Instructions – Please Read Carefully

Dear Study Subject:

The following questions will ask you about your background (such as your marital status, current address, and recent travel history), health-related habits such as diet and digestive disease history, and stool frequency and type.

Please complete all sections of this questionnaire. We understand that some things may be difficult to remember. We would like to have your best possible answer, so please take the time you need to think things over.

If you have any question, please ask the research staff.

Thank you for agreeing to participate!

The information in this questionnaire (hardcopy) will be stored in a locked cabinet in a locked office of the Tulane Center for Bioinformatics and Genomics (CBG). The information will be input and stored into a password-protected database at Tulane CBG. All information collected will remain confidential. The access to the collection information is restricted to the authorized personnel from the research team and Tulane University Human Research Protection Office and the Biomedical Institutional Review Board.

Questionnaire

Decoding Methylation Mediated Epigenomic Contributions to Male Osteoporosis

ID: _____ LOS ID: _____

SUBJECT INFORMATION

First Name _____Middle Name_____Last Name_____

Blood Type (Please circle): A / AB / B / O / Unknown

Occupation: _____

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced
□ Living with a partner □ Other: _____

Do you have children? □ Yes □ No Age of Children_____

Primary Physician _____ Date of last physical exam _____

Have you traveled recently in the past 3 months? □ Yes □ No

If YES, where is your last travel destination? _____

Last travel dates (from MM/DD/YY to MM/DD/YY) _____

When is your last eating time on the day for the blood drawn? _____(HH: MM)

IF YOU HAVE CHANGED address, phone number, or email address since your last LOS visit, please fill following information

Address _____

City _____ State_____ Zip:_____

Please circle your preferred method of contact: Home Work Cell Email

Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____ Email address:_____

Please circle your preferred time to be contacted:

Morning (8–11am) Noon (12–1pm) Afternoon (2-5pm) Evening (6-9pm)

CLINICAL INFORMATION

1. Have you used (oral or intravenous) antibiotics **in the past 12 months**? □ Yes □ No

   If yes, when was your last-time usage? (MM/YY): _____

2. Are you currently taking any probiotics supplements (e.g, Culturelle® Digestive Health Probiotic Capsules, Align® Probiotic Supplement, Nature's Bounty® Ultra Strength Probiotic 10, Schiff® Digestive Advantage Probiotic Capsules, etc)? □ Yes □ No

   If **yes**, please describe:

   Since when (MM/DD/YY): _____ (Approximate date is allowed, e.g., MM/YY)

   How often? (select once)

   □ once daily □ once every 2 days □ once a week □ Other_____

3. If you are not currently taking probiotics, have you previously taken any probiotics **IN THE PAST 12 MONTHS**? □ Yes □ No

4. Are you currently taking any acid lowering medications (e.g, Prilosec, Nexium, Prevacid, Dexilant, Protonix, Zegerid, AcipHex, Vimovo, Prilosec OTC, Prevacid24, etc)? □ Yes □ No

   If **yes**, please describe:

   Since when (MM/DD/YY): _____ (Approximate date is allowed, e.g., MM/YY)

   How often? (select one)

   □ once a week □ More than once a week

5. If you are not currently taking acid lowering medications, have you taken any acid lowering medications **in the past 12 months**? □ Yes □ No

6. Please indicate your mode of birth (select one of each question)

   a. How? □ Cesarean section □ Vaginal □ Don't know

   b. Where? □ Hospital/Clinic □ Home □ Don't know

7. Were you breastfed during your infancy?

   □ Yes □ No □ Don't know

   If **yes**, can you indicate how long? (select one)

   □ < 1 week □ > 1 week □ > 1 month □ > 1 years

8. Can you indicate your average stool frequency? (select one)

   □ twice (or more) daily □ once daily □ once every 2 days □ <once every 2 days

9. Please classify the form of your stools (select one) on the Bristol Stool Scale:

DIGESTIVE HISTORY

1. Do you associate any digestive symptoms with eating certain foods? □ Yes □ No

   If **yes**, please describe: _____

2. Have you taken laxatives **IN THE PAST 3 MONTHS**? □ Yes □ No

   If **yes**, what type/brand and how often?

Type/brand_____

□ 4+ days/week □ <4 days/week

3. Have you been diagnosed with a digestive disease/condition? □Yes □No

   If **yes**, please indicate your disease(s) from this following list (Multiple choice is possible):

   1) Barrett's Esophagus □
   2) Diverticular Disease □
   3) Duodenal Ulcer □
   4) Dyspepsia □
   5) Gastric Ulcer □
   6) Gastroesophageal Reflux Disease □
   7) Hepatitis □
   8) *H. Pylori* infection □
   9) Lactose Intolerance □
   10) Pancreatitis □
   11) Others digestive diseases? (free text):_____

4. Please indicate how often you experience the following symptoms:

Heartburn	□Often	□Sometimes	□Rarely
Gas	□Often	□Sometimes	□Rarely
Bloating	□Often	□Sometimes	□Rarely
Stomach Pain	□Often	□Sometimes	□Rarely
Nausea/Vomiting	□Often	□Sometimes	□Rarely
Diarrhea	□Often	□Sometimes	□Rarely
Constipation	□Often	□Sometimes	□Rarely

DIET HISTORY

1. Are you currently following any special diet or having diet restrictions or limitations for any reason (health, lose weight, cultural, religious or other)? □ Yes □ No

   If **yes**, check the following that apply:

□ Low Fat	□ Low Carb	□ High Protein	□ Low Sodium
□ No Gluten	□ Vegetarian	□ Vegan	□ Diabetic
□ No Dairy	□ No Wheat	□ Weight Loss	□ Pescatarian

   □ Other_____

2. Are you currently taking prescribed or over-the-counter medications and supplements to lose weight or control your current weight?

   □ No

   □ Yes. Please list all related medications and supplements _____

   _____

3. **IN THE PAST 12 MONTHS**, have you tried to lose weight or control your weight by taking special diet, medications, or supplements?

   □ No (skip to the question 5)

   □ Yes, please describe all the methods that you tried

   Diet Type _____, Duration (from MM/YY to MM/YY): _____

   Diet Type _____, Duration (from MM/YY to MM/YY): _____

   Diet Type _____, Duration (from MM/YY to MM/YY): _____

   Medication/Supplement_____, Duration (from MM/YY to MM/YY):_____

   Medication/Supplement_____, Duration (from MM/YY to MM/YY):_____

   Medication/Supplement_____, Duration (from MM/YY to MM/YY):_____

   Other _____, Duration (from MM/YY to MM/YY):_____

4. If **yes** to number 3, did you lose weight?

   □ No

   □ Yes. How much weight have you lost? _____Ibs. Over this period of time: _____

   How much of this weight, if any did you gain back? _____Ibs.

5. Which meals do you eat regularly, check all that apply:
   - □ Breakfast
   - □ Lunch
   - □ Dinner/Supper
   - □ Snacks (times/day _____)

6. Check all that apply:
   - □ My family eats most meals together
   - □ Family meals are served at regular times on most days
   - □ Another member of my family is on a special diet or is trying to lose weight.

Describe. _____

☐ N/A

7. Please list any food allergies, sensitivities or intolerances _____