



[Information Statement Here]

Contact Information

What is your name?

What is your email address?

What is your current residence address? This is the street address where you are physically living now.

What is your permanent address/the address where you would like to receive mail?

What is your primary phone number?

- | | |
|-------------------------------|---------------------------------|
| <input type="checkbox"/> Home | <input type="checkbox"/> Parent |
| <input type="checkbox"/> Cell | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Work | <input type="checkbox"/> Other |
-

What is your alternate phone number?

- | | |
|-------------------------------|---------------------------------|
| <input type="checkbox"/> Home | <input type="checkbox"/> Parent |
| <input type="checkbox"/> Cell | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Work | <input type="checkbox"/> Other |
-

Has your twin updated any of their information recently? If so, we would appreciate any updated contact information that you might have for them.

Please complete the following survey.
Thank you!

Demographic Information

1. What is your date of birth? _____/_____/_____
2. Where were you born? State: _____ Country: _____
3. Do you consider yourself to be Hispanic or Latino?
 Yes
 No
4. What race do you consider yourself to be? Choose one or more of the following:
 American Indian or Alaska Native
 Asian
 Black or African American
 Native Hawaiian or Pacific Islander
 White
 Other: _____
5. Are you currently...
 Single, never married
 Married
 Widowed
 Divorced
 Separated
 Living with partner

For how long? _____ months _____ years
6. Do you consider yourself to be
 Heterosexual or straight
 Gay or lesbian
 Bisexual
7. How many living biological children do you have?
 1 2 3 4 5 6 7 or more
8. How old were you when your first child was born? _____
9. How many adopted children do you have?
 1 2 3 4 5 6 7 or more
10. Are there children under the age of 18 currently living with you?
 Yes
 No

How many children under 18?
 1 2 3 4 5 6 7 or more

11. What is the highest level of education you have completed?

- Never attended school or only attended kindergarten
- Grades 1-8
- Grades 9-11
- Grade 12/High school graduate/GED
- Some college (no degree)
- Associate's degree
- Technical or vocational degree
- Bachelor's degree
- Master's degree (MA, MS, MEng, Med, MSW, MBA)
- Professional degree beyond a bachelor's degree (MD, DDS, DVM, LLB, JD)
- Doctoral degree (PhD, EdD)

12. Generally speaking, do you consider yourself a Republican, a Democrat, an independent, or some other party?

- Strong democrat
- Not very strong democrat
- Independent, close to democrat
- Independent (neither democrat nor republican)
- Independent, close to republican
- Not very strong republican
- Strong republican
- Other party (Libertarian, Green, Constitution)

13. Using the following scale, where would you place yourself?

- Extremely liberal
- Liberal
- Slightly liberal
- Moderate, middle of the road
- Slightly conservative
- Conservative
- Extremely conservative

14. At which age did you and your twin move apart (that is, you no longer lived at the same place)?

- Before age 6
- 6-10
- 11-14
- 15-17
- 18-21
- 22-24
- 25 or older
- Still together

15. What sex were you assigned at birth, meaning on your original birth certificate?

- Male
- Female

16. How do you describe yourself?

- Male
- Female
- Gender non-conforming

Eating habits and weight changes

1. During the past 4 weeks, how many servings of the following did you have on a typical day?

a. Fruits	<input type="checkbox"/> None	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5+
b. Vegetables	<input type="checkbox"/> None	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5+
c. Cans or glasses of soda	<input type="checkbox"/> None	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5+
d. Caffeinated coffee, tea, or cola	<input type="checkbox"/> None	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5+
e. Energy drinks	<input type="checkbox"/> None	<input type="checkbox"/> 1-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5+
2. During the past 4 weeks, how many times in a typical week did you eat a meal at a fast food restaurant, such as McDonalds, Burger King, or KFC?
 0 1-2 3-4 5 or more
3. What is your current height? _____ feet _____ inches
4. What is your current weight? _____ pounds
5. What is the most you have ever weighed? If you have ever been pregnant, do not include your weight during pregnancy.
_____ pounds

