Study questionnaire for telephone survey (Patient Interview)

Before the start of the interview, ask patient if he/she has filled the sheets with the information on medications and contact of health professionals. If the answer is no, ensure that the patient has all his/her current medications handy at the time of the phone interview.

Note to interviewer: Fill out prior to interview

1. Patient ID (Provided by center prior to start of interview) _____

2. Surrogate respondent? (A surrogate respondent should be used if the patient is unable to speak) ☐ Yes ☐ No

3. Interviewer ☐ Dentist ☐ Hygienist ☐ Research Assistant

4. Name of interviewer: _____

5. Date of interview: Date: ____/____/_____*(mm/dd/yyyy)*

6. Patient gender ☐ Female ☐ Male

7. Patient date of birth Date:____/____/_____*(mm/dd/yyyy)*

8. Patient zip code *of residence* _____

9. Patient initials (*First, Middle, Last*) _____

Note to interviewer: Before starting the interview, ensure that a signed consent form is on file. Then proceed with introduction (see the script).

☐ ONJ Case - Year of diagnosis (*as indicated by doctor on screening form)*: _____

☐ Control Patient

Section A. Oral Health Related to Quality of Life

I'll begin asking you a few questions about how you feel about your teeth, mouth and gums.

1. How would you describe the health of your teeth and gums today?

□ Excellent □ Very Good □ Good □ Fair □ Poor

2. During the last six weeks, have you had difficulty chewing any foods because of problems with your teeth, mouth or dentures?

□ Never □ Hardly Ever □ Occasionally □ Fairly Often □ Very Often

3. During the last six weeks, have you had painful aching in your mouth?

□ Never □ Hardly Ever □ Occasionally □ Fairly Often □ Very Often

4. During the last six weeks, have you felt uncomfortable about the appearance of your teeth, mouth or dentures?

□ Never □ Hardly Ever □ Occasionally □ Fairly Often □ Very Often

5. During the last six weeks, have you felt that your food has been less flavorful due to any problems with your teeth, mouth or dentures?

□ Never □ Hardly Ever □ Occasionally □ Fairly Often □ Very Often

6. During the last six weeks, have you had difficulty doing your usual jobs because of problems with your teeth, mouth or dentures?

□ Never □ Hardly Ever □ Occasionally □ Fairly Often □ Very Often

Section B. Oral Hygiene and Dental Service Utilization

The next set of questions refers to your personal oral hygiene before the year 2000.

1. In a typical year before the year 2000, how frequently did you BRUSH your teeth?
   - ☐ Once or more per day
   - ☐ 4-6 times per week
   - ☐ 2-3 times per week
   - ☐ Once or less than once per week

2. In a typical year before the year 2000, how frequently did you FLOSS your teeth?
   - ☐ Once or more per day
   - ☐ 4-6 times per week
   - ☐ 2-3 times per week
   - ☐ Once or less than once per week

3. In a typical year before the year 2000, how frequently did you use an Oral Rinse?
   - ☐ Once or more per day
   - ☐ 4-6 times per week
   - ☐ 2-3 times per week
   - ☐ Once or less than once per week

4. Have you ever been diagnosed with gum disease that involved bone loss? ☐ Yes ☐ No ☐ Unknown
   If No, skip to 6

5. If yes, how old were you when you were first diagnosed? _____ Age (years)

6. In a typical year before the year 2000, how often did you visit the dentist?
   - ☐ Once or more per year
   - ☐ Every two years
   - ☐ Less often than every two years
   - ☐ Only when you have a problem

7. Did you visit any of the following health care providers after January 1st, 2000? *Oral Surgeon, Periodontist (gum specialist), Orthodontist, Prosthodontist - Crown/Bridge Specialist, Denturist, Endodontist (root canal), Implant Specialist, Oral Medicine or Oral Pathologist, General Dentist, or other Medical Providers* What was the date of your first visit? Could you give the name and telephone of the dental care providers you visited since January 1st, 2000?

