

# Fibroid Growth Study

FGS \_\_\_\_\_  
FGS FORM 100  
VERSION: 051603

Initial Telephone Questionnaire

DATA ENTRY INTL.: \_\_\_\_\_

**Participant ID:** FGS-

**Interviewer ID:**

**Date of Interview:**     
MONTH DAY YEAR

**Length of Interview:**   Minutes

**No. of Sessions:**

**Outcome Code:**



This work was supported by NIH grant #MO1RR00046, NIEHS contracts #N01-ES-95446 and #273-01-C-0157.  
For more information, contact Dr. Shyamal Peddada (peddada@niehs.nih.gov; 919-541-1122)

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Time Began:  :  AM PM

## A. INTRODUCTORY SCRIPT

**This should be free form and includes the following sections:**

-Introduction

1. Ask for the participant, identify yourself.

-Reason for call

1. Explain why you are calling.
2. Tell how long it will take.
3. Ask if she has time now.

-Type of information you are asking

1. Explain the type of questions you will ask, making sure to mention that some of the information is very personal.

-Explain her rights

1. She is free to ask why we are asking any questions.
2. She does not have to answer any questions that make her feel uncomfortable--this will not affect her participation in the study itself.

-Ask:

1. If she has any questions before starting.
2. If she could get a calendar to keep by the phone.
3. If she has a record of her period, if she could get that as well.

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## Sample Script:

Hello. I am \_\_\_\_\_ and I am calling to talk with \_\_\_\_\_. Is this \_\_\_\_\_ or may I speak with \_\_\_\_\_.

Hello \_\_\_\_\_. I am \_\_\_\_\_ and I am calling based on your participation in the Fibroid Growth Study. I would like to ask you questions that will be used by researchers to help determine why fibroids grow. This will take about 30 minutes. Do you have the time now for me to ask you these questions?

**[If not]**, when would be a better time to call?

**[If Yes]** I will ask you a series of questions that deal with your menstrual cycle, medical history, and lifestyle, such as exercise, diet, and sex. Because fibroids are located in the uterus, many of the questions I will ask you are very personal.

You do not have to answer any questions if you feel they are too personal or that you do not want to answer for any reason. This will not affect your participation in the study itself.

Feel free to ask questions if you do not understand the question or would like to know why we ask such questions.

Do you have any questions right now? Could you get a calendar to have near the phone to help with some of the questions, and if you have a record of your menstrual period, could you get that and keep it handy as well?

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## B. OCCUPATIONAL HISTORY

The first questions are about your work.

B1. Are you currently employed?

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	.....	.....	<b>8</b>
<b>Don't know</b>	.....	.....	<b>9</b>

B2. How many hours do you work per week as paid employment?

		Hours
--	--	-------

B3. During a typical day when you are working, do you mostly:

Sit	.....	.....	1
Stand	.....	.....	2
Walk	.....	.....	3
Do heavier physical activity (lifting, digging, carrying, etc.)	.....	.....	4
Other	.....	.....	5

**Specify:** \_\_\_\_\_  
(e.g. sit/stand equally)

## C. MEDICAL HISTORY

C1. What month and year were you first told by a health professional that you had uterine fibroids?

		If not known, fill boxes with 9's
Month	Year	

Write out MONTH: \_\_\_\_\_

C2. Did you learn about your fibroids because they were investigating a problem you were having or were they found incidentally during a routine examination?

**Reason is more important than type of exam.  
For example, If response is "Pelvic Exam," probe with repeat of question for the type of exam they were found during.**

Investigating a problem	.....	1
Normal pregnancy exam	.....	2
Routine Exam	.....	3
Uterine Surgery	.....	4
Other ( <b>Specify below</b> )	.....	5

C3. At that time, how many fibroids were found?

**If number not known ask C3a**

		No. of Fibroids
--	--	-----------------

**C3a.** Did you have one or more than one fibroid at that time?

One	.....	.....	1
More than one	.....	.....	2
<b>Refused</b>	.....	.....	<b>3</b>
<b>Don't know</b>	.....	.....	<b>4</b>

C4. What was size the largest?

		Unit of measure
Size		

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Now I am going to ask you about your overall health and general feelings about your health. This series of questions has multiple choice answers. I will read the possible answers to you with each question.

- C5.** Overall, how would you rate your health now?
- |                       |       |   |
|-----------------------|-------|---|
| Excellent / Very Good | ..... | 1 |
| Good                  | ..... | 2 |
| Fair                  | ..... | 3 |
| Poor                  | ..... | 4 |
| <b>Refused</b>        | ..... | 8 |
| <b>Don't know</b>     | ..... | 9 |
- C6.** How limited are your daily activities because of your health?
- |                   |       |   |
|-------------------|-------|---|
| A lot             | ..... | 1 |
| Some              | ..... | 2 |
| A little          | ..... | 3 |
| Not at all        | ..... | 4 |
| <b>Refused</b>    | ..... | 8 |
| <b>Don't know</b> | ..... | 9 |
- C7.** How much daily discomfort do you have?
- |                   |       |   |
|-------------------|-------|---|
| A lot             | ..... | 1 |
| Some              | ..... | 2 |
| A little          | ..... | 3 |
| Not at all        | ..... | 4 |
| <b>Refused</b>    | ..... | 8 |
| <b>Don't know</b> | ..... | 9 |
- C8.** Suppose you were told that you were going to spend the rest of your life feeling just the way you have for the past month or so. Your symptoms would be no better or worse. Which of the following answers best describes how you would feel about that?
- |                             |       |   |
|-----------------------------|-------|---|
| Pleased or mostly satisfied | ..... | 1 |
| Mixed                       | ..... | 2 |
| Mostly dissatisfied         | ..... | 3 |
| Very Dissatisfied           | ..... | 4 |
| <b>Refused</b>              | ..... | 8 |
| <b>Don't know</b>           | ..... | 9 |
- C9.** To what extent, if at all, do you worry about your health?
- |                   |       |   |
|-------------------|-------|---|
| A lot             | ..... | 1 |
| Some              | ..... | 2 |
| A little          | ..... | 3 |
| Not at all        | ..... | 4 |
| <b>Refused</b>    | ..... | 8 |
| <b>Don't know</b> | ..... | 9 |

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The next questions are related to symptoms. Some of these are very personal and I would like to remind you that you may ask at any time why a question is being asked, and you don't have to answer any questions that make you feel uncomfortable.