How old were you at your maximum weight? _____ years old
6. During the past year, how many times did you try to lose weight?
 0 1 2 3 4 5 or more times
7. In your lifetime, how many times have you lost 10 or more pounds on purpose?
 0 1-2 3-4 5 or more
8. Have you ever had obesity surgery such as gastric or intestinal bypass, stomach stapling, or gastric banding?
 Yes No
9. In the past year, have you tried to gain weight?
 Yes No
10. In the past year, have you taken supplements (e.g. protein powder or creatine) to try to gain weight or muscle mass?
 Yes No

Sleep Habits

1. On average, how long do you sleep per night? _____ hours _____ minutes
2. On most nights, on average, how long does it take you to fall asleep after you start trying?
_____ minutes
3. On average, how many hours per week do you nap? _____ hours
4. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
 5:00-6:29 AM
 6:30-7:44 AM
 7:45-9:44 AM
 9:45-10:59 AM
 11:00-11:59 AM

5. During the first half hour after having awakened in the morning, how tired do you feel?

- Very tired
- Fairly tired
- Fairly refreshed
- Very refreshed

6. At what time in the evening do you feel tired and, as a result, in need of sleep?

- 8:00-8:59 PM
- 9:00-10:14 PM
- 10:15 PM-12:29 AM
- 12:30-1:44 AM
- 1:45-2:59 AM

7. At what time of the day do you think that you reach your "feeling best" peak?

- 5:00-7:59 AM
- 8:00-9:59 AM
- 10:00 AM-4:59 PM
- 5:00-9:00 PM
- 10:00 PM-4:59 AM

8. One hears about "morning" and "evening" types of people. Which one of these types do you consider yourself to be?

- Definitely a morning type
- More a morning than an evening type
- More an evening than a morning type
- Definitely an evening type

9. When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feelings in your legs that can be relieved by walking or movement? Yes No

10. How often do you have difficulty falling asleep or staying asleep?

- Never
- Sometimes
- Often
- Always

11. How often do you fall asleep during the day against your will?

- Never
- Sometimes
- Often
- Always

12. During the past month, have you had, or have you been told about the following symptoms?

	Never	Rarely	1-2 times per week	3-4 times per week	5-7 times per week	Don't know
Loud snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snorting or gasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your breathing stops or you struggle for breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Activity

- Over the past 4 weeks, how much time altogether did you spend on a typical day sitting and watching TV or videos, or using a computer outside of work?
 0 hours
 1-2 hours
 3-4 hours
 5 or more hours
- How many days during a typical week do you use transit services such as a bus, ferry, or commuter rail?
 0 1 2 3 4 5 6 7
- How many days during a typical week do you walk for recreation, exercise, to get to and from places, or for any other reason in your neighborhood?
 0 1 2 3 4 5 6 7
- When you walk in your neighborhood, about how many minutes, on average, do you spend walking each time you walk?
 Less than 15
 15
 30
 45
 60
 75
 90 or more
- Over the past 4 weeks, how many days during a typical week did you exercise vigorously for at least 20 minutes? Vigorous exercise causes heavy sweating or large increases in breathing or heart rate and includes activities such as running, lap swimming, aerobics classes, and fast bicycling.
 0 1 2 3 4 5 6 7
- Over the past 4 weeks, how many days during a typical week did you exercise moderately for at least 30 minutes? Moderate exercise causes only light sweating or slight to moderate increases in breathing or heart rate and includes activities such as brisk walking, bicycling for pleasure, golf and dancing.
 0 1 2 3 4 5 6 7

Medical History

- Have you ever had a head injury or blow to the head in which you were knocked out or unconscious, suffered a concussion or memory loss, or were dazed or confused? Yes No

(if yes) For what period of time before, during, or after the injury do you have no memory?
 No memory loss
 1-30 minutes
 31 minutes to 24 hours
 More than 24 hours
- Has a medical doctor, dentist, or other health care professional ever diagnosed you with...?
 Breast cancer
 Prostate cancer
 Lung cancer
 Colon cancer
 Melanoma
 Non-melanoma skin cancer
 Other cancer: _____

