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Online™

Study of Osteoporotic Fractures (SOF)

Study Collection Forms

Visit 1

Demographics

General

Form Type: Self-Administered Questionnaire

LEGEND:

Raw form variable names are located next to the question they represent and do not have a border around the variable name.

Calculated variable names are derived from other variables and have a border around the variable name. The calculated variables names are located in close proximity to the questions from which they were derived.

Some of the questions and measurements on these forms are not being released, and therefore no variable name is provided for them.

HEALTH AND PERSONAL HISTORY

Clinic use only

ID _____

Date _____

WHAT WE'RE ASKING YOU TO DO:

- Please answer the questions on the following pages as completely as you can. Read the questions carefully.
- If you don't understand some of the questions, leave those questions blank until your clinic visit. We can help you finish filling out the form at that time.
- Take your time. You don't have to fill it out all at once. You may get help from relatives or friends if needed.
- Some questions have arrows that will help you in finding the next question. A person who drinks 3 glasses of milk every day would answer the question below this way:

EXAMPLE:

Do you drink milk every day or almost every day? (MARK ONE BOX.)

Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
↓	↓	↓
PLEASE GO TO NEXT QUESTION		
<p>IF YES, about how many glasses of milk do you drink a day? 3 glasses.</p>		

If the answer is "NO" or "DON'T KNOW," then go on to the next question.

- Mark only one box for each question, unless the directions tell you differently.

5. How old are you? _____ years.

6. When were you born? _____ / _____ / _____ V1AGE
Month Day Year

7. What is your Social Security number? _____ - _____ - _____

8. What is your Medicare number? _____ - _____ - _____

9. Please write down the following information for two persons who do not live with you and who would know how to reach you in case you move and we need to get in touch with you. Neither person has to be a local person.

Contact person number one:

Name: _____
First Middle Initial Last

Address: _____
Number Street Apt/Room Number

City State Zip Code

Telephone: (_____) _____
Area Code Number

How is this person related to you?

- my son or daughter
- my grandchild
- my brother or sister
- friend/neighbor
- my niece or nephew
- someone else

↓
Please say how related: _____

13. Please circle the highest grade or year of school that you completed.

V1EDUC

- Elementary 1 2 3 4 5 6 7 8
- High School 9 10 11 12
- College Training 1 2 3 4
- Post Graduate 1 2 3+

clinic use ed _____

14. If you have ever been married, please circle the highest grade or year of school that your husband completed. (If married more than once, answer for your husband from your longest marriage.)

V1HEDUC

- Elementary 1 2 3 4 5 6 7 8
- High School 9 10 11 12
- College Training 1 2 3 4
- Post Graduate 1 2 3+

clinic use ed _____

15. Which of the following best describes your ethnic origin or family's original nationality? Please mark no more than two.

- | | | |
|--|---|--|
| <input type="checkbox"/> Canadian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> French Canadian | <input type="checkbox"/> Jewish V1JEWISH | <input type="checkbox"/> Swiss |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Mexican/Chicano | <input type="checkbox"/> Ukranian |
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Native American/Indian | <input type="checkbox"/> Welsh |
| <input type="checkbox"/> Czech | <input type="checkbox"/> Filipino V1NTAMER | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Dutch | <input type="checkbox"/> Polish | <input type="checkbox"/> Central American |
| <input type="checkbox"/> English | <input type="checkbox"/> Portuguese | <input type="checkbox"/> South American |
| <input type="checkbox"/> French | <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Black/Negro |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Russian V1RUSSN | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> German | <input type="checkbox"/> Scandinavian | <input type="checkbox"/> Other (Please say which.) |
| <input type="checkbox"/> Irish | <input type="checkbox"/> Scottish | _____ |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Serbo-Croatian | |

V1NEUROP

V1CEUROP

V1SEUROP

V1ORGOTH

16. What was the natural color of your hair when you were 20 years old?
(MARK ONE BOX.)

V1HAIR

- Black
- Brown/brunette
- Blond
- Red

17. What is your racial background? (MARK ONE BOX.)

V1RACE

- * Hispanic or Latino
- * Asian or Pacific Islander
- * Black
- White (Caucasian)
- * Another group not listed (Please say which.)

* Categories with the same symbol have been combined into a single category.