

Spring 2000

California Teachers Study

Report Card

A+

A+

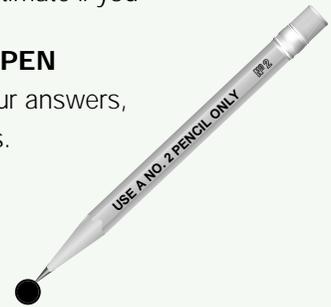
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Marking Instructions

- Answer each question as best as you can – estimate if you aren't sure.
- Use only a #2, ordinary pencil. **DO NOT USE PEN**
- Be certain to completely blacken in each of your answers, and erase completely if you make any changes.
- Do not make any other marks on this form.
- If you wish to make comments, please use a separate piece of paper.

Correct Mark ●

Incorrect Marks    



- Please enter your current phone number.

				-					-				
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Home Work

- Fill in today's date.

MO		DAY		YEAR	
<input type="radio"/>	2000				
<input type="radio"/>	2001				
<input type="radio"/>	2002				
<input type="radio"/>	2003				
0	0	0	0		
1	1	1	1		
2	2	2	2		
3	3	3	3		
4		4			
5		5			
6		6			
7		7			
8		8			
9		9			

- Is there an error in your name or address at the left?

No

Yes (please write the correct information)

Name _____

Street _____

City _____ State _____ Zip _____

USC Keck School of Medicine
1420 San Pablo Suite B105 Los Angeles CA 90089-9044 (800) 568-9471

6. If you are currently working, in the past year how frequently have you been absent from work because you were ill or injured?

- Not currently working A few days A few weeks
 No time About a week A month or more

7. Please tell us about your social contacts.

	0	1-2	3-5	6-9	10+
In general, how many relatives and friends do you feel close to? (These are people that you feel at ease with, can talk to about private matters, and can call on for help.)					
Relatives?	<input type="radio"/>				
Friends?	<input type="radio"/>				
How many of these friends or relatives do you:					
See at least once a month?	<input type="radio"/>				
Talk to (via phone, letter or email) at least once a month?	<input type="radio"/>				
During a typical month, how many times do you participate in the following:					
Church or religious groups?	<input type="radio"/>				
Other groups (for example: social/recreational group, labor union, professional association, PTA, charity, etc.)?	<input type="radio"/>				
How many people live with you in your household (excluding yourself)?	<input type="radio"/>				
How many in your current household are children ages 17 or younger?	<input type="radio"/>				

8. What is your current marital status?

- Married or living with partner Widowed
 Divorced Never Married
 Separated

9. Please indicate the degree to which you feel that the following apply to your husband or partner, other family members and friends.

	Husband or Partner				Other Family Members				Friends			
	A Lot	Some	A Little	Not at All	A Lot	Some	A Little	Not at All	A Lot	Some	A Little	Not at All
	<input type="radio"/> NOT APPLICABLE				<input type="radio"/> NOT APPLICABLE				<input type="radio"/> NOT APPLICABLE			
How much do they:												
Really care about you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Understand the way you feel?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much can you:												
Rely on them for help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Open up to them if you need to talk about your worries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do they:												
Make too many demands on you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Criticize you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Let you down when you are counting on them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Get on your nerves?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



10. Here is a list that describes some of the ways people feel at different times.

How often do you feel each of these ways?	Often	Sometimes	Rarely	Never
On top of the world	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depressed or very unhappy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bored	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Particularly excited or interested in something	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It's hard to feel close to others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
So restless that I couldn't sit long in a chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I am with a group of people, I feel left out, even if they are my friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Upset because someone criticized me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Very lonely or remote from other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Proud because someone complimented me on something I had done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I tend to keep people at a distance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Things are going my way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pleased about having accomplished something	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. All in all, how happy are you these days?

- Very happy
- Somewhat happy
- Not very happy



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C ontraception and M enopause

12. Have you ever used oral contraceptives (birth control pills)?

- No (skip to question 14)
- Yes

13. For how many months have you used oral contraceptives in the past 4 years?

- Used, but not in past 4 years
- 1 - 6 months
- 7 - 12 months
- 13 - 24 months
- 25 - 36 months
- 37 - 48 months

14. Have your menstrual periods stopped permanently? (select No or Yes, and then pick the most appropriate response in that category)

NO	YES
<input type="radio"/> I am premenopausal and not taking hormones.	<input type="radio"/> My periods stopped on their own (naturally).
<input type="radio"/> I am premenopausal and taking oral contraceptives.	<input type="radio"/> My periods stopped after my uterus was removed (hysterectomy).
<input type="radio"/> I began taking hormone replacement therapy before my periods stopped.	<input type="radio"/> My periods stopped after my ovaries and uterus were removed.
<input type="radio"/> I stopped temporarily, but restarted when I began hormone replacement therapy.	<input type="radio"/> My periods stopped after my ovaries (but not my uterus) were removed.
<input type="radio"/> I am currently pregnant or breast feeding.	<input type="radio"/> My periods stopped after radiation or chemotherapy.