3. Has a medical doctor, dentist, or other health care professional ever diagnosed you with...?

- Heart disease (e.g. heart attack, angina, bypass surgery)
- High cholesterol
- Hypertension/high blood pressure
- Stroke

4. Has a medical doctor or other health care professional ever diagnosed you with...?

- Hypothyroidism
- Type 1 diabetes
- Type 2 diabetes

5. Has a medical doctor or other health care professional ever diagnosed you with...?

- Narcolepsy
- Obstructive sleep apnea
- Restless legs syndrome

6. Has a medical doctor, psychiatrist, or other health care professional ever diagnosed you with...?

- Attention deficit/hyperactivity disorder (ADHD)
- Autistic spectrum disorder
- Bipolar disorder/manic depression
- Depression
- Panic or anxiety attacks
- Post-traumatic stress disorder (PTSD)

7. Has a medical doctor or other health care professional ever diagnosed you with...?

- Chronic fatigue syndrome
- Hearing loss
- Meningitis (infection of the brain or spinal cord)
- Migraine headaches
- Multiple sclerosis
- Parkinson's disease
- Seizures or epilepsy

8. Has a medical doctor or other health care professional ever diagnosed you with...?

- Asthma
- Chronic bronchitis
- Chronic sinus problems
- Emphysema/Chronic obstructive pulmonary disease
- Seasonal allergies or hay fever

9. Has a medical doctor, dentist, or other health care professional ever diagnosed you with...

- Canker sores
- Cold sores or fever blisters
- Gastroesophageal reflux disease (GERD)
- Irritable bowel syndrome
- Peptic ulcer
- Periodontal or gum disease
- Temporomandibular joint disorder (TMD/TMJ)

10. Has a medical doctor or other health care professional ever diagnosed you with...?

- Osteoarthritis
- Fibromyalgia
- Herniated or slipped disc
- Lupus (SLE)
- Rheumatoid arthritis

11. Has a medical doctor or other health care professional ever diagnosed you with...?

- Bladder infection
- Kidney disease
- Kidney infection
- Kidney stones
- Genital herpes
- Shingles

12. Have you and a partner ever tried to get pregnant for a year or more without success? Yes No

13. Approximately how many bladder or kidney infections have you been treated for in your lifetime?

- 0
- 1
- 2-3
- 5-14
- 15 or more

14. Do you have pain, pressure, or discomfort in the pelvis, groin, or upper thighs that worsens when your bladder fills? Yes No

15. Do you have pain, pressure, or discomfort in the pelvis, groin, or upper thighs that is relieved or improved by emptying your bladder? Yes No

16. Do you have to urinate frequently? Yes No

The following section is for female twins only.

1. Are you currently pregnant? Yes No

2. Have you ever been pregnant? Yes No

3. Have you given birth in the past 12 months? Yes No

4. At what age did your period begin?

- 9 or younger
- 10
- 11
- 12
- 13
- 14
- 15
- 16 or older

5. Have you ever had...?

- Polycystic ovarian syndrome (PCOS)
- Preeclampsia
- Preterm or premature labor
- Diabetes only during pregnancy (Gestational diabetes)
- High blood pressure only during pregnancy
- Miscarriage
- Fibrocystic breast disease

Headaches

The questions below refer to the headaches or migraine episodes without headache that you may have experienced in your lifetime. Answer each question as indicated. If you are not sure how to answer a given question, please answer what you believe is most correct.