- |  |                               |          |
|--|-------------------------------|----------|
| <b>C10.</b> During the last 30 days, how much of a problem was vaginal bleeding (including menstruation) for you?  | Big .....                     | 1        |
|  | Medium .....                  | 2        |
|  | Small .....                   | 3        |
|  | None .....                    | 4        |
|  | <b>Refused</b> .....          | <b>8</b> |
|  | <b>Don't know</b> .....       | <b>9</b> |
|  |                               |          |
| <b>C11.</b> During the last 30 days, how much did vaginal bleeding interfere with your daily responsibilities, such as going to work/caring for family members, and doing housework? | A lot .....                   | 1        |
|  | Some .....                    | 2        |
|  | A little .....                | 3        |
|  | Not at all .....              | 4        |
|  | <b>Refused</b> .....          | <b>8</b> |
|  | <b>Don't know</b> .....       | <b>9</b> |
|  |                               |          |
| <b>C12.</b> During the last 30 days how much did vaginal bleeding limit your social activities, such as visiting friends, taking vacations, and having company?                      | A lot .....                   | 1        |
|  | Some .....                    | 2        |
|  | A little .....                | 3        |
|  | Not at all .....              | 4        |
|  | <b>Refused</b> .....          | <b>8</b> |
|  | <b>Don't know</b> .....       | <b>9</b> |
|  |                               |          |
| <b>C13.</b> During the last 30 days how much of the time have you felt excessively tired?  | All or Most of the time ..... | 1        |
|  | Some of the time .....        | 2        |
|  | A little of the time .....    | 3        |
|  | None of the time .....        | 4        |
|  | <b>Refused</b> .....          | <b>8</b> |
|  | <b>Don't know</b> .....       | <b>9</b> |
|  |                               |          |
| <b>C14.</b> During the last 30 days, how much of the time have you had back pain?  | All or Most of the time ..... | 1        |
|  | Some of the time .....        | 2        |
|  | A little of the time .....    | 3        |
|  | None of the time .....        | 4        |
|  | <b>Refused</b> .....          | <b>8</b> |
|  | <b>Don't know</b> .....       | <b>9</b> |

The next two questions ask you to recall the number of days.

**C15.** During the last 30 days, about how many days did you have cramps, discomfort or pain the pelvic area?

No. of days	

**C16.** During the last 30 days, about how many days did you have a feeling of heaviness in the pelvic area?

No. of days	

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The next questions are multiple choice.

- |   |  |                         |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
|---|--|-------------------------|-------|---|------------------|-------|---|----------------------|-------|---|-------------------|-------|---|----------------|-------|---|-------------------|-------|---|
| <p><b>C17.</b> During the last 30 days, how much of a problem was pelvic heaviness, discomfort, or pain for you? Was it:</p>  | <table border="0" style="width: 100%;"> <tr><td>A big problem</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>Medium Problem</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td>Small Problem</td><td style="text-align: right;">.....</td><td style="text-align: right;">3</td></tr> <tr><td>No Problem</td><td style="text-align: right;">.....</td><td style="text-align: right;">4</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table>                          | A big problem           | ..... | 1 | Medium Problem   | ..... | 2 | Small Problem        | ..... | 3 | No Problem        | ..... | 4 | <b>Refused</b> | ..... | 8 | <b>Don't know</b> | ..... | 9 |
| A big problem   | .....  | 1                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| Medium Problem  | .....  | 2                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| Small Problem   | .....  | 3                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| No Problem  | .....  | 4                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Refused</b>  | .....  | 8                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Don't know</b>   | .....  | 9                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <p><b>C18.</b> During the last 30 days, how much did pelvic heaviness, discomfort or pain interfere with your being able to do the things you like to do or have to do? Did it interfere:</p> | <table border="0" style="width: 100%;"> <tr><td>A lot</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>Some</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td>A little</td><td style="text-align: right;">.....</td><td style="text-align: right;">3</td></tr> <tr><td>Not at all</td><td style="text-align: right;">.....</td><td style="text-align: right;">4</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table>   | A lot                   | ..... | 1 | Some             | ..... | 2 | A little             | ..... | 3 | Not at all        | ..... | 4 | <b>Refused</b> | ..... | 8 | <b>Don't know</b> | ..... | 9 |
| A lot   | .....  | 1                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| Some  | .....  | 2                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| A little  | .....  | 3                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| Not at all  | .....  | 4                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Refused</b>  | .....  | 8                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Don't know</b>   | .....  | 9                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <p><b>C18 (a).</b> <b>If at least "a little";</b> were there days when you just had to stay home because of pelvic discomfort or pain?</p>  | <table border="0" style="width: 100%;"> <tr><td>Yes</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>No</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table>   | Yes                     | ..... | 1 | No               | ..... | 2 | <b>Refused</b>       | ..... | 8 | <b>Don't know</b> | ..... | 9 |                |       |   |                   |       |   |
| Yes   | .....  | 1                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| No  | .....  | 2                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Refused</b>  | .....  | 8                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Don't know</b>   | .....  | 9                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <p><b>C18 (b).</b> <b>IF YES:</b> During the last 30 days, how many days did you stay home because of pelvic discomfort or pain?</p>  | <table border="1" style="width: 100%; height: 30px; margin-bottom: 5px;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;"></td> </tr> </table> <p style="text-align: center; margin: 0;"><b>No. of days</b></p>   |                         |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
|   |  |                         |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <p><b>C19.</b> During the last 30 days how much of the time have you been constipated?</p>  | <table border="0" style="width: 100%;"> <tr><td>All or Most of the time</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>Some of the time</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td>A little of the time</td><td style="text-align: right;">.....</td><td style="text-align: right;">3</td></tr> <tr><td>None of the time</td><td style="text-align: right;">.....</td><td style="text-align: right;">4</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table> | All or Most of the time | ..... | 1 | Some of the time | ..... | 2 | A little of the time | ..... | 3 | None of the time  | ..... | 4 | <b>Refused</b> | ..... | 8 | <b>Don't know</b> | ..... | 9 |
| All or Most of the time   | .....  | 1                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| Some of the time  | .....  | 2                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| A little of the time  | .....  | 3                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| None of the time  | .....  | 4                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Refused</b>  | .....  | 8                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Don't know</b>   | .....  | 9                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <p><b>C20.</b> Do you take laxatives, such as Metamucil, on a regular basis?</p>  | <table border="0" style="width: 100%;"> <tr><td>Yes</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>No</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table>   | Yes                     | ..... | 1 | No               | ..... | 2 | <b>Refused</b>       | ..... | 8 | <b>Don't know</b> | ..... | 9 |                |       |   |                   |       |   |
| Yes   | .....  | 1                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| No  | .....  | 2                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Refused</b>  | .....  | 8                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Don't know</b>   | .....  | 9                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <p><b>IF YES TO C20.</b></p>  |  |                         |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <p><b>C21.</b> What is your reason for taking laxatives? Is it because you are having a problem, or is it part of your regular habits?</p>  | <table border="0" style="width: 100%;"> <tr><td>Having a problem</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>Regular habits</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table>  | Having a problem        | ..... | 1 | Regular habits   | ..... | 2 | <b>Refused</b>       | ..... | 8 | <b>Don't know</b> | ..... | 9 |                |       |   |                   |       |   |
| Having a problem  | .....  | 1                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| Regular habits  | .....  | 2                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Refused</b>  | .....  | 8                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Don't know</b>   | .....  | 9                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <p><b>C22.</b> During the last 30 days how much of the time have you had a lot of gas?</p>  | <table border="0" style="width: 100%;"> <tr><td>All or Most of the time</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>Some of the time</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td>A little of the time</td><td style="text-align: right;">.....</td><td style="text-align: right;">3</td></tr> <tr><td>None of the time</td><td style="text-align: right;">.....</td><td style="text-align: right;">4</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table> | All or Most of the time | ..... | 1 | Some of the time | ..... | 2 | A little of the time | ..... | 3 | None of the time  | ..... | 4 | <b>Refused</b> | ..... | 8 | <b>Don't know</b> | ..... | 9 |
| All or Most of the time   | .....  | 1                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| Some of the time  | .....  | 2                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| A little of the time  | .....  | 3                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| None of the time  | .....  | 4                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Refused</b>  | .....  | 8                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |
| <b>Don't know</b>   | .....  | 9                       |       |   |                  |       |   |                      |       |   |                   |       |   |                |       |   |                   |       |   |