Healthcare Provider	Date of First Visit M | M / Y | Y | Y | Y	Provider Name	Telephone
☐ Oral surgeon			
☐ Periodontist (gum specialist)			
☐ Orthodontist			
☐ Prosthodontist - crown/bridge specialist			
☐ Denturist			

□ Endodontist(root canal)			
□ Implant specialist			
□ Oral medicine or oral pathologist			
□ General dentist			
□Medical Provider Specialty:_____			
□Medical Provider Specialty:_____			
□Medical Provider Specialty:_____			
□Medical Provider Specialty:_____			
□Medical Provider Specialty:_____			
□			
□			
□			
□			
□			

Section C. Osteonecrosis of the Jaw: *Natural History*

I am going to ask you a few questions regarding the condition we are studying in this research. The name of this condition is osteonecrosis of the jaw and information about it was mailed to you with the consent form you signed to agree to participate in this interview.

(FOR CASES) Your dentist informed us that you have Osteonecrosis of the Jaw, but we need to confirm this information with you.

(FOR CONTROLS) Your dentist informed us that you do not have Osteonecrosis of the Jaw. We need to confirm this information with you.

1. Do you currently or have you ever had an area of exposed bone in your mouth? This condition, where the bone becomes exposed and does not heal, is known as **osteonecrosis of the jaw**. This condition was described in the informational brochure that was mailed to you and you may refer to this information if needed.

☐ Yes
☐ No

Now, we are going to ask questions relating to your mouth.

The mouth is broken up into four sections: the upper right, upper left, lower right, and lower left. To locate these regions place your right index finger on the right-hand side of your face, the upper right section would be your upper jaw on the right-hand side of your face. The lower right section would be your lower jaw on the right-hand side of your face. You can use your left index finger to locate your upper left section and lower left section.

Do you have any questions on how to locate the upper right, upper left, lower right and lower left regions of your mouth?

If No to question 1, skip to Section D.

Note to interviewer: Please, ask the following questions for each region with exposed bone and fill the box below.

If there is a Yes to question 1, please complete questions 2 to 12 related to each region prior to progressing to the next region.

2. Which region of your mouth had an area of exposed bone?	☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left	☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left	☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left	☐ Upper Right ☐ Upper Left ☐ Lower Right ☐ Lower Left
3. When was the first time you were told or you noticed that there was some exposed bone in this area? *(MM/YYYY)*	____/_____	____/_____	____/_____	____/_____
4. Prior to the bone becoming exposed, did you have any tingling pain or other funny feelings in the affected area?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

5. Did the bone become exposed spontaneously?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Did you ever take anything to improve the condition?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. If yes, what did you use?	☐ Systemic Antibiotics (pills) ☐ Chlorhexidine Oral Rinses ☐ Povidone Iodine Rinses ☐ Anti-inflammatory Drugs ☐Analgesic – narcotics ☐ Other, specify: ____________________	☐ Systemic Antibiotics (pills) ☐ Chlorhexidine Oral Rinses ☐ Povidone Iodine Rinses ☐ Anti-inflammatory Drugs ☐Analgesic – narcotics ☐ Other, specify: ____________________	☐ Systemic Antibiotics (pills) ☐ Chlorhexidine Oral Rinses ☐ Povidone Iodine Rinses ☐ Anti-inflammatory Drugs ☐Analgesic – narcotics ☐ Other, specify: ____________________	☐ Systemic Antibiotics (pills) ☐ Chlorhexidine Oral Rinses ☐ Povidone Iodine Rinses ☐ Anti-inflammatory Drugs ☐Analgesic – narcotics ☐ Other, specify: ____________________
8. To the best of your knowledge, approximately how many weeks was the bone exposed?	_______	________	_______	_______
9. Is the area of exposed bone currently healed? (i.e., covered with skin, no exposed bone visible any more)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10. If yes, when approximately did it heal? *(MM/YYYY)*	____/_________	____/_________	____/_________	____/_________
11. Would you say that the area of exposed bone at its worst was the size of a dime, a quarter or larger than a quarter?	☐ Dime or smaller ☐ Quarter ☐ Larger than a quarter	☐ Dime or smaller ☐ Quarter ☐ Larger than a quarter	☐ Dime or smaller ☐ Quarter ☐ Larger than a quarter	☐ Dime or smaller ☐ Quarter ☐ Larger than a quarter
12. Did you experience pain when the area of bone first became exposed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section D. Concomitant Dental Factors

Now, I'd like to ask you about some dental procedures or events that may have occurred in the areas of your mouth after the year 2000. Please try to remember some important events in your life around the year 2000 to use as a reference.