1. Do you have frequent or intense headaches? Yes No
2. Do your headaches usually last more than 4 hours? Yes No
3. Do you usually suffer from nausea when you have a headache? Yes No
4. Does light or noise bother you when you have a headache? Yes No
5. Does a headache limit any of your physical or intellectual activities? Yes No

Pain & Fatigue

1. At any point in your life (other than during a pregnancy), were you ever exhausted, extremely tired, or fatigued, that wasn't substantially improved by a period of rest? Yes No
(if yes) When your exhaustion, tiredness, or fatigue was at its worst, how long did it last?
 - Less than a month
 - 1 to 5 months
 - 6 months or more
 - All my life
2. In the past 3 months, have you had pain in your muscles, joints, or bones lasting at least one week?
 Yes No
3. In the past 3 months, have you had pain in your shoulders, arms, or hands?
 Yes No
4. In the past 3 months, have you had pain in your legs or feet?
 Yes No
5. In the past 3 months, have you had pain in your neck, chest, or back?
 Yes No
6. In the past 3 months, have you had...?
 - Back pain that lasted for at least one day?
 - Back pain that travels into one or both legs?
 - Pain in the midback?
 - Abdominal pain relieved with bowel movements or associated loose stools or constipation?
 - Persistent or recurrent pain in the face, jaw, temple, in front of the ear or in the ear?
 - Chest pain?

Quality of Life

1. In general, would you say your health is
 - Excellent
 - Very good
 - Good
 - Fair
 - Poor
2. During a typical day, does your health limit you in doing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?
 - No, not limited
 - Yes, limited a little
 - Yes, limited a lot
3. During a typical day, does your health limit you in climbing several flights of stairs, or climbing a hill?
 - No, not limited
 - Yes, limited a little
 - Yes, limited a lot
4. During the past 4 weeks, have you accomplished less than you would like in your work or other regular activities as a result of your physical health?
 - No, none of the time
 - Yes, a little of the time
 - Yes, some of the time
 - Yes, most of the time
 - Yes, all of the time
5. During the past 4 weeks, were you limited in the kind of work or other activities that you usually do as a result of your physical health?
 - No, none of the time
 - Yes, a little of the time
 - Yes, some of the time
 - Yes, most of the time
 - Yes, all of the time
6. During the past 4 weeks, have you accomplished less than you would like in your work or other regular daily activities as a result of emotional problems, such as feeling depressed or anxious?
 - No, none of the time
 - Yes, a little of the time
 - Yes, some of the time
 - Yes, most of the time
 - Yes, all of the time
7. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
 - Not at all
 - A little bit
 - Moderately
 - Quite a bit
 - Extremely
8. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends or relatives)?
 - All of the time
 - Most of the time
 - Some of the time
 - A little of the time
 - None of the time

9. Compared to one year ago, how would you rate your physical health in general today?

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

10. Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed or irritable)?

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse

Lifestyle Habits

1. Have you smoked 100 cigarettes in your entire life? Yes No

2. Do you currently smoke... Everyday Some days Not at all

3. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week

4. How many standard drinks containing alcohol do you have on a typical day?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

5. How often do you have 6 or more drinks on one occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

Emotions

1. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly everyday
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. In the last month, how often have you...

	Never	Almost never	Sometimes	Fairly often	Very often
a. Been upset because of something that happened unexpectedly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Felt that you were unable to control the important things in your life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Felt nervous and "stressed"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Felt confident about your ability to handle your personal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Felt that things were going your way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Found that you could not cope with all the things that you had to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Been able to control irritations in your life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Felt that you were on top of things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Been angered because of things that were outside of your control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Felt difficulties were piling up so high that you could not overcome them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Below is a list of problems and complaints that people sometimes have. Read each line carefully, and select the column that best describes how much discomfort that problem has caused you during the past week including today.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Nervousness or shakiness inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Suddenly scared for no reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Feeling fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tense or keyed up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Spells of terror or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling so restless you couldn't sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Some people have terrible experiences happen to them. Have you experienced any of the following?

a. Combat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Fire/explosion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Physical assault	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Other (natural disaster, assault w/weapon, sexual assault)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

5. Have you ever had persistent or recurrent bothersome thoughts, images, or dreams after a stressful or traumatic event?

Yes No

6. Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you **during the past 7 days**. If they did not occur during that time, please check the 'not at all' column.

	Not at all	Rarely	Sometimes	Often
a. I thought about it when I didn't mean to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I avoided letting myself get upset when I thought about it or was reminded of it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I tried to remove it from memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I had waves of strong feelings about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. I had dreams about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I stayed away from reminders of it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I tried not to talk about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Other things kept making me think about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Any reminder brought back feelings about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. I tried not to think about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. My feelings about it were kind of numb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Consider how well the following statements describe your behavior and actions on a scale from 1 to 5, where 1 means the statement does not describe you at all, and 5 means it describes you very well.

