

## Blood, Urine, and Mouthwash Sample Survey

[SrvBio\_MODULEINTRO\_v1r0] Thank you for being part of Connect and for donating your samples. We have some questions about you and your health history. This information will help us better understand your health status, and how it is related to the samples that you donated. If you are not sure of an answer, please make your best guess.

1. [SrvBio\_SEX\_v1r0] Later questions in this survey will ask about your reproductive health, including your menstrual cycle (if you are menstruating) and your contraceptive use. We want to ask questions that make sense for you. What was your biological sex assigned at birth?  
  
0      Female  
1      Male  
2      Intersex or other
  
2. [SrvBio\_SYMPTDAY\_v1r0] Did you have any of the following symptoms in the 24 hours before you donated your samples? Select all that apply.  
  
0      [SrvBio\_COUGHDAY\_v1r0] Cough  
1      [SrvBio\_DIARRDAY\_v1r0] Diarrhea  
2      [SrvBio\_NOSEDAY\_v1r0] Stuffy nose (also known as nasal congestion)  
3      [SrvBio\_VOMITDAY\_v1r0] Feeling sick to your stomach or throwing up  
4      [SrvBio\_FEVERDAY\_v1r0] Fever  
88     [SrvBio\_NOSYMPTDAY\_v1r0] No, I had none of these symptoms
  
3. [SrvBio\_EATDRINKBEFORE\_v1r0] When did you last eat or drink anything other than water before donating your samples?  
  
0      The same day  
1      The day before  
2      More than a day before → **TO SrvBio\_SLEEPTIME\_v1r0**
  
4. [SrvBio\_EATDRINKTIME\_v1r0] At about what time did you last eat or drink anything other than water before donating your samples? Select your answer from the drop-down list below. If you are using a phone or tablet, please tap the gray box to enter your response.  
  
HH:MM AM/PM
  
5. [SrvBio\_SLEEPTIME\_v1r0] What time did you go to sleep on the night before donating your samples? Select your answer from the drop-down list below. If you are using a phone or tablet, please tap the gray box to enter your response.  
  
HH:MM AM/PM
  
6. [SrvBio\_WAKETIME\_v1r0] What time did you wake up on the day that you donated your samples? Select your answer from the drop-down list below. If you are using a phone or tablet, please tap the gray box to enter your response.

HH:MM AM/PM

### [SrvBIU\_MED\_v1r0] Medications

7. [GRID\_SrvBLU\_MED1\_V1R0] Have you taken any of these medications in the past month? If so, please share the last time you took each type of medication before donating your samples. If you are not sure of an answer, please make your best guess.

<i>[Radio button grid, select one each row]</i>	0 No	1 Yes, in the past day	2 Yes, in the past two days	3 Yes, in the past week	4 Yes, in the past month
[SrvBIU_TYLENOL_v1r0] Tylenol®					
[SrvBIU_NSAIDS_v1r0] NSAIDs [such as aspirin, Advil®, Aleve®]					
[SrvBIU_ACID_v1r0] Medications to lower stomach acid [such as Prilosec®, Prevacid®, Protonix®, Aciphex®, Omeprazole, Nexium®, Tagamet®, Zantac®]					

**[DISPLAY SrvBIU\_REPROINTRO\_v1r0 IF (SrvBio\_SEX\_v1r0= 0),  
ELSE, GO TO SrvMtW\_ORALHLTH\_v1r0]**

### [SrvBIU\_REPROINTRO\_v1r0] Reproductive Health

The following questions ask about your menstrual periods, if you are pregnant, and contraceptive use. Your answers will help us understand where your body was in your menstrual cycle when you donated your samples. You may have answered some questions like these on another survey, but the questions below ask about your status on the day that you donated your samples.

8. [SrvBIU\_MENSTPRD\_v2r0] Have you had a menstrual period in the last **12 months**? Please do **not** consider breakthrough bleeding (also known as spotting) as part of the menstrual period. *[this question requires a response]*
- 0 No → **GO TO SrvBIU\_PREGNANT\_v1r0**  
1 Yes
9. [SrvBIU\_MENST60\_v2r0] Have you had a menstrual period in the last **60 days**? Please do **not** consider breakthrough bleeding (also known as spotting) as part of the menstrual period. *[this question requires a response]*
- 0 No → **GO TO SrvBIU\_PREGNANT\_v1r0**  
1 Yes
10. [SrvBIU\_MENSTART\_v2r0] When was the start date of your most recent menstrual period (the first day on which you saw menstrual blood)? Please do **not** consider breakthrough bleeding (also known as spotting) as part of the menstrual period. If you are not sure or do not remember, please make your best guess. *[this question requires a response]*

MM/DD/YYYY

11. [SrvBIU\_PREGNANT\_v1r0] Are you pregnant now?