Note to interviewer: Please, when necessary repeat the questions for each region.

Dental Treatment: *The following questions relate to dental treatments that you may have undergone since the year 2000.*

1. A dental extraction is when a tooth is pulled from your jaw by a dentist. Sometimes a tooth can also be pulled by you when it is very loose.
   (*FOR CONTROLS*) Since the year 2000, have you had any teeth pulled or extracted until today?
   (*FOR CASES*) Since the year 2000, have you had any teeth pulled or extracted before the bone became exposed?

   ☐ Yes ☐ No ☐ Unknown If No, skip to 6.

2. How many teeth were pulled? _____

Note to Interviewer: The following questions should be asked for each extracted tooth. Please use the table below to capture the appropriate answers.

3. What was the date when each tooth was extracted?
4. From which region of the mouth was the tooth extracted?
5. What was the reason? 1) Pain 2) Dental infection 3) Failing root canal 4) Gum disease 5) Cavity 6) Orthodontic Treatment 7) Do not know

	Extraction	Date of Extraction (MM/YYYY)	Tooth Quadrant	Reason for Extaction (Check all that apply)	
A	Extraction 1		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)
B	Extraction 2		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)
C	Extraction 3		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)

D	Extraction 4		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)
E	Extraction 5		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)
F	Extraction 6		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)
G	Extraction 7		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)
H	Extraction 8		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)
I	Extraction 9		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)
J	Extraction 10		☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right	☐ Pain (1) ☐ Failing Root Canal (3) ☐ Cavity (5) ☐ Do not know (7)	☐ Dental Infection (2) ☐ Gum Disease (4) ☐ Orthodontic Treatment (6)

6. It sometimes occurs that an invasive dental surgery is needed. With dental surgery, the gums are reflected or pulled away from the tooth by the dentist and local anesthetic is used to make the area numb. A dental assistant is typically present to aspirate bleeding that may occur.

(*FOR CONTROLS*) Since the year 2000, did you have a dental surgical procedure, other than extraction?

(*FOR CASES*) Since the year 2000, did you have a dental surgical procedure, other than extraction, before the bone became exposed?

☐ Yes ☐ No ☐ Unknown If No, skip to 12.

Note to Interviewer: Please use the table below to capture questions (7-11)

7. What dental surgical procedure was performed?
8. In which region of your mouth was the procedure performed?
9. What was the date the procedure was performed?
10. If Dental Gum Surgery was performed, what was the reason for Dental Gum Surgery?
11. Were any of these procedures performed to reduce pain or discomfort or any funny or strange feelings?

Dental Procedure Performed	**Tooth Quadrant**	**Date of Procedure (MM/YYYY)**	***If Dental Gum Surgery was performed,* what was the reason for Dental Gum Surgery**	**Were any of these procedures performed to reduce pain or discomfort or any funny or strange feelings?**
☐ Dental gum surgery ☐ Implant therapy ☐ Biopsy ☐ Other surgical procedure	☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right		☐ Failing root canal ☐ Gum disease ☐ Cavity below gum line ☐ Do not know ☐ Other, specify: ____________	☐ Yes ☐ No
☐ Dental gum surgery ☐ Implant therapy ☐ Biopsy ☐ Other surgical procedure	☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right		☐ Failing root canal ☐ Gum disease ☐ Cavity below gum line ☐ Do not know ☐ Other, specify: ____________	☐ Yes ☐ No
☐ Dental gum surgery ☐ Implant therapy ☐ Biopsy ☐ Other surgical procedure	☐ Upper Left ☐ Lower Left ☐ Upper Right ☐ Lower Right		☐ Failing root canal ☐ Gum disease ☐ Cavity below gum line ☐ Do not know ☐ Other, specify: ____________	☐ Yes ☐ No
☐ Dental gum surgery ☐ Implant therapy	☐ Upper Left ☐ Lower Left		☐ Failing root canal ☐ Gum disease	☐ Yes ☐ No

☐ Biopsy ☐ Other surgical procedure	☐ Upper Right ☐ Lower Right		☐ Cavity below gum line ☐ Do not know ☐ Other, specify: ________________	

12. (*FOR CONTROLS*) Since the year 2000, did you have removable dentures?
(*FOR CASES*) Since the year 2000, did you have removable dentures before the bone became exposed?

