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: [ ]-19[ ]

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
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

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

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

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

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

10. When did you last eat?

(For Office Use Only)
11. At what age did your menstrual periods begin?
- <= 9 years old
- 10 years old
- 11 years old
- 12 years old
- 13 years old
- 14 years old
- 15 years old
- 16 years old
- >= 17 years old

12. How many years after the onset of your menstrual periods did your cycles become regular?
- < 1 year
- 1-2 years
- 3-4 years
- > 5 years
- never

13. What is the current usual length of your menstrual cycle? (i.e., interval from first day of period to first day of next period)
- less than 21 days
- 21-25 days
- 26-31 days
- 32-39 days
- 40-50 days
- over 51 days/too irregular to estimate

14. During your period, how many days do you generally have bleeding?
- <= 3 days
- 4-5 days
- >= 8 days

15. What is the current usual pattern of your menstrual cycles?
- extremely regular (no more than 1-2 days before or after expected)
- very regular (within 3-4 days)
- regular (within 5-7 days)
- usually irregular
- always irregular

16. Have you ever been pregnant?  yes  no

17. a. Have you ever used oral contraceptives?  yes  no
   b. If yes, at what age did you first use them?
   c. If yes, how many years, in total, did you use them?
   d. Are you currently using oral contraceptives?  yes  no
   e. If yes, what type of oral contraceptives? Please name the brand or formula below:

18. Are you currently using any of the following? (Mark all that apply)
- contraceptive implants
- Depo-Provera/injectible contraceptives
- intrauterine device/IUD
- None of the above
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).

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not at all</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>Abdominal bloating</td>
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<td>Breast tenderness</td>
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<td>Lower back pain</td>
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</table>

Other:

Other:

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.
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).

<table>
<thead>
<tr>
<th></th>
<th>Not a problem</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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</thead>
</table>
   Relationship discord with family or partner | O              | O    | O        | O      |
   Relationship discord with friends or coworkers | O              | O    | O        | O      |
   Poor work performance/attendance | O              | O    | O        | O      |
   Social isolation | O              | O    | O        | O      |
   Suicidal thoughts | O              | O    | O        | O      |
27. Please indicate if you are experiencing any of the following symptoms today. If so, please indicate how severe the symptom is today.

<table>
<thead>
<tr>
<th>Symptom</th>
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<td>Other:</td>
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</table>

Severity of "other" symptom(s): O O O O

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.
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?  

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:  

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking or hiking outdoors or on a treadmill (include walking to work or school)</td>
<td>ZERO 1-4 Min.</td>
</tr>
<tr>
<td>Jogging outdoors or on a treadmill</td>
<td>o</td>
</tr>
<tr>
<td>Running outdoors or on a treadmill</td>
<td>o</td>
</tr>
<tr>
<td>Bicycling/using a stationary bike</td>
<td>o</td>
</tr>
<tr>
<td>Aerobics/dance/rowing machine</td>
<td>o</td>
</tr>
<tr>
<td>Tennis, squash or racket sports</td>
<td>o</td>
</tr>
<tr>
<td>Lap swimming</td>
<td>o</td>
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<tr>
<td>Other aerobic activity such as martial arts or lawn mowing</td>
<td>o</td>
</tr>
<tr>
<td>Yoga or pilates</td>
<td>o</td>
</tr>
<tr>
<td>Weight training or resistance exercises</td>
<td>o</td>
</tr>
</tbody>
</table>
32. What is your usual walking pace outdoors?
   - easy, casual (less than 2 miles per hour)
   - normal (2 to 2.9 miles per hour)
   - brisk pace (3 to 3.9 miles per hour)
   - very brisk/striding (4 miles per hour or faster)
   - unable to walk

33. How many flights of stairs (not individual steps) do you climb daily?
   - 2 flights or less
   - 3-4 flights
   - 5-9 flights
   - 10-14 flights
   - 15 or more flights
   - unable to walk

34. On average, how much time per week do you spend at the following?

<table>
<thead>
<tr>
<th>Time per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZERO hrs.</td>
</tr>
<tr>
<td>ONE hour</td>
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<tr>
<td>2-5 hrs.</td>
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<td>6-10 hrs.</td>
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<td>11-20 hrs.</td>
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<td>21-40 hrs.</td>
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<td>41-60 hrs.</td>
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<tr>
<td>61-90 hrs.</td>
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<tr>
<td>Over 90 hrs.</td>
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</tbody>
</table>

   - Standing or walking around at school or work
   - Standing or walking around at home
   - Sitting while at the computer, in class, work or driving
   - Sitting while reading, talking or eating
   - Sitting watching TV

35. Have you smoked 20 or more packs of cigarettes in your lifetime?  ○ yes  ○ no

36. Do you currently smoke?  ○ yes  ○ no

37. If you currently smoke:
   What specific brand and type of cigarettes do you smoke? (e.g., Marlboro Lights 100's)
   Please enter the brand and type below (leave blank if not a current smoker):

38. If you currently smoke, how many cigarettes do you smoke per day?
   - 1-10
   - 11-20
   - 21-30
   - 31-40
   - 41 or more

39. If you ever have smoked (current smoker or quit), at what age did you start smoking?
   Enter age:  

40. If you have quit smoking, at what age did you quit?
   Enter age:  
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

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"

○ 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.

○ drinks
51969

49. In the past 6 months, on how many days did you have 5 or more drinks of any alcoholic beverage? Example: If you have 5 or more drinks/day twice a month, please write in the number 2 and bubble in "per month"

- [ ] Per week
- [ ] Per month
- [ ] Per year

50. Was there ever a time in your life when you drank 5 or more drinks of any kind of alcoholic beverage almost every day?

- [ ] Yes
- [ ] No

51. Have you ever had any of the following clinician-diagnosed illnesses? (Mark all that apply)

- [ ] Lactose intolerance
- [ ] Depression (unipolar depression)
- [ ] Bipolar disorder (manic depressive illness)
- [ ] Endometriosis
- [ ] Uterine fibroids
- [ ] None of the above

52. Are you currently taking any of the following medications? (Mark all that apply)

- [ ] Not taking any medications
- [ ] Selective serotonin reuptake inhibitors/SSRIs (Prozac, Zoloft, Paxil, Effector, etc.)
- [ ] Other antidepressants (Elavil, Wellbutrin, MAOIs such as Parnate and Nardil, etc.)
- [ ] Tranquilizers (Valium, Thorazine, Xanax, BuSpar, etc.)
- [ ] Lithium
- [ ] Migraine prevention (Imitrex, etc.)
- [ ] Antacids (Tums, Rolaids, etc.)
- [ ] Other medications (please specify below)

53. Have you ever had wheezing or whistling in the chest at any time in the past?

- [ ] Yes
- [ ] No

   If you answered "no" please skip to question 55

54. a. Have you had wheezing or whistling in the chest in the last 12 months?

- [ ] Yes
- [ ] No

   If you answered "no" please skip to question 55

b. How many attacks of wheezing have you had in the last 12 months?

- [ ] None
- [ ] 1 to 3
- [ ] 4 to 12
- [ ] More than 12

c. In the last 12 months, how often, on average, has your sleep been disturbed due to wheezing?

- [ ] Never woken with wheezing
- [ ] Less than one night a week
- [ ] One or more nights per week

d. In the last 12 months, has wheezing ever been severe enough to limit your speech to only one or two words between breaths?

- [ ] Yes
- [ ] No
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
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?
   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
   ○ less than 5.5 pounds
   ○ 5.5 to 6.9 pounds
   ○ 7.0 to 8.4 pounds
   ○ 8.5 to 9.9 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.
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)
- Metronidazone (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.