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FGS \_\_\_\_\_  
 FGS FORM 100  
 VERSION: 051603

Initial Telephone Questionnaire

DATA ENTRY INTL.: \_\_\_\_\_

<b>C23.</b> During the last 30 days how much of the time have you had stomach aches or nausea?	All or Most of the time	.....	<b>1</b>
	Some of the time	.....	<b>2</b>
	A little of the time	.....	<b>3</b>
	None of the time	.....	<b>4</b>
	<b>Refused</b>	.....	<b>8</b>
	<b>Don't know</b>	.....	<b>9</b>
<b>C24.</b> During the last 30 days have you ever had a urine leak?	Yes	.....	<b>1</b>
	No	.....	<b>2</b>
	<b>Refused</b>	.....	<b>8</b>
	<b>Don't know</b>	.....	<b>9</b>
<b>IF YES TO C24.</b>			
<b>C25.</b> How much of a problem was it?	A big problem	.....	<b>1</b>
	Medium Problem	.....	<b>2</b>
	Small Problem	.....	<b>3</b>
	No Problem	.....	<b>4</b>
	<b>Refused</b>	.....	<b>8</b>
	<b>Don't know</b>	.....	<b>9</b>
<b>C26.</b> Was it due to things like coughing, laughing, sneezing or lifting? Or was it just an uncontrolled response?	Laughing, etc.	.....	<b>1</b>
	Uncontrolled	.....	<b>2</b>
	<b>Refused</b>	.....	<b>8</b>
	<b>Don't know</b>	.....	<b>9</b>
<b>C27.</b> During the last 30 days, did you sometimes feel like you needed to urinate urgently, even though you had little or no warning?	Yes	.....	<b>1</b>
	No	.....	<b>2</b>
	<b>Refused</b>	.....	<b>8</b>
	<b>Don't know</b>	.....	<b>9</b>
<b>IF YES TO C27.</b>			
<b>C28.</b> How much of a problem was it?	A big problem	.....	<b>1</b>
	Medium Problem	.....	<b>2</b>
	Small Problem	.....	<b>3</b>
	No Problem	.....	<b>4</b>
	<b>Refused</b>	.....	<b>8</b>

# Fibroid Growth Study

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Initial Telephone Questionnaire

DATA ENTRY INTL.: \_\_\_\_\_

The next question is about scheduled treatment, including surgery. We wish to stress that any decisions about treatment should be made by you. Your decision is not related to study participation. However, it is helpful for us to be informed when a study participant has chosen a treatment option.

