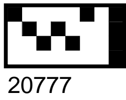
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UNC Alumni Heart Study Questionnaire 12

Study ID#

1. Health Status Updates: Please update us on any new conditions or procedures. You do not need to repeat information on a condition or procedure that you know you have reported previously unless there has been a change.

A. Cardiovascular Disease/Conditions/Procedures:

Have you ever been diagnosed with:		*When? (mo./yr.)*	*Have you ever had any of the following procedures:*		*When? (mo./yr.)*
Heart Attack	○ Yes	____ / ____	**Cardiac Catheterization (Angiography)**	○ Yes	____ / ____
Coronary Artery Disease (blocked arteries)	○ Yes	____ / ____	**Coronary Procedures for treatment: e.g., Angioplasty (PTCA), Bypass surgery (CABG), Atherectomy**	○ Yes	
Stroke	○ Yes	____ / ____	Procedure: ____________________		____ / ____
			Procedure: ____________________		____ / ____

May we obtain copies of your medical records for the above?
Obtaining medical records is a very important part of our research.

Please sign the consent form on the cover of the Questionnaire and fill in the following:

Name of Hospital where you were treated/diagnosed: ______________________________

Your Doctor's Name: ______________________________

Hospital Address: ______________________________
____

Doctor's Address: ______________________________
____

B. Cancer:

Have you ever been diagnosed with:		*When? (mo./yr.)*	*Have you ever been diagnosed with:*		*When? (mo./yr.)*
Breast cancer	○ Yes	____ / ____	**Colon or rectal cancer**	○ Yes	____ / ____
Prostate cancer	○ Yes	____ / ____	**Melanoma**	○ Yes	
Skin cancer (basal cell cancer)	○ Yes		Site: ____________________		____ / ____
Site: ____________________		____ / ____	Site: ____________________		____ / ____
Site: ____________________		____ / ____	**Other cancer**	○ Yes	
Site: ____________________		____ / ____	*Type/Site:* ____________________		____ / ____
			Type/Site: ____________________		____ / ____

C. Other Conditions:

Have you ever been diagnosed with:		*When? (mo./yr.)*	*Do you take medication for this condition?*	*Please list name and dosage:*
Hypertension	○ Yes	____ / ____	○ Yes	
High Cholesterol	○ Yes	____ / ____	○ Yes	
Depression	○ Yes	____ / ____	○ Yes	
Anxiety	○ Yes	____ / ____	○ Yes	
Memory Loss/ Alzheimer's Disease	○ Yes	____ / ____	○ Yes	
Diabetes	○ Yes	Age diagnosed: ☐☐ age	○ Oral medication ○ Insulin injections ○ Both oral and injections	Age began insulin injections: ☐☐ age

2. How would you rate:

your current health?	○ Excellent	○ Good	○ Fair	○ Poor
your memory?	○ Excellent	○ Good	○ Fair	○ Poor
your ability to cope with stress?	○ Excellent	○ Good	○ Fair	○ Poor
your current financial well-being?	○ Excellent	○ Good	○ Fair	○ Poor
the support you receive from persons close to you?	○ Excellent	○ Good	○ Fair	○ Poor

3. What is your current weight?

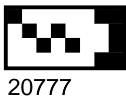
pounds ☐☐☐

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

4. What is your current height?

- ○ 4 feet
- ○ 5 feet
- ○ 6 feet

- ○ 0 inches
- ○ 1 inch
- ○ 2 inches
- ○ 3 inches
- ○ 4 inches
- ○ 5 inches
- ○ 6 inches
- ○ 7 inches
- ○ 8 inches
- ○ 9 inches
- ○ 10 inches
- ○ 11 inches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5. MARITAL HISTORY: We would like as complete a picture as possible of your marital history. Please answer the following from your current (or most recent) marriage or equivalent relationship to your earliest one.

A. What is your current marital status?

- ○ Married
- ○ Living with partner as married
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Single, never married (skip to next page)

Is your current spouse/partner also a member of the study?

- ○ Yes
- ○ No
- ○ No, but a former spouse was/is
- ○ Not applicable

If you are currently married or living with a partner, how many years have you been in this relationship? If you are currently divorced, separated or widowed, how many years were you in your last relationship?

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

B. Going back in time, how did your next most recent marriage (or equivalent relationship) end?

- ○ Not applicable
- ○ Divorced/Separated
- ○ Widowed

How many years were you in this former relationship?

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

C. Going back in time, how did your next most recent marriage (or equivalent relationship) end?

- ○ Not applicable
- ○ Divorced/Separated
- ○ Widowed

How many years were you in this former relationship?

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

D. Going back in time, how did your next most recent marriage (or equivalent relationship) end?

- ○ Not applicable
- ○ Divorced/Separated
- ○ Widowed

How many years were you in this former relationship?