☐ Yes ☐ No ☐ Unknown If No, skip to 17

13. What type of denture was it? Complete Upper Complete Lower Partial Upper Partial Lower

14. If partial, what side of your mouth is it located? Right Left

15. How often do you wear the denture? Frequent Infrequent
(Frequent means that in any given week you would wear the denture 5 out of 7 days. On the days you wear the denture you would wear it for more than 6 hours. Infrequent means anything less than this).

16. Date you first received the denture?

Type of Denture	**If partial, what side of your mouth is it located?**	**Frequency of Denture Use**	**Date you first received the denture (MM/YYYY)**
☐ Complete Upper Denture ☐ Complete Lower Denture ☐ Partial Upper Denture ☐ Partial Lower Denture	☐ Right ☐ Left	☐ Frequent ☐ Infrequent	
☐ Complete Upper Denture ☐ Complete Lower Denture ☐ Partial Upper Denture ☐ Partial Lower Denture	☐ Right ☐ Left	☐ Frequent ☐ Infrequent	
☐ Complete Upper Denture ☐ Complete Lower Denture ☐ Partial Upper Denture ☐ Partial Lower Denture	☐ Right ☐ Left	☐ Frequent ☐ Infrequent	
☐ Complete Upper Denture ☐ Complete Lower Denture ☐ Partial Upper Denture ☐ Partial Lower Denture	☐ Right ☐ Left	☐ Frequent ☐ Infrequent	

17. (*FOR CONTROLS*) Since the year 2000, did you have a root canal treatment?
(FOR CASES) Since the year2000, did you have a root canal treatment before the bone became exposed?

☐ Yes ☐ No ☐ Unknown If No, skip to 19.

18. In which region of your mouth was the root canal performed? What was the date the root canal was performed?

Root Canal	**Tooth Quadrant**		**Date of Root Canal (MM/YYYY)**
Tooth 1	☐ Upper Right ☐ Lower Right	☐ Upper Left ☐ Lower Left	
Tooth 2	☐ Upper Right ☐ Lower Right	☐ Upper Left ☐ Lower Left	
Tooth 3	☐ Upper Right ☐ Lower Right	☐ Upper Left ☐ Lower Left	

19. (*FOR CONTROLS*) Since the year 2000, did you have any of your teeth straightened by orthodontic treatment?
(*FOR CASES*) Since the year 2000, did you have any of your teeth straightened by orthodontic treatment before the bone became exposed?

☐ Yes ☐ No ☐ Unknown If No, skip to 22.

20. What type of orthodontic treatment did you have? A) Fixed appliances, eg. Braces, B) Removable appliances, eg. Invisalign, or C) Both fixed and removable appliance.

21. In which region of your mouth was the procedure performed? What was the date the treatment started? What was the date the treatment finished?

Orthodontic Treatment	**Tooth Quadrant**		**Start Date (MM/YYYY)**	**End Date (MM/YYYY)**
☐ Fixed appliances, eg. Braces ☐ Removable appliances, eg. Invisalign ☐ Both fixed and removable appliance	☐ Upper Right ☐ Lower Right	☐ Upper Left ☐ Lower Left		
☐ Fixed appliances, eg. Braces ☐ Removable appliances, eg. Invisalign ☐ Both fixed and removable appliance	☐ Upper Right ☐ Lower Right	☐ Upper Left ☐ Lower Left		
☐ Fixed appliances, eg. Braces ☐ Removable appliances, eg. Invisalign ☐ Both fixed and removable appliance	☐ Upper Right ☐ Lower Right	☐ Upper Left ☐ Lower Left		
☐ Fixed appliances, eg. Braces ☐ Removable appliances, eg. Invisalign ☐ Both fixed and removable appliance	☐ Upper Right ☐ Lower Right	☐ Upper Left ☐ Lower Left		

Dental Disease and Acute Trauma

We finished the section on dental procedures. The following questions are regarding dental problems such as dental diseases and traumatic injuries that you may have had that could affect your oral health.