**C29. In the last month, have you been scheduled to receive treatment (including surgery) for your fibroids?**

Yes	.....	1
No	.....	2
<b>Refused</b>	.....	<b>8</b>
<b>Don't know</b>	.....	<b>9</b>

**C30. If yes: What type of treatment is scheduled?**

Hysterectomy	.....	1
Myomectomy	.....	2
Embolization	.....	3
Other:	.....	4

Specify: \_\_\_\_\_

<b>Refused</b>	.....	<b>8</b>
<b>Don't know</b>	.....	<b>9</b>

**C31. If yes: Has a date of the surgery been set?**

Yes	.....	1
No	.....	2
<b>Refused</b>	.....	<b>8</b>
<b>Don't know</b>	.....	<b>9</b>

**C32. If yes: What is the date of the surgery?**

Month	Day	Year

**Write out Month** \_\_\_\_\_

**The next three questions are about infections.**

**C33. In the last 30 days, have you had cold sores (fever sores, fever blisters)?**

Yes	.....	1
No	.....	2
<b>Refused</b>	.....	<b>8</b>
<b>Don't know</b>	.....	<b>9</b>

**C34. In the last 30 days, have you had canker sores (mouth sores or mouth ulcers)?**

Yes	.....	1
No	.....	2
<b>Refused</b>	.....	<b>8</b>
<b>Don't know</b>	.....	<b>9</b>

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DATA ENTRY INTL.: \_\_\_\_\_

- C35.** In the last 30 days, have you had genital herpes sores or blisters?
- |                   |       |   |
|-------------------|-------|---|
| Yes               | ..... | 1 |
| No                | ..... | 2 |
| <b>Refused</b>    | ..... | 8 |
| <b>Don't know</b> | ..... | 9 |

### D. PHYSICAL ACTIVITY

The next questions are about vigorous physical activity.

- D1.** Currently do you engage in vigorous recreational activities that increase your heart rate or make you sweat for at least 30 minutes at a time?
- |                   |       |   |
|-------------------|-------|---|
| Yes               | ..... | 1 |
| No                | ..... | 2 |
| <b>Refused</b>    | ..... | 8 |
| <b>Don't know</b> | ..... | 9 |

**IF YES TO D1**

- D2.** How many times per week do you engage in vigorous recreational activity?

--	--

No. of times

Now I'd like to ask you about time that you spend walking to work, during lunch or shopping, as well as recreational walking.

- D3.** During a typical day, how much time do you spend walking?
- |           |                      |         |
|-----------|----------------------|---------|
|           |                      |         |
| Between → |                      |         |
|           | Up to ½ hour         | ..... 1 |
|           | ½ hour and an hour   | ..... 2 |
|           | 1 hour and 1 ½ hour  | ..... 3 |
|           | 1 ½ hour and 2 hours | ..... 4 |
|           | 2 and 2 ½ hours      | ..... 5 |
|           | 2 ½ and 3 hours      | ..... 6 |
|           | More than 3 hours    | ..... 7 |
|           | <b>Refused</b>       | ..... 8 |
|           | <b>Don't know</b>    | ..... 9 |

### E. DIET

The next questions are about your current diet.

- E1.** How often do you eat red meat?
- |                       |       |   |
|-----------------------|-------|---|
| Daily                 | ..... | 1 |
| 3-6 times per week    | ..... | 2 |
| 1-2 times per week    | ..... | 3 |
| Less than once a week | ..... | 4 |
| Never                 | ..... | 5 |
| <b>Refused</b>        | ..... | 8 |
| <b>Don't know</b>     | ..... | 9 |

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DATA ENTRY INTL.: \_\_\_\_\_

**E2.** Not counting fruit juices, how many servings of fruits and vegetables do you eat per day?

5 + per day	.....	1
3-4 per day	.....	2
1-2 per day	.....	3
<1 per day	.....	4
<b>Refused</b>	.....	8
<b>Don't know</b>	.....	9

**E3.** How often do you eat at fast food restaurants?

Daily	.....	1
3-6 times per week	.....	2
1-2 times per week	.....	3
Less than once a week	.....	4
Never	.....	5
<b>Refused</b>	.....	8
<b>Don't know</b>	.....	9

**E4.** How often do you eat fried foods?

Daily	.....	1
3-6 times per week	.....	2
1-2 times per week	.....	3
Less than once a week	.....	4
Never	.....	5
<b>Refused</b>	.....	8
<b>Don't know</b>	.....	9

**E5.** In the last 30 days, how many caffeinated beverages did you drink each day, each week, or over the month?

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	or	<input style="width: 100%; height: 20px;" type="text"/>
<b>per month</b>	<b>per week</b>		<b>per day</b>
<b>Refused</b> .....			
<b>Don't know</b> .....			

**E6.** In the last 30 days, how many alcoholic beverages (beer, wine or liquor) did you drink each day, each week or over the month?

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	or	<input style="width: 100%; height: 20px;" type="text"/>
<b>per month</b>	<b>per week</b>		<b>per day</b>
<b>Refused</b> .....			
<b>Don't know</b> .....			

**E7.** In the last 30 days, were there any days when you didn't eat or drink anything except water or other drinks without calories?

Yes	.....	1
No	.....	2
<b>Refused</b>	.....	8
<b>Don't know</b>	.....	9

**IF YES TO E7**

**E8.** How many days?

<input style="width: 100%; height: 20px;" type="text"/>	<b>No. of days</b>
<b>Refused</b> .....	
<b>Don't know</b> .....	

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DATA ENTRY INTL.: \_\_\_\_\_

**E9.** In any of the last 30 days, have you been on a diet?

- Yes ..... 1
- No ..... 2
- Refused** ..... 8
- Don't know** ..... 9

**IF YES TO E9**

**E9a.** In the last 30 days were you on any of the following types of diets?

**You can choose one or more than one category**

- Low calorie ..... 1
- Low fat ..... 2
- Low carbohydrate ..... 3
- Vegetarian ..... 4
- High protein like the Atkins Diet ..... 5
- Liquid diet like Slim Fast ..... 6
- Other (please specify) ..... 7

- Refused** ..... 8
- Don't know** ..... 9

**E10.** In the last 30 days, have you been taking diet pills for any reason?

- Yes ..... 1
- No ..... 2
- Refused** ..... 8
- Don't know** ..... 9

**IF YES TO E10**

**E11.** What type of diet pill did you take?

---

### F. WEIGHT QUESTIONS

**Now I am going to ask you about your weight.**

**F1.** Approximately what was your weight at age 20?

			lbs.
--	--	--	------

**F2.** Approximately what was your weight at age 30?

			lbs.
--	--	--	------

**F3.** What is your current weight?

			lbs.
--	--	--	------

**F4.** What was the most you ever weighed? Don't count pregnancy.

			lbs.
--	--	--	------

**F5.** What was the least you ever weighed since the age of 20?

			lbs.
--	--	--	------

# Fibroid Growth Study

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## Initial Telephone Questionnaire

DATA ENTRY INTL.: \_\_\_\_\_

- F6.** Over your lifetime, how many times have you lost 20 pounds or more and gained at least 20 pounds back?  
Don't count normal weight change related to pregnancy.