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

○ **If you have been married (or in an equivalent relationship) more than 4 times, please write in similar answers below. Also, if you have any comments, please feel free to add them as well.**

6. **Sleep: Please answer the following questions about your sleep.**

How many hours of actual sleep do you get at night (this may be different than the number of hours you spend in bed)?

In general: ○ Greater than 7 ○ 6 to 7 ○ 5 to 6 ○ less than 5

For the past month: ○ Greater than 7 ○ 6 to 7 ○ 5 to 6 ○ less than 5

How would you rate your sleep?

In general: ○ Very good ○ Fairly good ○ Fairly bad ○ Very bad

For the past month: ○ Very good ○ Fairly good ○ Fairly bad ○ Very bad

How often do you have trouble falling asleep?

In general: ○ Most of the time ○ Rarely ○ Never

For the past month: ○ Most of the time ○ Rarely ○ Never

How often do you have trouble with waking during the night?

In general: ○ Most of the time ○ Rarely ○ Never

For the past month: ○ Most of the time ○ Rarely ○ Never

How often do you have trouble with waking too early?

In general: ○ Most of the time ○ Rarely ○ Never

For the past month: ○ Most of the time ○ Rarely ○ Never

Is your sleep restless?

In general: ○ Yes ○ No

For the past month: ○ Yes ○ No

Are you usually sleepy during the daytime?

In general: ○ Yes ○ No

For the past month: ○ Yes ○ No

If you reported any sleep problem, is this a new or chronic problem for you?

○ New ○ Chronic ○ No sleep problems (skip to next page)

Is the sleep disturbance related to any specific event (surgery, loss of a loved one, etc.)?

○ Yes ○ No

If yes, please describe:

Do you (or have you) taken any sleep aids to help with this problem?

○ Yes ○ No

If yes, please list:

7. Happiness: Please answer the following questions about your happiness using the scale that follows each.

In general, I consider myself:	Not a very happy person						A very happy person
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Compared to most of my peers, I consider myself:	Less happy						More happy
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Some people are generally very happy. They enjoy life regardless of what is going on, getting the most out of everything. To what extent does this characterization describe you?	Not at all						A great deal
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
Some people are generally not very happy. Although they are not depressed, they never seem as happy as they might be. To what extent does this characterization describe you?	Not at all						A great deal
	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

The next eight pages of Questionnaire 12 will deal with Post Traumatic Stress Disorder (PTSD). These pages were designed by Dr. Siegler and Dr. David Rubin, a co-investigator of the UNCAHS.

First, a quick note on the PTSD pages from Dr. Rubin:

Dr Siegler and I have been talking about investigating PTSD with the UNC Heart Study for about a decade. Since the study began, you have recorded many aspects of your health and personality. By adding a history of the traumatic or stressful events that have occurred during your lives, and by asking which, if any, symptoms of PTSD you now have, we hope to answer the following questions:

First, and of central interest to the original goals of the study, we can examine the impact of stressful events on health. Environment plays an increasingly important role in formulating theory about health outcomes. Using a standardized measure of negative events, as well as noting when those events occurred, is a good first step in adding environmental measures to existing information, to be used to study impact on health. Some of the wording may seem odd, but that is the result of using a standard version of the questions.

Second, everyone has more or less negative things happen, but only some people get PTSD symptoms. By taking an inventory of PTSD symptoms now in your life, we can look at the interplay of negative events, health, and personality measures over the course of your lifetime. Such data are extremely hard to find. Typically, PTSD studies are done on people who have had a trauma and are seeking help. Therefore all measures of personality and health are retrospective. You in the UNC Alumni Heart Study have been providing this data over a long time and it is not subject to recall as in retrospective studies.

Thus we include on the following pages the Traumatic Life Events Questionnaire. Included in this Questionnaire are a standard inventory of PTSD symptoms and a section on how central a trauma has become to your life, as well as questions regarding a positive event for comparison.

Traumatic Life Events Questionnaire

The purpose of this questionnaire is to identify important life experiences that can affect a person's emotional well-being or later quality of life. The events listed are far more common than many realize. Please read each question carefully and mark the answers that best describe your experience.

At the end, you will be asked to indicate which of these events most bothers you now.

If an event happened more than once, please answer for the most severe instance.

1. Have you ever experienced a natural disaster for which you received medical attention or that badly injured or killed someone (a flood, hurricane, earthquake, etc.)?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

2. Have you ever been involved in a motor vehicle accident for which you received medical attention or that badly injured or killed someone?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

3. Have you been involved in any other kind of accident where you or someone else was badly hurt? (examples: a plane crash, a drowning or near drowning, an electrical or machinery accident, an explosion, home fire, chemical leak, overexposure to radiation or toxic chemicals)

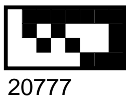
- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

1 ① ①
2 ② ②
3 ③ ③
4 ④ ④
5 ⑤ ⑤
6 ⑥ ⑥
7 ⑦ ⑦
8 ⑧ ⑧
9 ⑨ ⑨
0 ⓪ ⓪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UNC Alumni Heart Study Questionnaire 12

Study ID#

If an event happened more than once, please tell us about the most severe instance.