- 0 No
- 1 Yes → **GO TO SrvBIU\_BRSTFD\_v1r0**

12. [SrvBIU\_PREG3MON\_v1r0] Have you been pregnant in the last **three months**?

- 0 No
- 1 Yes

13. [SrvBIU\_BRSTFD\_v1r0] Are you breastfeeding now?

- 0 No
- 1 Yes → **GO TO SrvBIU\_CONTRACEPT\_v1r0**

14. [SrvBIU\_BRSTFD3MON\_v1r0] Did you breastfeed in the last **three months**?

- 0 No
- 1 Yes

**[DISPLAY SrvBIU\_CONTRACEPT\_v1r0 IF (SrvBIU\_PREGNANT\_v1r0= 0),  
ELSE, GO TO SrvMtW\_ORALHLTH\_v1r0]**

15. [SrvBIU\_CONTRACEPT\_v1r0] Within the **last month**, have you used hormonal contraceptives? These types of contraceptives include oral contraceptives (“the pill”), injections, implants, skin patches, vaginal rings, and hormonal intrauterine devices (IUDs).

- 0 No
- 1 Yes

16. [SrvBIU\_HORMONE\_v1r0] Within the **last month**, have you used prescription hormone therapy to relieve common symptoms of perimenopause and menopause (for example, hot flashes and vaginal dryness), or to reduce bone loss due to lowering levels of estrogen and progesterone?

- 0 No
- 1 Yes

## **Mouthwash Data Collection**

17. [SrvMtW\_ORALHLTH\_v1r0] Overall, how would you rate the health of your teeth and gums?

- 0 Excellent
- 1 Very Good
- 2 Good
- 3 Fair
- 4 Poor

77 Don't know

18. [SrvMtW\_MWBEFORE\_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you brush your teeth?

1 Yes  
0 No

19. [SrvMtW\_RINSEBEFORE\_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you rinse out your mouth?

1 Yes  
0 No

20. [SrvMtW\_GUMBEFORE\_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you chew gum?

1 Yes  
0 No

21. [SrvMtW\_TOBACCOBEFORE\_v1r0] In the **1 hour before** you donated your mouthwash (saliva) sample, did you smoke, vape, or chew any products (including tobacco)?

1 Yes  
0 No

## Oral Hygiene Products

22. [SrvMtW\_HYGIENE\_v1r0] Next, we have a few questions about your oral health and routine that will help us better understand your mouthwash (saliva) sample.

In the last **month**, which of these oral hygiene products have you used? Select all that apply.

- 0 [SrvMtW\_BRUSH1\_v1r0] Toothbrush
- 1 [SrvMtW\_FLOSS1\_v1r0] Floss
- 2 [SrvMtW\_WTRPICK1\_v1r0] Water-based flosser or pick/jet
- 3 [SrvMtW\_TONGUE1\_v1r0] Tongue Cleaner or Scraper
- 4 [SrvMtW\_WHITE1\_v1r0] Teeth-whiteners (strips, etc.)
- 5 [SrvMtW\_MW1\_v1r0] Mouthwash

[DISPLAY SrvMtW\_BRUSH2\_v1r0 IF (SrvMtW\_HYGEINE\_v1r0= 0)]

23. [SrvMtW\_BRUSH2\_v1r0] In the last **month**, how often did you use a toothbrush?

44 Never

- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMtW\_FLOSS2\_v1r0 IF (SrvMtW\_HYGEINE\_v1r0= 1)]

24. [SrvMtW\_FLOSS2\_v1r0] In the last **month**, how often did you use floss?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMtW\_WTRPICK2\_v1r0 IF (SrvMtW\_HYGEINE\_v1r0= 2)]

25. [SrvMtW\_WTRPICK2\_v1r0] In the last **month**, how often did you use a water-based flosser or pick/jet?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMtW\_TONGUE2\_v1r0 IF (SrvMtW\_HYGEINE\_v1r0= 3)]

26. [SrvMtW\_TONGUE2\_v1r0] In the last **month**, how often did you use a tongue cleaner or scraper?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

[DISPLAY SrvMtW\_WHITE2\_v1r0 IF (SrvMtW\_HYGEINE\_v1r0= 4)]

27. [SrvMtW\_WHITE2\_v1r0] In the last **month**, how often did you use teeth-whiteners (such as whitening strips)?

- 44      Never
- 0        Less than once per week
- 1        Once or twice per week
- 2        Three to five times per week
- 3        Once per day
- 4        Two or more times per day

## Mouthwash Products

[DISPLAY SrvMtW\_MWUSE\_v1r0 IF (SrvMtW\_HYGEINE\_v1r0= 5)  
ELSE, GO TO SrvMtW\_PERMTTHLOST\_v2r0]

28. [SrvMtW\_MWUSE\_v1r0] In the last **month**, which of these mouthwash products have you used?  
Select all that apply.