22. (*FOR CONTROLS*) Since the year 2000, did your dental care provider ever tell you that you had deepened periodontal pockets and bone loss?
(*FOR CASES*) Since the year 2000, did your dental care provider ever tell you that you had deepened periodontal pockets and bone loss before the bone became exposed?

☐ Yes ☐ No ☐ Unknown If No, skip to 25.

23. Was it generalized (present throughout the mouth)? ☐ Yes ☐ No

If Yes, skip to 25.

24. If No, in which region of your mouth was the periodontal disease located?	☐ Upper Right	☐ Upper Left	☐ Lower Right	☐ Lower Left

25. (*FOR CONTROLS*) Since the year 2000, did you have an injury, trauma, or accident to the lower part of your face or in your mouth?
(*FOR CASES*) Since the year 2000, did you have an injury, trauma, or accident to the lower part of your face or in your mouth before the bone became exposed?

☐ Yes ☐ No ☐ Unknown If No, skip to Section E.

26. In which region of your mouth was the injury?	☐ Upper Right	☐ Upper Left	☐ Lower Right	☐ Lower Left
27. What was the injury, trauma, or accident?	☐ Burn ☐ Sharp object ☐ Forceful Blow to the Jaw (e.g. car accident) ☐ Other, specify: _____	☐ Burn ☐ Sharp object ☐ Forceful Blow to the Jaw (e.g. car accident) ☐ Other, specify: _____	☐ Burn ☐ Sharp object ☐ Forceful Blow to the Jaw (e.g. car accident) ☐ Other, specify: _____	☐ Burn ☐ Sharp object ☐ Forceful Blow to the Jaw (e.g. car accident) ☐ Other, specify: _____

Section E. Medical History

We finished the section of dental related questions. Now I would like to ask you some questions about your general health and your medical history.

1. Have you been treated for any of the following cancers? If yes, when were you diagnosed?

a) Prostate Cancer (*for men only)*	☐ Yes	☐ No	☐ Unknown	Date:____/_____*(mm/yyyy)*
b) Breast Cancer (*for men and women)*	☐ Yes	☐ No	☐ Unknown	Date:____/_____*(mm/yyyy)*
c) Multiple Myeloma	☐ Yes	☐ No	☐ Unknown	Date:____/_____*(mm/yyyy)*
d) Other	☐ Yes	☐ No	☐ Unknown	Date:____/_____*(mm/yyyy)*

If other, please specify: _____

If No, skip to 5.

2. Did your cancer spread to your bones or did you have a bone metastasis? ☐ Yes ☐ No ☐ Unknown
3. Did you receive chemotherapy? ☐ Yes ☐ No ☐ Unknown
4. Did you receive cancer radiation therapy to the head and neck? ☐ Yes ☐ No ☐ Unknown
5. Have you ever been diagnosed by your doctor with the following:
   a) Paget's Disease? ☐ Yes ☐ No ☐ Unknown
   b) Lupus or any other auto-immune disease? ☐ Yes ☐ No ☐ Unknown
   c) Arthritis? ☐ Yes ☐ No ☐ Unknown
   d) Osteoporosis (weak bones)? ☐ Yes ☐ No ☐ Unknown
   e) Osteopenia (weak bones)? ☐ Yes ☐ No ☐ Unknown
   f) Diabetes (sugar disease)? ☐ Yes ☐ No ☐ Unknown
   g) Osteonecrosis in bones other than your jaws? ☐ Yes ☐ No ☐ Unknown
   h) HIV or AIDS? ☐ Yes ☐ No ☐ Unknown
   i) Anemia? ☐ Yes ☐ No ☐ Unknown
   j) Coagulopathy or blood clotting problems? ☐ Yes ☐ No ☐ Unknown
6. *(for women only)* Did you ever use Hormone Replacement Therapy? ☐ Yes ☐ No ☐ Unknown

Section F. Occupational Exposures

Now I have some questions I would like to ask you regarding your occupational experiences.