		# of times
--	--	------------

### G. SMOKING HISTORY

The next questions are about tobacco smoke.

- G1.** Have you ever smoked cigarettes on a regular basis?  
That is, have you ever smoked at least one cigarette a day for six months or more?  
**If NO go to section H**

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	(section H)	.....	8
<b>Don't know</b>	(section H)	.....	9

- G2.** At what age did you first start smoking cigarettes on a regular basis?

		Age
--	--	-----

- G3.** Do you currently smoke even one cigarette per day?

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	.....	.....	8
<b>Don't know</b>	.....	.....	9

#### IF YES TO G3

- G3a.** How many cigarettes per day?

		per day
--	--	---------

**NOTE: GO TO G4**

#### IF NO TO G3

- G3b.** How old were you when you quit?

		Age
--	--	-----

- G3c.** On average, how many cigarettes did you smoke per day?

		per day
--	--	---------

- G4.** How many years in total have you smoked, subtracting away any times when you quit?

		years
--	--	-------

### H. PREGNANCY HISTORY

The next section of the interview concerns your pregnancy history.

- H1.** Have you ever been pregnant?  
If answer is NO, clarify that pregnancy includes abortions, tublar pregnancies, molar pregnancies, still births, as well as live births.  
**If NO, go to section I**

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	(Section I)	.....	8
<b>Don't know</b>	(Section I)	.....	9

# Fibroid Growth Study

## Initial Telephone Questionnaire

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H2. How many deliveries have you had, including live births and still births?

--	--

Deliveries

If NONE, skip to section I  
 If at least ONE, go to H3

H3. When was the last time you gave birth?

--	--

Month Year

Write Month \_\_\_\_\_

Now I would like to find out more about your last delivery.

H4. How did your pregnancy end?

Live birth ..... 1  
 Still birth ..... 2  
 Multiple births ..... 3

**SPECIFY OUTCOME:**

--

REFUSED ..... 8  
 DON'T KNOW ..... 9

[IF STILLBORN, GO TO SECTION I]

H5. Was this baby born early, late or on time?

Early ..... 1  
 Late ..... 2  
 On Time ..... 3  
 Refused ..... 8  
 Don't know ..... 9

**IF EARLY OR LATE**

H6. How many weeks (early/late?)

--	--

# of weeks

H7. Did you have a C-section rather than a vaginal delivery?

Yes ..... 1  
 No ..... 2  
 Refused ..... 8  
 Don't know ..... 9

**IF YES TO H7**

H8. Was the C-section done after or before you started labor?

After ..... 1  
 Before ..... 2  
 Refused ..... 8  
 Don't know ..... 9

# Fibroid Growth Study

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## Initial Telephone Questionnaire

DATA ENTRY INTL.: \_\_\_\_\_

- H9.** Was labor induced?
- |                   |       |       |   |
|-------------------|-------|-------|---|
| Yes               | ..... | ..... | 1 |
| No                | ..... | ..... | 2 |
| <b>Refused</b>    | ..... | ..... | 8 |
| <b>Don't know</b> | ..... | ..... | 9 |
- H10.** Were you given anything to make your contractions stronger?
- |                   |       |       |   |
|-------------------|-------|-------|---|
| Yes               | ..... | ..... | 1 |
| No                | ..... | ..... | 2 |
| <b>Refused</b>    | ..... | ..... | 8 |
| <b>Don't know</b> | ..... | ..... | 9 |
- H11.** Did you breastfeed this baby?
- |                   |       |       |   |
|-------------------|-------|-------|---|
| Yes               | ..... | ..... | 1 |
| No                | ..... | ..... | 2 |
| <b>Refused</b>    | ..... | ..... | 8 |
| <b>Don't know</b> | ..... | ..... | 9 |

**IF YES TO H11**

**H12.** How many months did you breastfeed this baby?  
 By breastfeeding we mean nursing at least twice  
 in a 24-hour period.

--	--

# Months

### I. MENSTRUATION

**The next questions are about menstrual periods.**

**I1.** What was the beginning date of your most recent menstrual period? Please check your calendar. Take your time and be as accurate as possible.

--	--	--

Month Day Year

WRITE MONTH \_\_\_\_\_

**If the participant is currently having a period, also record the beginning date of the current period:**

--	--	--

Month Day Year

WRITE MONTH \_\_\_\_\_

**I2. IF LESS THAN TWO MONTHS SINCE MOST RECENT PERIOD CHECK HERE  AND SKIP TO I4.**

**I3.** Are there reasons that you know of why you have not had menstrual period since [MONTH and YEAR from I1(if different from this year)]?

---



---



---



---

**I4.** Thinking of your most recent period, how many days of bleeding did you have (don't count spotting)?

--	--

# of days

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DATA ENTRY INTL.: \_\_\_\_\_

15. On the days of the heaviest bleeding, how many pads and tampons did you need during 24 hours? **(Add pads and tampons together, but not panty liners).**

--	--

# of pads+tampons/day

16. Do you use high absorbency pads or tampons on these days?

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	.....	.....	8
<b>Don't know</b>	.....	.....	9

17. Are there additional methods that you need to use for bleeding, such as towels, Depends or cups?

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	.....	.....	8
<b>Don't know</b>	.....	.....	9

**Now I have a question about spotting, very light bleeding-just spots of blood rather than real blood flow.**

18. At the time of your last period, how many days of spotting, if any, did you have (READ CATEGORIES):

--	--

Just before real blood flow?

--	--

Just after real blood flow ended?

19. Thinking about the last 6 months, how often are you having menstrual periods? That is, how many days are there between the start of one period to the start of the next period?

--	--

# of days

OR

**If less than 20 days, probe:**

Was that the number of days between the start of one bleeding period to the start of the next bleeding period?