	Does not describe me at all 1	2	3	4	Describes me very well 5
a. I look for creative ways to alter difficult situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Regardless of what happens to me, I believe I can control my reaction to it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I believe I can grow in positive ways by dealing with difficult life situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I actively look for ways to replace the losses I encounter in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Caregiving

1. In the past 12 months, were you a caregiver for a family member or friend? Caregiving is providing personal services (e.g., feeding, dressing, communicating) for a family member or friend who was not able to do them by him/herself because of an illness or disability. This definition does not include caring for healthy children.

- Yes No (**go to next section, Personality**)

2. What is your relationship to this person?

- Your child
- Spouse or partner
- Your parent
- Other relative
- Friend

3. How long have you provided (or did you provide) care for this person?

_____ months _____ years

4. On average, how many hours per day and days per week do (did) you provide care?

_____ hours per day _____ days per week

5. What types of functions do (did) you perform for this person?

- Bathing
- Grooming
- Feeding
- Toileting
- Dressing
- Managing finances
- Reading
- Writing
- Making appointments
- Transportation

6. What is (was) the person's illness or disability?

- Acute illness
- Accident
- Advanced aging
- Chronic physical disease (e.g., cancer, heart disease, diabetes)
- Chronic brain disease (dementia, stroke)
- Chronic mental disease or illness
- Developmental disabilities
- Recovery from surgery
- Other

7. To what degree are (were) you distressed by being a caregiver?

- Not at all
- A little
- Somewhat
- Very much so

8. To what degree do (did) you find it fulfilling to be a caregiver?

- Not at all
- A little
- Somewhat
- Very much so

Personality

In this section, there are phrases describing people's behaviors. Please use the rating scales below to describe how accurately each statement describes you. Describe yourself as you generally are now, not as you wish to be in the future. Describe yourself as you honestly see yourself, in relation to other people you know of the same sex as you are, and roughly your same age.

Please read each statement carefully, and choose the answer that corresponds to your response.

	Very inaccurate	Moderately inaccurate	Neither inaccurate nor accurate	Moderately accurate	Very accurate
1. I am the life of the party.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I sympathize with others' feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I get chores done right away.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have frequent mood swings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I have a vivid imagination.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I don't talk a lot.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I am not interested in other people's problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I often forget to put things back in their proper place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I am relaxed most of the time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I am not interested in abstract ideas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I talk to a lot of different people at parties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I feel others' emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I like order.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I get upset easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I have difficulty understanding abstract ideas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I keep in the background.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I am not really interested in others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I make a mess of things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I seldom feel blue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I do not have a good imagination.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employment

1. What is your current employment status?

- Working full time
- Working part time
- Unemployed
- Temporarily laid off, sick leave, other leave
- Disabled
- Homemaker
- Retired, no longer working
- Retired, working part or full time

2. In which month and year did your current employment status begin?

- | | | | |
|-----------------------------------|---------------------------------|------------------------------------|-------------|
| <input type="checkbox"/> January | <input type="checkbox"/> May | <input type="checkbox"/> September | |
| <input type="checkbox"/> February | <input type="checkbox"/> June | <input type="checkbox"/> October | year: _____ |
| <input type="checkbox"/> March | <input type="checkbox"/> July | <input type="checkbox"/> November | |
| <input type="checkbox"/> April | <input type="checkbox"/> August | <input type="checkbox"/> December | |

3. How many hours per week do you typically work? _____ hours per week

4. Do you work a regular schedule, like 8-5 or 9-5, or do you work other times during the day or night?

- Regular schedule
- Shift schedule

If you work a shift schedule, what hours do you usually work?