1. Have you ever worked in the chemical industry? □ Yes □ No □ Unknown

If No, skip to 3.

2. Do you know some of the chemicals you were exposed to?

_____

3. To the best of your knowledge, have you ever been exposed to white phosphor either in the arms/gun manufacturing industry or in a phosphor plant? □ Yes □ No

If No, skip to Section G.

4. Could you please describe how you were exposed to white phosphor?

_____

5. What was the length of employment, in years, during which you were exposed to white phosphor?

_____

Section G. Education and Lifestyle Exposures

The following questions are related to your personal attributes, experiences, and lifestyle.

Note to Interviewer: Please ask the patient what ethnicity they consider themselves to be.

1. Patient Ethnicity:

Hispanic or Latino	☐
Not Hispanic or Latino	☐
Unknown	☐
Unable to specify	☐

Note to Interviewer: Please ask the patient what race they consider themselves to be.

2. Patient Race:

American Indian/Alaska Native	☐
Asian	☐
Black/African American	☐
Native Hawaiian/Pacific Islander	☐
White	☐
Other	☐
Prefer not to specify	☐

3. What is the highest grade or level of school you have completed or the highest degree you have received?

a) No high school diploma (or GED) ☐

b) High school diploma (including GED) ☐

c) More than high school (includes Associate, Bachelor's, Master's, Professional, or Doctoral degrees) ☐

The next question is about your combined family income in the last 12 months. Please remember that by combined family income, I mean your income plus the income of all family members living in the household before taxes. This would include income from sources such as wages, salaries, Social Security or retirement benefits, help from relatives and so forth.

4. Of the following income groups, can you tell me which best represents your total household income in the last 12 months before taxes?

a)	$ 0 to $ 10,000	☐
b)	>$10,000 to $ 15,000	☐
c)	>$15,000 to $ 20,000	☐
d)	>$20,000 to $ 25,000	☐
e)	>$25,000 to $ 35,000	☐
f)	>$35,000 to $ 45,000	☐
g)	>$45,000 to $75,000	☐
h)	>$75,000	☐
i)	Refused	☐
j)	Don't know	☐

5. How many persons live in your household? _____

Now, I'd like to ask some questions about your use of alcoholic beverages. Answer the questions as honestly and accurately as you can. Remember that one drink is defined as 12 ounces of beer, 5 ounces of wine, or one standard cocktail (1.5 ounces of 80-proof liquor).

6. In a typical year before the year 2000, how often did you have a drink containing alcohol?

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

If "Never" skip to 8.

7. In a typical year before the year 2000, how many drinks containing alcohol did you have on a typical day when you were drinking?

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

Now, I'm going to ask questions about your smoking habits and use of other tobacco products.

8. Have you smoked 100 CIGARETTES or more in your entire life? ☐ Yes ☐ No

If No, skip to 13.

9. How old were you when you started smoking? _____

10. Do you smoke cigarettes now? ☐ Yes ☐ No

If Yes, skip to 12.

11. If No, how old were you when you quit smoking? _____

12. On average, how many cigarettes do/did you smoke per day? _____

13. Have you smoked at least 100 CIGARS in your entire life? ☐ Yes ☐ No

If No, skip to 18

14. How old were you when you started smoking CIGARS? _____

15. Do you smoke CIGARS now? ☐ Yes ☐ No

If Yes, skip to 17

16. If No, how old were you when you quit smoking CIGARS? _____

Note to interviewer: If participant reports smoking cigars less frequently than daily, enter <1.

