



Your contact information

Your first name

Your middle name

Your last name

Date of Birth
 / /

MM DD YYYY

Main Phone Number
 () - Home Cell

Alternate Phone Number
 () - Home Cell

Help us go green!
 Provide your email address to receive study invitations and newsletters.

Residence Address (street address where you are living now):
 Street address

Apt./Unit/PO Box

City State

Zip/Postal Code Country (if not USA)

Permanent Address (where you would like to receive mail, if different from residence address):
 Street address

Apt./Unit/PO Box

City State

Zip/Postal Code Country (if not USA)

(OPTIONAL)
 Social security number - -

Please read the information statement provided with this survey and mail this entire form back to the Twin Registry in the enclosed postage paid envelope. If you have any questions, feel free to contact us toll free at [phone number], by email at [email address], or visit our website at [web address]. Please note we cannot guarantee the confidentiality of any information sent via email. Thank you for your participation!

To help us tell you and your twin apart from other pairs of twins, please provide us with your mother's **maiden** name (her name before she was ever married).
 Mother's first name

Mother's maiden name

Contact information for someone who will always know how to reach you (other than your twin)
 Name

Phone number
 () -

Your twin's contact information
 In order to be enrolled into the Twin Registry, **both** you and your twin must be willing to participate. **With your twin's permission**, please provide us with their name, current mailing address and email address. In order to invite your twin to participate, we need to have their mailing or email address.

Twin's first name

Twin's middle name

Twin's last name

I am not in contact with my twin
 Please follow up with me for my twin's contact information

Street address

Apt./Unit/PO Box

City State

Zip/Postal Code Country (if not USA)

Your twin can be invited to join via email!
 Simply provide their email address and we will email them an invitation.

For office use only:

Please fill in today's date: / /

MM DD YYYY

Please take a moment to answer the following questions by using a dark pen to fill in the bubbles and boxes as clearly as possible.

Some questions have multiple parts; be sure to answer each question completely.

- Are you a twin, or triplet, or higher multiple birth?
 Twin (Continue with Question 2) Triplet or higher (Please stop here and fill in the contact information on the last page) Neither
- Is your twin Alive Deceased (Please stop here and fill in the contact information on the last page)
 Don't know (Continue with Question 3)
- When you were children, were you and your twin as alike as two peas in a pod, or were you of ordinary family resemblance?
 Two peas in a pod Of ordinary family resemblance Don't know
- How often, when you were children, did the following people have difficulty telling you and your twin apart?
 a. Your parents..... Never Rarely Sometimes Often
 b. Other relatives..... Never Rarely Sometimes Often
 c. Teachers..... Never Rarely Sometimes Often
 d. Strangers..... Never Rarely Sometimes Often
- About the sex of you and your twin:
 a. I am a..... Male Female
 b. My twin is a..... Male Female
- What is your current.....
 a. Height feet inches
 b. Weight pounds
- What is the most you have ever weighed?
 If you have ever been pregnant, do NOT include your weight during pregnancy. pounds
- Have you ever had obesity surgery, such as gastric bypass, stomach stapling, or banding?..... Yes No
- In your lifetime, how many times have you lost 10 or more pounds on purpose?..... 0 1-2 3-4 5+
- During the past 4 weeks, how many servings of the following did you have on a typical day?
 a. Fruits?..... None 1-2 3-4 5+
 b. Vegetables?..... None 1-2 3-4 5+
 c. Cans or glasses of soda?..... None 1-2 3-4 5+
 d. Caffeinated coffee, tea, or cola? None 1-2 3-4 5+
 e. Energy drinks?..... None 1-2 3-4 5+
- 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+

- Have you ever had an illness or trouble caused by eating any of the following?
 Peanuts Tree nuts Fish Shellfish Other
 No
 - Mark the types of problems you have experienced from the food(s) if they developed **within an hour of eating the food** (mark all that apply):
 Hives Throat tightness
 Redness of skin Coughing
 Swelling Wheezing
 Diarrhea Trouble breathing
 Congestion Passing out
 Itchy throat/mouth Other
 I have never had a reaction
- 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+ hours
- 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 such activities 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 such activities as brisk walking, bicycling for pleasure, golf, and dancing.
 0 1 2 3 4 5 6 7
- 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
- On average, how long do you sleep per night? hours and minutes
- How often do you...
 a. have difficulty falling asleep or staying asleep?
 Never Sometimes Often Always
 b. fall asleep during the day against your will?
 Never Sometimes Often Always
- 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

21. In the past 4 weeks have you had, or have you been told about, loud snoring?
 Never 3-4 times per week
 Rarely 5-7 times per week
 1-2 times per week Don't know

22. 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

23. In general, would you say your health is:
 Excellent Very good Good Fair Poor

24. Has a medical doctor, dentist, or other health care professional ever diagnosed you with...?
 a. Arthritis..... Yes No
 b. Asthma..... Yes No
 c. Attention deficit hyperactivity disorder (ADHD)..... Yes No
 d. Blood clots in legs or lungs..... Yes No
 e. Breast cancer..... Yes No
 f. Chronic fatigue syndrome..... Yes No
 g. Chronic sinus problems..... Yes No
 h. Chronic tension headaches..... Yes No
 i. Depression..... Yes No
 j. Fibromyalgia..... Yes No
 k. Gastroesophageal reflux disease (GERD)..... Yes No
 l. Hearing loss..... Yes No
 m. Heart disease..... Yes No
 n. Herniated or slipped disc..... Yes No
 o. High cholesterol..... Yes No
 p. Hypertension/high blood pressure..... Yes No
 q. Irritable bowel syndrome (IBS)..... Yes No
 r. Kidney stones..... Yes No
 s. Low back pain..... Yes No
 t. Migraine headaches..... Yes No
 u. Panic or anxiety attacks..... Yes No
 v. Parkinson's disease..... Yes No
 w. Post traumatic stress disorder (PTSD)..... Yes No
 x. Seasonal allergies or hay fever..... Yes No
 y. Seizures or epilepsy..... Yes No
 z. Speech or language problems..... Yes No
 aa. Temporomandibular joint disorder (TMD or TMJ)..... Yes No
 bb. Type 1 Diabetes (formerly called "juvenile-onset diabetes")..... Yes No
 cc. Type 2 Diabetes (formerly called "adult-onset diabetes")..... Yes No