- First (morning shift) always
- Second (afternoon or evening) shift always
- Third (night) shift always
- Rotating shifts
- Split shifts (e.g., 4 hours in AM and 4 more in PM for same job)
- Weekends only
- Hours vary

5. Are you currently in school? Yes No

6. In which industry do you currently work? If you are retired, from which industry did you retire?

- | | |
|---|---|
| <input type="checkbox"/> Agriculture, forestry, fishing and hunting | <input type="checkbox"/> Professional and scientific services |
| <input type="checkbox"/> Mining | <input type="checkbox"/> Management and administrative services |
| <input type="checkbox"/> Utilities | <input type="checkbox"/> Waste management services |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Education |
| <input type="checkbox"/> Manufacturing | <input type="checkbox"/> Health care |
| <input type="checkbox"/> Wholesale trade | <input type="checkbox"/> Social assistance |
| <input type="checkbox"/> Retail trade | <input type="checkbox"/> Arts, entertainment, and recreation |
| <input type="checkbox"/> Transportation and warehousing | <input type="checkbox"/> Accommodation and food services |
| <input type="checkbox"/> Information | <input type="checkbox"/> Public administration |
| <input type="checkbox"/> Finance and insurance | <input type="checkbox"/> Other services |
| <input type="checkbox"/> Real estate, rental and leasing | |

7. Are you (or were you)...

- An employee of a private for-profit company or business?
- An employee of a private not-for-profit, tax-exempt, or charitable organization?
- A local government employee (city, county)?
- A state government employee?
- A federal government employee?
- Self-employed in own business, professional practice, or farm?
- Working without pay in family business or farm?

8. Do (or did) you and your twin work together? Yes No

9. In the past year, which income group best represents the total income for **your household** from all sources?

- | | |
|--|--|
| <input type="checkbox"/> Less than \$20,000 | <input type="checkbox"/> \$70,000 - \$79,999 |
| <input type="checkbox"/> \$20,000 - \$29,999 | <input type="checkbox"/> \$80,000 - \$89,999 |
| <input type="checkbox"/> \$30,000 - \$39,999 | <input type="checkbox"/> \$90,000 - \$99,999 |
| <input type="checkbox"/> \$40,000 - \$49,999 | <input type="checkbox"/> \$100,000 - \$149,999 |
| <input type="checkbox"/> \$50,000 - \$59,999 | <input type="checkbox"/> \$150,000 or more |
| <input type="checkbox"/> \$60,000 - \$69,999 | |

10. In the past year, which income group best represents the total income for **you personally** from all sources?

- | | |
|--|--|
| <input type="checkbox"/> Less than \$20,000 | <input type="checkbox"/> \$70,000 - \$79,999 |
| <input type="checkbox"/> \$20,000 - \$29,999 | <input type="checkbox"/> \$80,000 - \$89,999 |
| <input type="checkbox"/> \$30,000 - \$39,999 | <input type="checkbox"/> \$90,000 - \$99,999 |
| <input type="checkbox"/> \$40,000 - \$49,999 | <input type="checkbox"/> \$100,000 - \$149,999 |
| <input type="checkbox"/> \$50,000 - \$59,999 | <input type="checkbox"/> \$150,000 or more |
| <input type="checkbox"/> \$60,000 - \$69,999 | |

11. Do you now or have you ever served on active duty in the US Armed Forces, Reserves, or National Guard?

- Never served in the military
- Only on active duty for training in the Reserves or National Guard
- Now on active duty
- On active duty in the past, but not now

12. In which branch of the military did you serve?

- Army
- Navy
- Air Force
- Marines
- Coast Guard

13. In which era or period of service did you serve on active duty? Choose all that apply.

- September 2011 or later
- August 1990 to August 2001 (including Persian Gulf War)
- May 1975 to July 1990
- Vietnam era (August 1964 to April 1975)
- February 1955 to July 1964
- Korean War (July 1950 to January 1955)
- January 1947 to June 1950
- World War II (December 1941 to December 1946)
- November 1941 or earlier

14. Did you serve in an active combat or war zone? Yes No

Thank you for taking the time to complete our Health and Wellbeing Survey!
If you have any comments, questions, or concerns, please let us know!