17. On average, how many CIGARS do/did you smoke? *(choose one)*_____ ☐ per day

_____ ☐ per week

_____ ☐ per month

18. Have you EVER used CHEW TOBACCO regularly for a period of six weeks or more?

☐ Yes ☐ No

If No, skip to 23

19. How old were you when you started using CHEW TOBACCO? _____

20. Do you use CHEW TOBACCO now? ☐ Yes ☐ No

If Yes, skip to 22

21. If No, how old were you when you quit using CHEW TOBACCO? _____

22. On average, how many times per day do/did you CHEW TOBACCO? _____

23. Have you EVER used MOIST OR DRY SNUFF regularly for a period of six weeks or more?

☐ Yes ☐ No

If No, skip to Section H

24. How old were you when you started using MOIST OR DRY SNUFF? _____

25. Do you use MOIST OR DRY SNUFF now? ☐ Yes ☐ No

If Yes, skip to 27.

26. If No, how old were you when you quit using MOIST OR DRY SNUFF? _____

27. On average, how many times per day do/did you use MOIST OR DRY SNUFF? _____

Section H. Medications

Now I would like to ask you about some of the medications that you have taken during your lifetime. This is the last section of the interview. It would be helpful to use the sheets that we sent you in our last letter.

1. Have you EVER taken any of the following drugs orally or BY MOUTH?

a)	Actonel® or Risedronate	☐ Yes	☐ No	☐ Unknown
b)	Actonel and Calcium® or Risedronate + Calcium Carbonate	☐ Yes	☐ No	☐ Unknown
c)	Boniva® or Ibandronate	☐ Yes	☐ No	☐ Unknown
d)	Didronel® or Etidronate	☐ Yes	☐ No	☐ Unknown
e)	Fosamax® or Alendronate	☐ Yes	☐ No	☐ Unknown
f)	Fosamax Plus D® or Alendronate + Vitamin D	☐ Yes	☐ No	☐ Unknown
g)	Skelid® or Tiludronate	☐ Yes	☐ No	☐ Unknown
h)	An oral bisphosphonate of which you don't remember the name	☐ Yes	☐ No	☐ Unknown

If No to all drugs, skip to 8.

A *Note to interviewer: **Complete the A box before proceeding to the B box** Please, ask the questions 2-5 for each drug marked above and fill the box below.*

2. Which was the first drug you took?
3. For what condition(s) were you taking _____ (name of the drug)?
4. What is the dosage, number of units and frequency that you take _____(name of the drug)?
5. Did you ever change this prescription? Either the drug itself, the dose, the units or the frequency?

If yes, enter changed prescription in a new line

If answer to question is 'Unknown', enter UNK

B *Note to interviewer: Please, after completing the section A, ask the questions below for each drug/dosage combination.*

6. When did you start taking _____ (name of the drug) of _____(dosage)?
7. When did you stop taking them?

Record date in MM/YYYY format.
If month not known, enter 99
If year not known, ask for best guess or 9999

Agent (Drug)	Indication (if known)	Dose (e.g.40 mg)	Units (e.g. 1 tablet)	Frequency	Changed drug, dose or unit?	Date Started	Date Stopped enter **current date**, if still taking the drug,
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		

				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				_____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		

Note to interviewer: Possible indications of oral bisphosphonates are Osteoporosis, Paget's disease, and Heterotopic ossification.

8. Have you EVER received any of the following drugs intravenously (IV)?

a)	Aredia® or Pamidronate	☐ Yes	☐ No	☐ Unknown
b)	Bonefos® and Ostac® or Clodronate (not available in the US)	☐ Yes	☐ No	☐ Unknown
c)	Boniva® or Ibandronate	☐ Yes	☐ No	☐ Unknown
d)	Didronel® or Etidronate	☐ Yes	☐ No	☐ Unknown
e)	Zometa® or Zoledronic Acid	☐ Yes	☐ No	☐ Unknown
f)	An intravenous bisphosphonate of which you don't remember the name	☐ Yes	☐ No	☐ Unknown

If No to all drugs, skip to 15.

A *Note to interviewer: **Complete the A box before proceeding to the B box** Please, ask the questions 2-5 for each drug marked above and fill the box below.*

9. Which was the first drug you took?
10. For what condition(s) were you taking _____ (name of the drug)?
11. What is the dosage, number of units and frequency that you take _____(name of the drug)?
12. Did you ever change this prescription? Either the drug itself, the dose, the units or the frequency?