15. In what year did your periods stop, either permanently or temporarily?

- Never ceased 1995 1997 1999 2001
 Before 1995 1996 1998 2000

16. Have you ever used female hormones (other than oral contraceptives) for symptoms of menopause or for other reasons?

- No (skip to question 20)
 Yes

17. For how many months have you used female hormones (not oral contraceptives) in the past 4 years?

- Used, but not in the past 4 years (skip to question 20)
 1 - 6 months
 7 - 12 months
 13 - 24 months
 25 - 36 months
 37 - 48 months

18. Have you used female hormones within the last month? No Yes

19. Please mark the type(s) of hormones you have used as Hormone Replacement Therapy during the past 4 years. (Indicate any type(s) you have used.)

Combined estrogen/progestin pill

- Did not use
 Prempro
 Premphase
 Other combined pill

What was your pattern of use (days per month) of the combined estrogen/progestin pill?

- < 1 day/month
 1 - 8 days/month
 9 - 18 days/month
 19 - 26 days/month
 27+ days/month

Estrogen preparations (select longest used):

- Did not use
 Oral Premarin pills
 Ogen pills
 Estrace pills
 Patch Estrogen
 Injection Estrogen
 Vaginal Estrogen
 Estrogen cream

What was your pattern of use (days per month) of the estrogen preparation?

- < 1 day/month
 1 - 8 days/month
 9 - 18 days/month
 19 - 26 days/month
 27+ days/month

Progesterone/Progestin preparations (for example, Provera) (select longest used):

- Did not use
 Oral
 Vaginal
 Injection

What was your pattern of use (days per month) of the progesterone/progestin preparation?

- < 1 day/month
 1 - 8 days/month
 9 - 18 days/month
 19 - 26 days/month
 27+ days/month

I llnesses

20. Has a doctor ever said that you have asthma? Yes No (skip to question 23)

21. If yes, how old were you the first time that a doctor said that you had asthma?

- 0 - 4
- 5 - 18
- 19 - 34
- 35 or older

22. If yes, during the past 12 months, which of the following describes your level of asthma symptoms? (mark all that apply)

- I've not been troubled by asthma during the past 12 months.
- I've had mild symptoms for which I have not taken any asthma medication.
- I've had asthma symptoms which required asthma medication.
- I've had asthma which required an urgent visit to a doctor (such as an urgent care center or hospital emergency room).
- I've had asthma symptoms which required me to stay overnight at a hospital.

23. Have you been diagnosed with any of the following in the past 4 years?

- | | | | | | |
|--------------------|---------------------------|--------------------------|----------------|---------------------------|--------------------------|
| Endometrial Cancer | <input type="radio"/> Yes | <input type="radio"/> No | Lung Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Breast Cancer | <input type="radio"/> Yes | <input type="radio"/> No | Ovarian Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Colon Cancer | <input type="radio"/> Yes | <input type="radio"/> No | Melanoma | <input type="radio"/> Yes | <input type="radio"/> No |

Other Cancer Yes No Specify type →

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

M edications

24. Please indicate whether or not you have used each of the following medications daily for at least 2 months during the past 2 years:

Medications for Diabetes	YES	NO
Insulin	<input type="radio"/>	<input type="radio"/>
Oral hypoglycemic medication	<input type="radio"/>	<input type="radio"/>
Medications for High Blood Pressure		
Thiazide diuretic (for example: Diuril, Hydrodiuril, Dyazide)	<input type="radio"/>	<input type="radio"/>
Lasix	<input type="radio"/>	<input type="radio"/>
Calcium blocker (for example: Calan, Procardia, Cardizem)	<input type="radio"/>	<input type="radio"/>
ACE inhibitors (for example: Capoten, Vasotec, Zestril)	<input type="radio"/>	<input type="radio"/>
Other high blood pressure medication	<input type="radio"/>	<input type="radio"/>
Medications for Gastro-intestinal Symptoms		
Cimetidine (Tagamet)	<input type="radio"/>	<input type="radio"/>
Other H2 blocker (for example: Zantac, Pepcid, Axid) -- or -- Proton pump inhibitor (for example: Omeprazol)	<input type="radio"/>	<input type="radio"/>
Other Medications		
Tamoxifen (Nolvadex)	<input type="radio"/>	<input type="radio"/>
Raloxifene (Evista)	<input type="radio"/>	<input type="radio"/>
Steroids taken orally (for example: Prednisone, Decadron, Medrol)	<input type="radio"/>	<input type="radio"/>
Inhaled bronchodilator	<input type="radio"/>	<input type="radio"/>
Cholesterol-lowering drug (for example: Questran, Mevacor, Lipid)	<input type="radio"/>	<input type="radio"/>
Antidepressant (for example: Elavil, Prozac)	<input type="radio"/>	<input type="radio"/>