Too irregular to say	.....	.....	1
----------------------	-------	-------	---

110. Did you have times when you had heavy, gushing type bleeding that was too much for your pads or tampons, even when changed frequently?

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	.....	.....	8
<b>Don't know</b>	.....	.....	9

111. During the last 6 months, have you passed blood clots that were larger than a tablespoon?

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	.....	.....	8
<b>Don't know</b>	.....	.....	9

**The next questions are about menopausal symptoms.**

112. Has a health professional ever told you that you had perimenopausal or menopausal symptoms?

Yes	.....	.....	1
No	.....	.....	2
<b>Refused</b>	.....	.....	8
<b>Don't know</b>	.....	.....	9

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DATA ENTRY INTL.: \_\_\_\_\_

- I13.** During the last 30 days, did you have hot flashes?
- |                   |       |          |
|-------------------|-------|----------|
| Yes               | ..... | 1        |
| No                | ..... | 2        |
| <b>Refused</b>    | ..... | <b>8</b> |
| <b>Don't know</b> | ..... | <b>9</b> |
- I14.** During the last 30 days, did you have night sweats?
- |                   |       |          |
|-------------------|-------|----------|
| Yes               | ..... | 1        |
| No                | ..... | 2        |
| <b>Refused</b>    | ..... | <b>8</b> |
| <b>Don't know</b> | ..... | <b>9</b> |

### J. SEXUAL AND CONTRACEPTIVE HISTORY

**Now I am going to ask you about sexual activity.**

- J1.** In the last 30 days, how many times did you have orgasms, either with sexual intercourse or other than with sexual intercourse?

--	--

**88=REFUSED**  
**99=DON'T KNOW**

- J2.** In the last 30 days, how frequently did you experience pain deep inside during sex?
- |                      |       |          |
|----------------------|-------|----------|
| Most or all the time | ..... | 1        |
| Some of the time     | ..... | 2        |
| A little of the time | ..... | 3        |
| None of the time     | ..... | 4        |
| Not having sex       | ..... | 5        |
| <b>Refused</b>       | ..... | <b>8</b> |
| <b>Don't know</b>    | ..... | <b>9</b> |

**The next questions are about vaginal dryness and birth control pills.**

- J3.** In the last 30 days how frequently did you experience vaginal dryness?  
**(READ FIRST 4 CATEGORIES TO PATIENT)**
- |                      |       |          |
|----------------------|-------|----------|
| Most or all the time | ..... | 1        |
| Some of the time     | ..... | 2        |
| A little of the time | ..... | 3        |
| None of the time     | ..... | 4        |
| <b>Refused</b>       | ..... | <b>8</b> |
| <b>Don't know</b>    | ..... | <b>9</b> |

- J4.** Have you ever used birth control pills?  
 This also includes "progesterone only" pills ("POP")
- |                   |       |          |
|-------------------|-------|----------|
| Yes               | ..... | 1        |
| No                | ..... | 2        |
| <b>Refused</b>    | ..... | <b>8</b> |
| <b>Don't know</b> | ..... | <b>9</b> |

**[IF YES]**

- J5.** Do you currently take birth control pills?
- |                   |       |          |
|-------------------|-------|----------|
| Yes               | ..... | 1        |
| No                | ..... | 2        |
| <b>Refused</b>    | ..... | <b>8</b> |
| <b>Don't know</b> | ..... | <b>9</b> |

- J6.** What type of birth control pills are you taking?

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## Initial Telephone Questionnaire

DATA ENTRY INTL.: \_\_\_\_\_

<b>J7.</b>	What is the reason for taking them? (READ CATEGORIES)	Contraception	.....	1
		Regulating your period	.....	2
		Menopausal symptoms	.....	3
		Other reasons	.....	4
		<b>Refused</b>	.....	8
		<b>Don't know</b>	.....	9
<b>J8.</b>	Have you ever had Norplant, small rods with hormone inserted under your skin?	Yes	.....	1
		No	.....	2
		<b>Refused</b>	.....	8
		<b>Don't know</b>	.....	9
	<b>[IF YES]</b>			
<b>J9.</b>	Are you still using Norplant?	Yes	.....	1
		No	.....	2
		<b>Refused</b>	.....	8
		<b>Don't know</b>	.....	9
<b>J10.</b>	Have you ever had injectables like Depo-Provera?	Yes	.....	1
		No	.....	2
		<b>Refused</b>	.....	8
		<b>Don't know</b>	.....	9
	<b>[IF YES]</b>			
<b>J11.</b>	Are you still using injectables like Depo-Provera?	Yes	.....	1
		No	.....	2
		<b>Refused</b>	.....	8
		<b>Don't know</b>	.....	9
<b>J12.</b>	Did you ever take any medication or hormone including shots, to help in getting pregnant? This might have been Clomid, Pergonal, hCG, Bromocriptine or other drugs.	Yes	.....	1
		No	.....	2
		<b>Refused</b>	.....	8
		<b>Don't know</b>	.....	9
<b>J13.</b>	Have you used progesterone cream in the last 30 days?	Yes	.....	1
		No	.....	2
		<b>Refused</b>	.....	8
		<b>Don't know</b>	.....	9
	<b>[IF YES]</b>			
<b>J14.</b>	What dosage did you use?			
<b>J15.</b>	Do you take hormone replacement therapy (HRT) such as Premerin or Prempro?	Yes	.....	1
		No	.....	2
		<b>Refused</b>	.....	8
		<b>Don't know</b>	.....	9

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DATA ENTRY INTL.: \_\_\_\_\_

- |  |                   |       |       |          |
|--|-------------------|-------|-------|----------|
| <b>J16.</b> Are there other hormone medications for any conditions such as infertility, endometriosis or polycystic ovary disease that you have taken or are taking now? | Yes               | ..... | ..... | <b>1</b> |
|  | No                | ..... | ..... | <b>2</b> |
|  | <b>Refused</b>    | ..... | ..... | <b>8</b> |
|  | <b>Don't know</b> | ..... | ..... | <b>9</b> |