If yes, enter changed prescription in a new line

If answer to question is 'Unknown', enter UNK

B *Note to interviewer: Please, after completing the section A, ask the questions below for each drug/dosage combination.*

13. When did you start taking _____ (name of the drug) of _____(dosage)?
14. When did you stop taking them?

Record date in MM/YYYY format.
If month not known, enter 99
If year not known, ask for best guess or 9999

Agent (Drug)	Indication (if known)	Dose (e.g.40 mg)	IV Time (e.g. 15 mim)	Frequency (e.g. once daily for 3 days, repeated for 2-3 months)	Changed drug, dose or unit?	Date Started	Date Stopped enter **current date**, if still taking the drug,
					☐ Yes ☐ No ☐ Unknown		
					☐ Yes ☐ No ☐ Unknown		
					☐ Yes ☐ No ☐ Unknown		
					☐ Yes ☐ No ☐ Unknown		

Note to interviewer: Possible indications of IV bisphosphonates are Metastatic bone lesions, Hypercalcemia, Multiple myeloma, Osteolytic bone lesions with metastatic breast cancer, and Paget's disease.

15. Do you remember EVER taking one of these steroid drugs? (Mark all that apply.)

a) Prednisone (e.g. Deltasone®, Meticorten®, Orasone®)	☐ Yes	☐ No	☐ Unknown
b) Dexamethasone (e.g. Decadron®, Dexone®, Hexadrol®)	☐ Yes	☐ No	☐ Unknown
c) Hydrocortisone (e.g. Cortef®)	☐ Yes	☐ No	☐ Unknown
d) Other	☐ Yes	☐ No	☐ Unknown

If other, please specify: _____

If No to all drugs, skip to question 22.

A *Note to interviewer: **Complete the A box before proceeding to the B box** Please, ask the questions for each drug marked above and fill the box below.*

16. Which was the first drug you took?
17. For what condition(s) were you taking _____ (name of the drug)?
18. What is the dosage, number of units and frequency that you take _____(name of the drug)?
19. Did you ever change this prescription? Either the drug itself, the dose, the units or the frequency?

If yes, enter changed prescription in a new line

If answer to question is 'Unknown', enter UNK

B *Note to interviewer: Please, after completing the section A, ask the questions below for each drug/dosage combination.*

20. When did you start taking _____ (name of the drug) of _____(dosage)?
21. When did you stop taking them?

Record date in MM/YYYY format.
If month not known, enter 99
If year not known, ask for best guess or 9999

Agent (Drug)	Indication (if known)	Dose (e.g.40 mg)	Units (e.g. 1 tablet)	Frequency	Changed drug, dose or unit?	Date Started	Date Stopped enter **current date**, if still taking the drug,
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		

22. Since the year 2000, have you taken any other medication regularly or for 6 months or more?

☐ Yes ☐ No

If No, finish the interview.

23. What are the names of the medications?

A *Note to interviewer: **Complete the A box before proceeding to the B box** Please, ask the questions for each drug cited above and fill the box below.*

24. For what condition(s) were you taking _____ (name of the drug)?
25. What is the dosage, number of units and frequency that you take _____(name of the drug)?
26. Did you ever change this prescription? Either the drug itself, the dose, the units or the frequency?

If yes, enter changed prescription in a new line *If answer to question is 'Unknown', enter UNK*

B *Note to interviewer: Please, after completing the section A, ask the questions below for each drug/dosage combination.*

27. When did you start taking _____ (name of the drug) of _____(dosage)?
28. When did you stop taking them?

Record date in MM/YYYY format.
If month not known, enter 99
If year not known, ask for best guess or 9999

Agent (Drug)	Indication (if known)	Dose (e.g.40 mg)	Units (e.g. 1 tablet)	Frequency	Changed drug, dose or unit?	Date Started	Date Stopped enter **current date**, if still taking the drug,
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown		

				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown
				____ ☐ Days ☐ Week ☐ Month ☐ Year	☐ Yes ☐ No ☐ Unknown
