symptoms are completely absent
- My symptoms are still present but are less severe than before my period
- My symptoms are present and are as severe as before my period

24. At approximately what age did most of these symptoms begin?

Please write in age:

25. Have you seen a health care provider because of these symptoms?

yes no

26. Do you experience any of the following because of your menstrual symptoms? For problems you experience, please indicate the severity (i.e., mild, moderate or severe).

	Not a problem	Mild	Moderate	Severe
Relationship discord with family or partner	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Relationship discord with friends or coworkers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor work performance/attendance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Social isolation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suicidal thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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27. Please indicate if you are experiencing any of the following symptoms today.
 If so, please indicate how severe the symptom is today.

	Not at all	Mild	Moderate	Severe
Abdominal bloating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast tenderness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hot flashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Swelling in extremities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acne	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea/constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food cravings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety/nervousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Increased/decreased appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emotional hypersensitivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood swings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tendency to cry easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insomnia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angry outbursts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Desire to be alone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forgetfulness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdominal cramping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other:

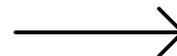
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Other:

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Severity of "other" symptom(s):

If you do not experience any of these symptoms (i.e., you marked "not at all" for each) skip to question 29 on page 7.





Grid for office use only

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- 28. How would you describe the overall severity of all your symptoms together today?
Minimal (no effect on normal activities)
Mild (noticeable, but not troublesome)
Moderate (interferes with normal activities)
Severe (intolerable, prevents normal activities)

- 29. a. Have you ever been diagnosed by a clinician with Premenstrual Syndrome (PMS)?
No Yes

- b. If yes, did your clinician have you keep a prospective record of your symptoms for at least one menstrual cycle (i.e., a "chart," calendar or daily record?)

No Yes -> If yes, how many cycles were recorded? [] cycles

- 30. Do you currently do any one of the following to prevent or treat your symptoms? (mark all that apply)

- no symptoms, do yoga/meditation, take hot baths, increase exercise level, drink alcohol, sleep more, change your diet, take medication

If you take medication, please indicate what type(s) you currently use:

Grid for medication types

- 31. During the past month, what was your average time per week spent at each of the following recreational activities?

Time per week

Table with 11 columns (ZERO, 1-4 Min., 5-19 Min., 20-59 Min., One Hour, 1-1.5 Hrs., 2-3 Hrs., 4-6 Hrs., 7-10 Hrs., 11+ Hrs.) and 10 rows of activities (Walking or hiking outdoors, Jogging outdoors, Running outdoors, Bicycling, Aerobics, Tennis, Lap swimming, Other aerobic activity, Yoga or pilates, Weight training).



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41. Does anyone smoke in the household where you currently live? yes no
 If yes, approximately how many cigarettes are smoked by each member of your household?

Smoker 1: 1-10 11-20 21-30 31-40 41 or more

Smoker 2: 1-10 11-20 21-30 31-40 41 or more

Smoker 3: 1-10 11-20 21-30 31-40 41 or more

42. How often are you exposed to cigarette smoke for 1 or more hours at a time at places other than home (i.e., work, social situations)?

- never
- less than once per week
- 1-3 times per week
- 4-6 times per week
- daily

43. Do you smoke marijuana? no yes

If yes, how often?

- less than once per month
- 1-3 times per month
- 1-3 times per week
- 4-6 times per week
- daily

NOTE: All responses will be kept completely confidential.

44. Do you use any of the following once per month or more? (Indicate all that apply)

- ecstasy heroin
- crystal meth mushrooms
- cocaine None of the above
- LSD

The next questions are about drinking alcoholic beverages. Included are liquor (such as whiskey or gin), beer, wine, wine coolers, and any other type of alcoholic beverage. One drink is equal to a 12oz. beer, a 5oz. glass of wine, or one and a half ounces of liquor.

45. In **your entire life**, have you had at least 12 drinks of any type of alcoholic beverage?

- Yes No

↳ Skip to question 51

46. In **any one year**, have you had at least 12 drinks of any type of alcoholic beverages?

- Yes No

47. In the **past 6 months**, how often did you drink any type of alcoholic beverage?

Example: If you drink 3 days a week, please write in the number "3" and bubble in "per week"

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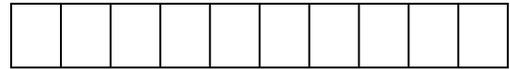
days

- Per week
- Per month
- Per year

48. In the **past 6 months**, on those days that you drank alcoholic beverages, on the average, how many drinks did you have? If you drank less than 1 drink, enter a 1.