4. Have you ever been exposed to warfare or combat? (for example: in the vicinity of a rocket attack or people being fired upon; seeing someone wounded or killed)

○ No, never (skip to next question)
○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
○ Yes, 4 times ○ Yes, 5 times
○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

6. Has a loved one ever survived a life threatening or permanently disabling accident, assault, or illness? (examples: spinal cord injury, rape, cancer, serious heart condition, life threatening virus)

○ No, never (skip to next question)
○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
○ Yes, 4 times ○ Yes, 5 times
○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

5. Have you experienced the sudden and unexpected death of a close friend or loved one?

○ No, never (skip to next question)
○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
○ Yes, 4 times ○ Yes, 5 times
○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

7. Have you ever had a life threatening illness?

○ No, never (skip to next question)
○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
○ Yes, 4 times ○ Yes, 5 times
○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

If an event happened more than once, please tell us about the most severe instance.

8. Have you been robbed or been present during a robbery--where the robber(s) used or displayed a weapon?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

9. Have you ever been hit or beaten up and badly hurt by a stranger or by someone you didn't know very well?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

10. Have you seen a stranger (or someone you didn't know very well) attack or beat up someone and seriously injure or kill them?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

11. Has anyone threatened to kill you or cause you serious physical harm?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

If an event happened more than once, please tell us about the most severe instance.

12. While growing up: Were you physically punished in a way that resulted in bruises, burns, cuts, or broken bones?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

13. While growing up: Did you see or hear family violence? (such as your father hitting your mother; or any family member beating up or inflicting bruises, burns or cuts on another family member)

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

14. Have you ever been slapped, punched, kicked, beaten up, or otherwise physically hurt by your spouse (or former spouse), a boyfriend/girlfriend, or some other intimate partner?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

15. Did anyone touch sexual parts of your body or make you touch sexual parts of their body - against your will or without your consent?

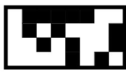
- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

1	①	①
2	②	②
3	③	③
4	④	④
5	⑤	⑤
6	⑥	⑥
7	⑦	⑦
8	⑧	⑧
9	⑨	⑨
0	⓪	⓪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If an event happened more than once, please tell us about the most severe instance.

16. Has anyone stalked you - in other words: followed you or kept track of your activities - causing you to feel intimidated or concerned for your safety?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

17. Have you or a romantic partner ever had a pregnancy that did not end in a live birth?

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

18. Have you experienced (or seen) any other events that were life threatening, caused serious injury, or were highly disturbing or distressing? (examples: lost in the wilderness; a serious animal bite; violent death of a pet; being kidnapped or held hostage; seeing a mutilated body or body parts)

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

19. Have you had any experiences like these that you feel you can't tell about? (note: you don't have to describe the event)

- ○ No, never (skip to next question)
- ○ Yes, once ○ Yes, 2 times ○ Yes, 3 times
- ○ Yes, 4 times ○ Yes, 5 times
- ○ Yes, more than 5 times

Did this event involve actual or threatened death, serious injury, or threat to the physical integrity of yourself or others? ○ Yes ○ No

Did you experience intense fear, helplessness, or horror when it happened? ○ Yes ○ No

Your age at the time: (Please write age and darken circles below)

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

20. Which of the preceding 19 events bothers you the most now?

- ○ 1. ...natural disaster...
- ○ 2. ...motor vehicle accident...
- ○ 3. ...other kind of accident...
- ○ 4. ...warfare or combat...
- ○ 5. ...unexpected death...
- ○ 6. ...loved one survived...
- ○ 7. ...life threatening illness...
- ○ 8. ...robbery...
- ○ 9. ...beaten up...
- ○ 10. ...stranger attack...
- ○ 11. ...threatened to kill...
- ○ 12. ...physically punished...
- ○ 13. ...family violence...
- ○ 14. ...hurt by spouse...
- ○ 15. ...touch sexual parts...
- ○ 16. ...stalked you...
- ○ 17. ...pregnancy...
- ○ 18. ...any other events...
- ○ 19. ...can't tell about...

21. Please answer the following in an honest and sincere way about the event you chose in the last question. Mark the circle that represents your level of agreement with each statement.