- 0        [SrvMtW\_MWALC1\_v1r0] Alcohol-based mouthwash (such as Scope® or LISTERINE®)
- 1        [SrvMtW\_MWALCFREE1\_v1r0] Alcohol-free mouthwash (such as LISTERINE® Zero)
- 2        [SrvMtW\_MWCHLOR1\_v1r0] Chlorhexidine mouthwash (such as Peridex™, PerioGard®,  
or Paroex®)
- 3        [SrvMtW\_MWFLUORIDE1\_v1r0] Fluoride mouthwash (such as ACT®)
- 4        [SrvMtW\_MWPEROX1\_v1r0] Peroxide mouthwash (such as Colgate® Peroxyl® Mouth  
Sore Rinse)
- 5        [SrvMtW\_MWCETYL1\_v1r0] Cetylpyridinium chloride mouthwash (such as Crest® Pro-  
Health)
- 6        [SrvMtW\_MWSENSITIVE1\_v1r0] Mouthwash for sensitive teeth (such as Sensodyne®)
- 7        [SrvMtW\_MWDRY1\_v1r0] Mouthwash for dry mouth (such as biotène®)

[DISPLAY SrvMtW\_MWALC\_v1r0 IF (SrvMtW\_MWUSE\_v1r0= 0)]

29. [SrvMtW\_MWALC\_v1r0] In the last **month**, how often did you use alcohol-based mouthwash  
(such as Scope® or LISTERINE®)?

- 44      Never
- 0        Less than once per week
- 1        Once or twice per week
- 2        Three to five times per week
- 3        Once per day
- 4        Two or more times per day

[DISPLAY SrvMtW\_MWALCFREE\_v1r0 IF (SrvMtW\_MWUSE\_v1r0= 1)]

30. [SrvMtW\_MWALCFREE\_v1r0] In the last **month**, how often did you use alcohol-free mouthwash  
(such as LISTERINE® Zero)?

- 44      Never

- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

**[DISPLAY SrvMtW\_MWCHLOR\_v1r0 IF (SrvMtW\_MWUSE\_v1r0= 2)]**

31. [SrvMtW\_MWCHLOR\_v1r0] In the last **month**, how often did you use chlorhexidine mouthwash (such as Peridex™, PerioGard®, or Paroex®)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

**[DISPLAY SrvMtW\_MWFLUORIDE\_v1r0 IF (SrvMtW\_MWUSE\_v1r0= 3)]**

32. [SrvMtW\_MWFLUORIDE\_v1r0] In the last **month**, how often did you use fluoride mouthwash (such as ACT®)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

**[DISPLAY SrvMtW\_MWPEROX\_v1r0 IF (SrvMtW\_MWUSE\_v1r0= 4)]**

33. [SrvMtW\_MWPEROX\_v1r0] In the last **month**, how often did you use peroxide mouthwash (such as Colgate® Peroxyl® Mouth Sore Rinse)?

- 44 Never
- 0 Less than once per week
- 1 Once or twice per week
- 2 Three to five times per week
- 3 Once per day
- 4 Two or more times per day

**[DISPLAY SrvMtW\_MWCETYL\_v1r0 IF (SrvMtW\_MWUSE\_v1r0= 5)]**

34. [SrvMtW\_MWCETYL\_v1r0] In the last **month**, how often did you use cetylpyridinium chloride mouthwash (such as Crest® Pro- Health)?

- 44      Never
- 0      Less than once per week
- 1      Once or twice per week
- 2      Three to five times per week
- 3      Once per day
- 4      Two or more times per day

**[DISPLAY SrvMtW\_MWSENSITIVE\_v1r0 IF (SrvMtW\_MWUSE\_v1r0= 6)]**

35. [SrvMtW\_MWSENSITIVE\_v1r0] In the last **month**, how often did you use mouthwash for sensitive teeth (such as Sensodyne®)?

- 44      Never
- 0      Less than once per week
- 1      Once or twice per week
- 2      Three to five times per week
- 3      Once per day
- 4      Two or more times per day

**[DISPLAY SrvMtW\_MWDRY\_v1r0 IF (SrvMtW\_MWUSE\_v1r0= 7)]**

36. [SrvMtW\_MWDRY\_v1r0] In the last **month**, how often did you use mouthwash for dry mouth (such as biotène®)?