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drinks



55. Have you ever had asthma?
 yes no
56. In the last 12 months, has your chest sounded wheezy during or after exercise?
 yes no
57. In the last 12 months, have you had a dry cough at night, apart from a cough associated with a cold or chest infection?
 yes no
58. a. Have you ever had an itchy rash which was coming and going for at least 6 months?
 yes no → If you answered "no" please skip to question 59
- b. Have you had this itchy rash at any time in the last 12 months?
 yes no → If you answered "no" please skip to question 59
- c. Has this itchy rash at any time affected any of the following places: the folds of the elbows, behind the knees, in front of the ankles, under the buttocks, or around the neck, ears or eyes?
 yes no
- d. Has this rash cleared up completely at any time during the last 12 months?
 yes no
- e. In the last 12 months, how often, on average, have you been kept awake at night by this itchy rash?
 Never in the last 12 months
 Less than one night a week
 One or more nights per week
59. Have you ever had eczema?
 yes no
60. Have you lost or gained more than 10 pounds in the last 2 months?
 no
 yes, lost ≥ 10 pounds
 yes, gained ≥ 10 pounds
61. How often do you eat organic foods such as fruits, vegetables, meats and/or dairy products?
 never rarely occasionally often always
62. In the past week, how many hours per day on average have you spent outdoors wearing minimal clothing? (i.e., shorts and a T-shirt/tank top)
 0 hours 3-4 hours
 1-2 hours ≥ 5 hours
63. Over the past summer, how many hours **per day** on average did you spend outdoors wearing minimal clothing?
 0 hours 3-4 hours
 1-2 hours ≥ 5 hours



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64. Do you regularly wear sunscreen? no yes

If yes, what SPF do you usually use?

- less than 15 30 to 39
- 15 to 19 40 or higher
- 20 to 29

65. In the past 3 months, have you traveled to a "sunny" location? no yes

If yes, where?

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If yes, how many days were you there? days

66. In the past 6 months, have you used a tanning bed or tanning booth? no yes

If yes, how often?

- more than once a week
- weekly
- bi-weekly (every two weeks)
- monthly
- bi-monthly (every two months)
- only once or twice

67. On an average weekday, how many hours do you sleep per night?

- <= 3 hours 8-9 hours
- 4-5 hours >= 10 hours
- 6-7 hours

68. On an average weekend day, how many hours do you sleep per night?

- <= 3 hours 8-9 hours
- 4-5 hours >= 10 hours
- 6-7 hours

The following questions regard YOUR infancy (feel free to call a parent if you need to):

69. Were you breastfed as a baby?

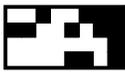
- Yes **If yes,** for how many months were you breastfed?
- No
- Not sure
- unknown
- 3 months or less
- 4 to 8 months
- 9 months or more

70. What was your birth weight *in pounds*?

- not sure 7.0 to 8.4 pounds
- less than 5.5 pounds 8.5 to 9.9 pounds
- 5.5 to 6.9 pounds 10 pounds or more

71. Were you (please answer all that apply):

- full term (not premature)
- 2 or more weeks premature
- a twin, triplet, etc.



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72. In the past six months, have you been treated by a healthcare provider or have you treated yourself for any of the following reproductive tract infections? Please mark all that apply:

- Bacterial vaginosis (BV)
- Yeast
- Chlamydia
- Gonorrhea
- Syphilis
- Genital warts
- Genital herpes
- Trichomoniasis
- Not sure
- None of the above (skip to question 73)

If you received treatment, what medication(s) did you receive? Mark all that apply:

- Over the counter creams or suppositories (examples: Monistat-7, Vagistat, Femstat)
- Metronidazole (Flagyl)
- Clindamycin (Cleocin)
- Penicillin pills
- Penicillin shot
- Doxycycline
- Zovirax
- Don't know/ can't remember
- None of the above

If you received treatment, when were you treated?

- one month ago or less
- 2 to 3 months ago
- 4 to 6 months ago

73. If you have not received treatment for a reproductive tract infection, please indicate whether you have experienced any of the following symptoms within the past six months:

- vaginal itching
- vaginal burning
- vaginal ulcer
- out of the ordinary (or unusual) vaginal discharge
- None of the above

If yes, was the discharge:

- gray-white, bad-smelling
- yellow-green, frothy
- white, no odor

74. In the past 6 months, have you been treated for a urinary tract infection (UTI)?
 no yes



If yes, how many urinary tract infections did you have in the last 6 months?

- one
- two
- three or more

If yes, when were you last treated?

- one month ago or less
- 2 to 3 months ago
- 4 to 6 months ago

Thank you! Please return questionnaire to study staff.