**[IF YES]**

**J17.** What type?

### **K. STRESS**

**Now I am going to ask about stress. These are multiple choice questions.**

- |  |                      |       |       |          |
|--|----------------------|-------|-------|----------|
| <b>K1.</b> In the last 30 days, how hard was it for your family to pay for basic expenses like food, clothing, shelter, medical care and transportation? | No Problem           | ..... | ..... | <b>1</b> |
|  | Sometimes Difficult  | ..... | ..... | <b>2</b> |
|  | Moderately Difficult | ..... | ..... | <b>3</b> |
|  | Very Difficult       | ..... | ..... | <b>4</b> |
|  | <b>Refused</b>       | ..... | ..... | <b>8</b> |
|  | <b>Don't know</b>    | ..... | ..... | <b>9</b> |
| <b>K2.</b> In the last 30 days, how often did you forget to do important things?   | Always               | ..... | ..... | <b>1</b> |
|  | A lot                | ..... | ..... | <b>2</b> |
|  | Some                 | ..... | ..... | <b>3</b> |
|  | Rarely or never      | ..... | ..... | <b>4</b> |
|  | <b>Refused</b>       | ..... | ..... | <b>8</b> |
|  | <b>Don't know</b>    | ..... | ..... | <b>9</b> |
| <b>K3.</b> In the last 30 days, how often did you feel like you had more to do than you could get done?  | Always               | ..... | ..... | <b>1</b> |
|  | A lot                | ..... | ..... | <b>2</b> |
|  | Some                 | ..... | ..... | <b>3</b> |
|  | Rarely or never      | ..... | ..... | <b>4</b> |
|  | <b>Refused</b>       | ..... | ..... | <b>8</b> |
|  | <b>Don't know</b>    | ..... | ..... | <b>9</b> |
| <b>K4.</b> In the last 30 days, how often did you feel like you were at your limit, like you couldn't handle another thing?                              | Always               | ..... | ..... | <b>1</b> |
|  | A lot                | ..... | ..... | <b>2</b> |
|  | Some                 | ..... | ..... | <b>3</b> |
|  | Rarely or never      | ..... | ..... | <b>4</b> |
|  | <b>Refused</b>       | ..... | ..... | <b>8</b> |
|  | <b>Don't know</b>    | ..... | ..... | <b>9</b> |
| <b>K5.</b> In the last 30 days, how often did you feel like important issues in your life were not under control?  | Always               | ..... | ..... | <b>1</b> |
|  | A lot                | ..... | ..... | <b>2</b> |
|  | Some                 | ..... | ..... | <b>3</b> |
|  | Rarely or never      | ..... | ..... | <b>4</b> |
|  | <b>Refused</b>       | ..... | ..... | <b>8</b> |
|  | <b>Don't know</b>    | ..... | ..... | <b>9</b> |

# Fibroid Growth Study

FGS \_\_\_\_\_  
 FGS FORM 100  
 VERSION: 051603

## Initial Telephone Questionnaire

DATA ENTRY INTL.: \_\_\_\_\_

**Now, please think about the two or three most stressful things in your life. Have these things in mind when answering the next three questions.**

- |  |   |        |       |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
|--|---|--------|-------|-------|---|-------|-------|-------|---|------|-------|-------|---|-----------------|-------|-------|---|----------------|-------|-------|---|-------------------|-------|-------|---|
| <p><b>K6.</b> In the last 30 days, how often did you think about these things when you didn't want to?</p>           | <table style="width: 100%; border-collapse: collapse;"> <tr><td>Always</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>A lot</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td>Some</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">3</td></tr> <tr><td>Rarely or never</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">4</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table> | Always | ..... | ..... | 1 | A lot | ..... | ..... | 2 | Some | ..... | ..... | 3 | Rarely or never | ..... | ..... | 4 | <b>Refused</b> | ..... | ..... | 8 | <b>Don't know</b> | ..... | ..... | 9 |
| Always   | .....   | .....  | 1     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| A lot  | .....   | .....  | 2     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| Some   | .....   | .....  | 3     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| Rarely or never  | .....   | .....  | 4     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| <b>Refused</b>   | .....   | .....  | 8     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| <b>Don't know</b>  | .....   | .....  | 9     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| <p><b>K7.</b> In the last 30 days, how often did you try to avoid letting yourself get upset about these things?</p> | <table style="width: 100%; border-collapse: collapse;"> <tr><td>Always</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>A lot</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td>Some</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">3</td></tr> <tr><td>Rarely or never</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">4</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table> | Always | ..... | ..... | 1 | A lot | ..... | ..... | 2 | Some | ..... | ..... | 3 | Rarely or never | ..... | ..... | 4 | <b>Refused</b> | ..... | ..... | 8 | <b>Don't know</b> | ..... | ..... | 9 |
| Always   | .....   | .....  | 1     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| A lot  | .....   | .....  | 2     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| Some   | .....   | .....  | 3     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| Rarely or never  | .....   | .....  | 4     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| <b>Refused</b>   | .....   | .....  | 8     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| <b>Don't know</b>  | .....   | .....  | 9     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| <p><b>K8.</b> In the last 30 days, how often did you have trouble falling asleep because of these things?</p>        | <table style="width: 100%; border-collapse: collapse;"> <tr><td>Always</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">1</td></tr> <tr><td>A lot</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">2</td></tr> <tr><td>Some</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">3</td></tr> <tr><td>Rarely or never</td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">4</td></tr> <tr><td><b>Refused</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">8</td></tr> <tr><td><b>Don't know</b></td><td style="text-align: right;">.....</td><td style="text-align: right;">.....</td><td style="text-align: right;">9</td></tr> </table> | Always | ..... | ..... | 1 | A lot | ..... | ..... | 2 | Some | ..... | ..... | 3 | Rarely or never | ..... | ..... | 4 | <b>Refused</b> | ..... | ..... | 8 | <b>Don't know</b> | ..... | ..... | 9 |
| Always   | .....   | .....  | 1     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| A lot  | .....   | .....  | 2     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| Some   | .....   | .....  | 3     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| Rarely or never  | .....   | .....  | 4     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| <b>Refused</b>   | .....   | .....  | 8     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |
| <b>Don't know</b>  | .....   | .....  | 9     |       |   |       |       |       |   |      |       |       |   |                 |       |       |   |                |       |       |   |                   |       |       |   |