27. a. 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
 b. If you have ever had a head injury, for what period of time before, during, or after the injury do you have no memory?
 I have not had a head injury 31 minutes to 24 hours
 No memory loss More than 24 hours
 1-30 minutes

28. In the past year, have your gums bled occasionally when you brushed your teeth or have you had swollen or red gums?
 Yes No

29. Have you ever had...
 a. genital herpes?
 Yes No
 b. cold sores or fever blisters?
 Yes No

30. a. 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
 b. When your exhaustion, tiredness, or fatigue was at its worst, how long did it last? Choose only one.
 Less than a month 1 to 5 months 6 months or more All my life

31. Approximately how many bladder or kidney infections have you been treated for in your lifetime?
 0 1 2-4 5-14 15 or more

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

33. 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

34. Do you have to urinate frequently?
 Yes No

35. In the past 3 months, have you had...
 a. back pain that lasted for at least one day?
 Yes No
 b. back pain that travels into one or both legs?
 Yes No
 c. pain in the midback?
 Yes No
 d. abdominal pain relieved with bowel movements, or associated loose stools or constipation?
 Yes No
 e. persistent or recurrent pain in the face, jaw, temple, in front of the ear, or in the ear?
 Yes No
 f. chest pain?
 Yes No

36. The questions below refer to the headaches or migraine episodes without headache that you may have experienced in your lifetime.
 a. Do you have frequent or intense headaches?
 Yes No
 b. Do your headaches usually last more than 4 hours?
 Yes No
 c. Do you usually suffer from nausea when you have a headache?
 Yes No
 d. Does light or noise bother you when you have a headache?
 Yes No
 e. Does headache limit any of your physical or intellectual activities?
 Yes No

37. In the past 3 months have you had pain in your muscles, bones, or joints lasting at least one week in your:
 a. shoulders, arms, or hands?
 Yes No
 b. legs or feet?
 Yes No
 c. neck, chest, or back?
 Yes No

38. Some people have terrible experiences happen to them. Have you experienced any of the following?
 a. Combat..... Yes No
 b. Fire/explosion..... Yes No
 c. Physical assault..... Yes No
 d. Other (natural disaster, assault w/weapon, sexual assault)..... Yes No

39. In the past 4 weeks, how often have you been bothered by 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="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Feeling tired or having little energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

40. Have you ever had persistent or recurrent bothersome thoughts, images or dreams after a stressful or traumatic event?
 Yes No

41. During the past 7 days, how often did the following occur when you thought about an event that was upsetting in your life?

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

42. Consider how well the following statements describe your behavior and actions.

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

43. How often do you have a drink containing alcohol?
 Never 2-3 times a week
 Monthly or less 4 or more times a week
 2-4 times a month

44. How many drinks of alcohol do you have on a typical day when you are drinking?
 1 to 2 7 to 9
 3 to 4 10 or more
 5 to 6 I don't drink alcohol

45. How often do you have 6 or more drinks on one occasion?
 Never Weekly
 Less than monthly Daily or almost daily
 Monthly

46. a. Have you smoked at least 100 cigarettes in your entire life?
 Yes No
 b. Do you currently smoke?
 Yes No

47. Where were you born?
 state/province
 country

48. At what age did you and your twin move apart?
 Before age 6 15-17 25 or older
 6-10 18-21 Still together
 11-14 22-24

49. Are you currently...?
 Single, never married Married
 Widowed Divorced
 Separated Living with partner

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

51. If you have a child, how old were you when your first child was born?
 years or No biological children

52. How many living biological or adopted children do you have?
 0 1 2 3 4 5 6 7 or more

53. Do you consider yourself to be Hispanic or Latino?
 Yes No

54. 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 White
 Native Hawaiian or Pacific Islander Other

55. What is the highest level of education you have completed? (Choose one.)
 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
 Bachelor's degree
 Graduate or professional degree

56. a. What is your current employment status?
 Working full time Disabled
 Working part time Homemaker
 Unemployed Retired, no longer working
 Temporarily laid off, sick leave, other leave Retired, working part or full time
 b. In which month and year did your current employment status begin?
 month year

57. In the past year, which income group best represents the total income for your household?
 Less than 20,000 \$50,000-59,999
 \$20,000-29,999 \$60,000-69,999
 \$30,000-39,999 \$70,000-79,999
 \$40,000-49,999 \$80,000 or more

This section for female twins only (males go to question 27)

25. At what age did your period begin?
 Under 9 10 11 12 13
 14 15 16 or older
 26. Have you ever had...?
 a. Polycystic ovarian syndrome (PCOS)..... Yes No
 b. Preeclampsia..... Yes No
 c. Preterm or premature labor..... Yes No
 d. Diabetes only during pregnancy..... Yes No
 e. High blood pressure only during pregnancy..... Yes No
 f. Miscarriage..... Yes No
 g. Fibrocystic breast disease..... Yes No