	Totally disagree				*Totally agree*
1. I feel that this event has become part of my identity.	○ 1	○ 2	○ 3	○ 4	○ 5
2. This event has become a reference point for the way I understand myself and the world.	○ 1	○ 2	○ 3	○ 4	○ 5
3. I feel that this event has become a central part of my life story.	○ 1	○ 2	○ 3	○ 4	○ 5
4. This event has colored the way I think and feel about other experiences.	○ 1	○ 2	○ 3	○ 4	○ 5
5. This event permanently changed my life.	○ 1	○ 2	○ 3	○ 4	○ 5
6. I often think about the effects this event will have on my future.	○ 1	○ 2	○ 3	○ 4	○ 5
7. This event was a turning point in my life.	○ 1	○ 2	○ 3	○ 4	○ 5

22. Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. For the event that you indicated previously bothers you the most, please read each statement carefully, then fill in the circle to the right that indicates how much you have been bothered by that problem <u>in the past month</u>.

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing memories, thoughts, or images of the event?	○	○	○	○	○
2. Repeated, disturbing dreams of the event?	○	○	○	○	○
3. Suddenly acting or feeling as if the event were happening again (as if you were reliving it)?	○	○	○	○	○
4. Feeling very upset when something reminded you of the event?	○	○	○	○	○
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the event?	○	○	○	○	○
6. Avoiding thinking about or talking about the event or avoiding having feelings related to it?	○	○	○	○	○
7. Avoiding activities or situations because they reminded you of the event?	○	○	○	○	○
8. Trouble remembering important parts of the event?	○	○	○	○	○
9. Loss of interest in activities that you used to enjoy?	○	○	○	○	○
10. Feeling distant or cut off from other people?	○	○	○	○	○
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	○	○	○	○	○
12. Feeling as if your future somehow will be cut short?	○	○	○	○	○
13. Trouble falling or staying asleep?	○	○	○	○	○
14. Feeling irritable or having angry outbursts?	○	○	○	○	○
15. Having difficulty concentrating?	○	○	○	○	○
16. Being "superalert" or watchful or on guard?	○	○	○	○	○
17. Feeling jumpy or easily startled?	○	○	○	○	○

23. Please think back upon the most positive event in your life, the one that brings you the most pride or happiness now. By event, we mean something that occurred within a single day.

Please describe the event in a sentence or two:

Your age at the time: (Please write age and darken circles below)

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

Please answer the following questions in an honest and sincere way.

	Totally disagree				*Totally agree*
1. I feel that this event has become part of my identity.	○ 1	○ 2	○ 3	○ 4	○ 5
2. This event has become a reference point for the way I understand myself and the world.	○ 1	○ 2	○ 3	○ 4	○ 5
3. I feel that this event has become a central part of my life story.	○ 1	○ 2	○ 3	○ 4	○ 5
4. This event has colored the way I think and feel about other experiences.	○ 1	○ 2	○ 3	○ 4	○ 5
5. This event permanently changed my life.	○ 1	○ 2	○ 3	○ 4	○ 5
6. I often think about the effects this event will have on my future.	○ 1	○ 2	○ 3	○ 4	○ 5
7. This event was a turning point in my life.	○ 1	○ 2	○ 3	○ 4	○ 5

As we consider what the UNCAHS will look like in the next 5 years, we are thinking about additional studies that may involve follow-up of individuals who have experienced certain events and/or are interested in specific topics.

EATING DISORDERS:

Many individuals struggle with concerns about weight and shape. For some, these concerns interfere with daily functioning.

Have you ever used any of the following to lose weight (mark all that apply)?
○ Vomiting ○ Fasting ○ Laxatives
○ Excessive physical exercise

If yes, did you do it/them:
○ Rarely ○ At least one time a month ○ At least one time a week

Is your weight the most important thing to your self image?
○ Not really ○ Yes, often ○ Yes, occasionally

Would you be willing to be contacted about a study of eating issues, if any?
○ Yes ○ No

Would you be willing to be contacted about a study of eating issues that you have observed in members of your family?
○ Yes ○ No

MEMORY AND COGNITION:

As we age, we worry about changes in memory and cognitive performance as well as the horrors of Alzheimer's disease. Now that we have the capacity to collect data on the Web, we also have the opportunity to think about collection of measures of your memory performance that would allow us to assess mild cognitive impairment.

Would you be willing to have your memory tested online?
○ Yes ○ No

RETIREMENT:

Many people in the UNCAHS are facing (or have faced) decisions about work and retirement: Should I continue to work? For how long? Should I "retire" and take a "retirement job"? How will my spouse and I make these decisions as a couple? We are considering studying these transitions for study members.

Would you be willing to be contacted about a study on decisions about work and retirement?
○ Yes ○ No

THANK YOU again for the time and consideration you give to each of our Questionnaires.
We sincerely appreciate your continued participation.

Please use the reverse of this page for comments.