### L. ETHNICITY, EDUCATION & INCOME

**L1.** What is your current age?

**AGE:** \_\_\_\_\_

**L2.** What is your date of birth?

Month	Day	Year

**L3.** Which category best describes your racial heritage?  
**(YOU CAN CHOOSE MORE THAN ONE)**

- |                            |        |  |       |   |
|----------------------------|--------|--|-------|---|
| American Indian or Alaskan |        |  | ..... | 1 |
|                            | Native |  | ..... | 2 |
| Asian or Pacific Islander  |        |  | ..... | 3 |
| Black                      |        |  | ..... | 4 |
| White                      |        |  | ..... | 5 |
| Other                      |        |  | ..... | 6 |
| <b>Specify:</b>            |        |  |       |   |
| <b>Refused</b>             |        |  | ..... | 8 |
| <b>Don't know</b>          |        |  | ..... | 9 |

**L4.** Which category best describes your ethnicity?

- |                        |  |  |       |   |
|------------------------|--|--|-------|---|
| Hispanic Origin        |  |  | ..... | 1 |
| Not of Hispanic Origin |  |  | ..... | 2 |
| <b>Refused</b>         |  |  | ..... | 8 |
| <b>Don't know</b>      |  |  | ..... | 9 |

# Fibroid Growth Study

FGS \_\_\_\_\_  
**FGS FORM 100**  
**VERSION: 051603**

Initial Telephone Questionnaire      **DATA ENTRY INTL.:** \_\_\_\_\_

**L5.** What is your highest level of education?

Less than high school	.....	1
High school degree	.....	2
Some college or some tech beyond high school	.....	3
College degree	.....	4
College plus additional training but no other degree	.....	5
Post-graduate degree such as master's, Ph. D., MD or other	.....	6

**L6.** Including income provided by you, your husband or any other person in your household, which range of incomes comes closest to your total household income before taxes for the past year?

LESS THAN \$40,000	.....	1
BETWEEN \$40,000 AND \$60,000	.....	2
BETWEEN \$60,000 AND \$100,000	.....	3
MORE THAN \$100,000	.....	4

**L7.** How many people, including yourself, were supported by this income for the last year?

# PERSONS	

**L8.** Are you currently [READ CATEGORIES]

SINGLE, NEVER MARRIED	.....	1
MARRIED, OR LIVING WITH SOMEONE AS MARRIED	.....	2
WIDOWED	.....	3
SEPARATED OR DIVORCED	.....	4

**L9.** During the last year, have you ever been without health insurance for a month or longer?

YES	.....	1
NO	.....	2
DON'T KNOW	.....	3

**L10.** Do you have health insurance now, including Medicare or Medicaid, or coverage by someone else in your family?

YES	.....	1
NO	.....	2
DON'T KNOW	.....	3

**[IF YES to L10.]**

**L11.** Which of the following types of insurance do you have now? [READ CATEGORIES]

public insurance (Medicare, or Medicaid)	.....	1
other insurance	.....	2
REFUSED	.....	3
DON'T KNOW	.....	4

**L12.** If you were unable to work for a month because of a medical problem, do you have sick leave or disability that would cover you during that time, or would you lose your income during such a time?

COVERED	.....	1
SOME LOSS OF INCOME	.....	2
LOSE ALL OR MOST OF INCOME	.....	3
NOT CURRENTLY WORKING FOR INCOME	.....	4

**Time End:**        :        AM PM

# Fibroid Growth Study

Initial Telephone Questionnaire

FGS \_\_\_\_\_  
FGS FORM 100  
VERSION: 051603  
DATA ENTRY INTL.: \_\_\_\_\_

## M. CLOSING REMARKS

The interview is now complete. Thank you very much for your time and effort. The information you provided will be very helpful in understanding fibroid growth. These updates will take about 15 minutes. We will continue calling monthly to find out about your symptoms and lifestyle then. Last time you indicated that \_\_\_\_\_ was convenient for you. Is that still the best time to reach you?

I would like to ask one more question before we end the call.

How did you hear about the Fibroid Growth Study?

Physician/Nurse ..... 1

Name: \_\_\_\_\_

Website ..... 2

Bookmark ..... 3

Radio ..... 4

Word of mouth ..... 5

Other ..... 6

Specify: \_\_\_\_\_

Thanks again. An interviewer will be calling you on (restate date and time). Do you have any questions before we end this call?

[If there are questions, respond to those as instructed in the interview procedure manual or as you were taught in the interview training.]

If no questions or after all questions are answered, "Goodbye/"

## N. INTERVIEWER'S REMARKS

N1. Respondent's cooperation was:

Very Good ..... 1

Good ..... 2

Fair ..... 3

Poor ..... 4

N2. The overall quality of this interview was:

Unsatisfactory ..... 1

Questionable ..... 2

Generally Reliable ..... 3

High Quality ..... 4

# Fibroid Growth Study

Initial Telephone Questionnaire

FGS \_\_\_\_\_  
 FGS FORM 100  
 VERSION: 051603  
 DATA ENTRY INTL.: \_\_\_\_\_

**N3.** Place a check for any section for which the quality of the interview was particularly unsatisfactory or questionable

		Unsatisfactory		Questionable	
<b>SECTION B.</b>	<b>Occupational Data</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION C.</b>	<b>Medical History</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION D.</b>	<b>Physical Activity</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION E.</b>	<b>Diet</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION F.</b>	<b>Weight Questions</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION G.</b>	<b>Smoking History</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION H.</b>	<b>Pregnancy History</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION I.</b>	<b>Menstruation</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION J.</b>	<b>Sexual and Contraceptive History</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION K.</b>	<b>Stress</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SECTION L.</b>	<b>Ethnicity, Education and Income</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**N4. Comments**

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