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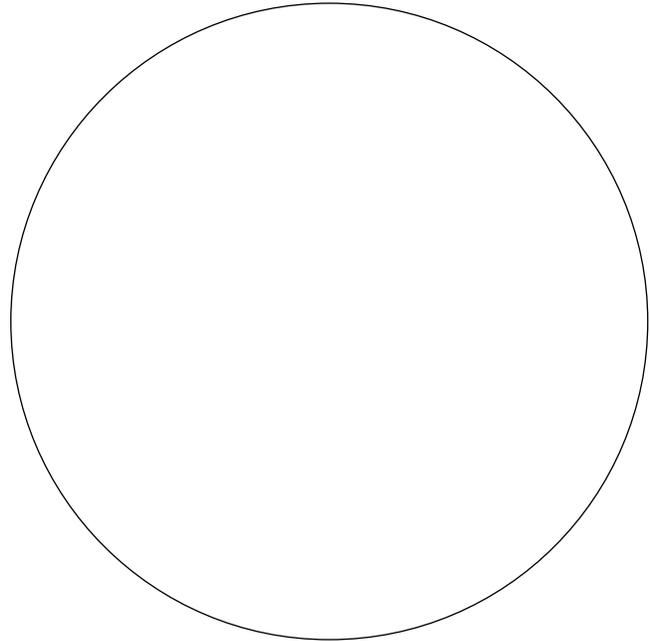
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Drawing and Writing

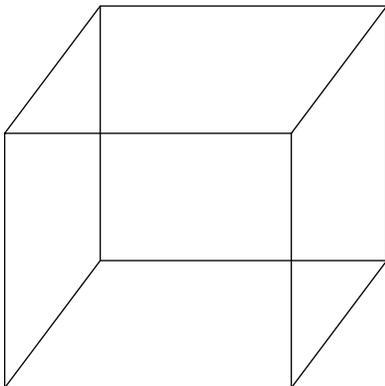
The next two pages contain assessment tools that have been used in many studies to identify factors related to successful aging. We look forward to providing feedback, as a group, on the results. Please do not use a ruler or other device for assistance.

We are interested in how drawing and writing skills might vary in different age groups.

25. In the circle provided, please draw in the numbers, as on a clock face. Then place the hands of the clock to show ten minutes past eleven. Make no erasures.



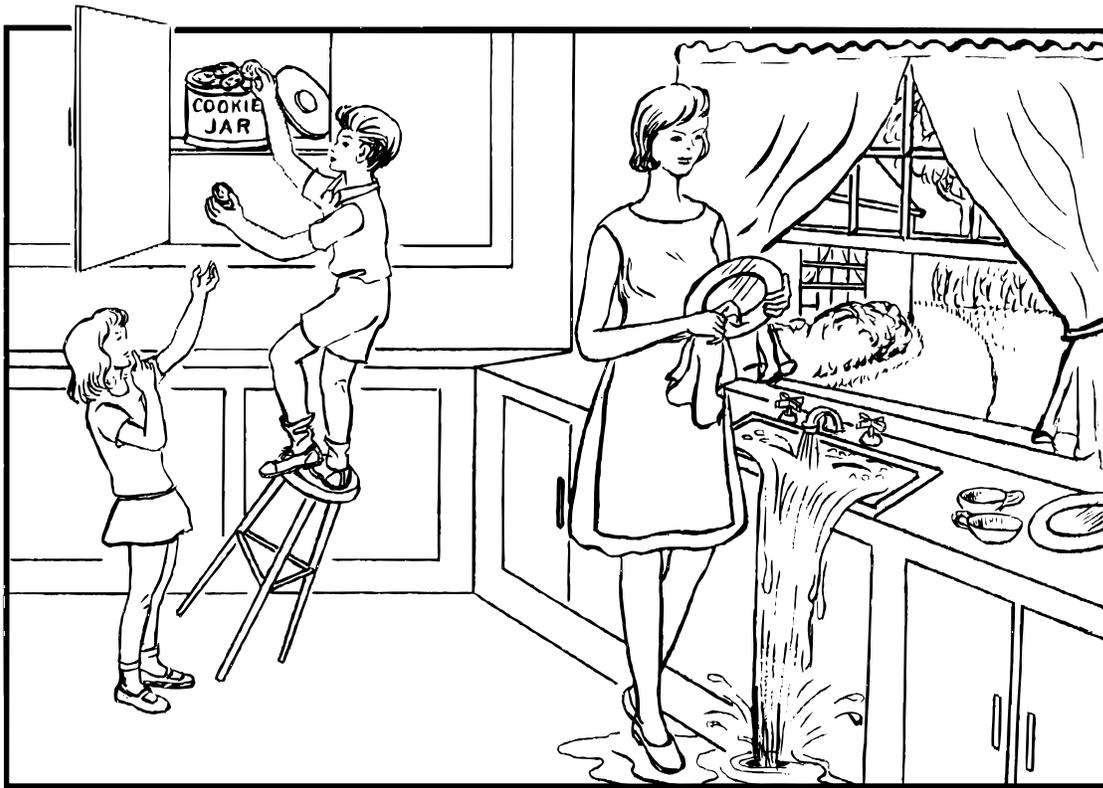
26. In the space provided please copy the box drawing, making no erasures.



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Over ...



27. Write as much as you can about what you see going on in the above picture. Please use complete sentences and make no erasures. Do not exceed the space provided below.

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Which hand did you use to write this?

Right Left