- 44      Never
- 0      Less than once per week
- 1      Once or twice per week
- 2      Three to five times per week
- 3      Once per day
- 4      Two or more times per day

## **Permanent Teeth Lost**

37. [SrvMtW\_PERMTTHLOST\_v2r0] Have you lost any of your permanent adult teeth, not including tooth crowns or your wisdom teeth? Select all that apply.

- 1      [SrvMtW\_PERMTTHLOST1\_v1r0] Yes, from accident or injury → **GO TO SrvMtW\_TEETHLOSTAI\_v1r0**
- 2      [SrvMtW\_PERMTTHLOST2\_v1r0] Yes, from tooth decay or disease → **GO TO SrvMtW\_TEETHLOSTD\_v1r0**
- 3      [SrvMtW\_PERMTTHLOST3\_v1r0] Yes, for some other reason → **GO TO SrvMtW\_TEETHLOSTOTH\_v1r0**
- 0      [SrvMtW\_NOPERMTTHLOST\_v1r0] No → **GO TO SrvMtW\_DENTURES\_v1r0**



***NO RESPONSE → GO TO SrvMtW\_DENTURES\_v1r0***

**[DISPLAY SrvMtW\_TEETHLOSTAI\_v2r0 IF (SrvMtW\_PERMTTHLOST\_v2r0= 1),  
ELSE GO TO SrvMtW\_TEETHLOSTD\_v2r0]**

38. [SrvMtW\_TEETHLOSTAI\_v2r0] How many teeth have you lost from accident or injury? Do not include tooth crowns or wisdom teeth.

- |    |                                      |
|----|--------------------------------------|
| 0  | 1                                    |
| 1  | 2 to 4                               |
| 2  | 5 to 9                               |
| 3  | 10 or more                           |
| 4  | More than one, but not sure how many |
| 77 | Don't know                           |

**[DISPLAY SrvMtW\_TEETHLOSTD\_v2r0 IF (SrvMtW\_PERMTTHLOST\_v2r0= 2),  
ELSE GO TO SrvMtW\_TEETHLOSTOTH\_v2r0]**

39. [SrvMtW\_TEETHLOSTD\_v2r0] How many teeth have you lost from tooth decay or disease? Do not include tooth crowns or wisdom teeth.

- |    |                                      |
|----|--------------------------------------|
| 0  | 1                                    |
| 1  | 2 to 4                               |
| 2  | 5 to 9                               |
| 3  | 10 or more                           |
| 4  | More than one, but not sure how many |
| 77 | Don't know                           |

**[DISPLAY SrvMtW\_TEETHLOSTOTH\_v2r0 IF (SrvMtW\_PERMTTHLOST\_v2r0= 3),  
ELSE GO TO SrvMtW\_DENTURES\_v1r0]**

40. [SrvMtW\_TEETHLOSTOTH\_v2r0] How many teeth have you lost for reasons other than tooth decay or disease, or accident or injury? Do not include tooth crowns or wisdom teeth.

- |    |                                      |
|----|--------------------------------------|
| 0  | 1                                    |
| 1  | 2 to 4                               |
| 2  | 5 to 9                               |
| 3  | 10 or more                           |
| 4  | More than one, but not sure how many |
| 77 | Don't know                           |

41. [SrvMtW\_DENTURES\_v1r0] Do you currently use any type of dentures or dental appliance? Please select all you have.

- |   |  |
|---|--|
| 1 | Dental Bridge [SrvMtW_DENTBRIDGE_v1r0] |
|---|--|

- 2 Partial denture [SrvMtW\_PARTDENT\_v1r0]
- 3 Full denture [SrvMtW\_FULLDENT\_v1r0]
- 4 Dental Implants [SrvMtW\_DENTIMP\_v1r0]
- 55 Other [SrvMtW\_DENTOTHER\_v1r0]
- 0 No, I have no dentures or dental appliances. [SrvMtW\_DENTURES2\_v1r0]
- 77 Don't know [SrvMtW\_DENTURES2\_v1r0]

## Oral Health

42. [SrvMtW\_DENTALCLEAN\_v1r0] When did you last have a professional dental cleaning by a dentist or hygienist?

- 0 In the past month
- 1 More than a month ago, but in the past 6 months
- 2 More than 6 months ago, but in the past year
- 3 More than a year ago, but in the past 2 years
- 4 More than 2 years ago
- 77 Don't know

43. [SrvMtW\_CAVITY\_v1r0] Have you ever had a cavity in any of your permanent adult teeth? Please include root caries, which are cavities on the root of the tooth.

- 1 Yes
- 0 No
- 77 Don't know

44. [SrvMtW\_GUMDISEASE\_v1r0] Has a dentist ever told you that you have gum disease (periodontal disease)?

- 1 Yes
- 0 No
- 77 Don't know

45. [SrvMtW\_GUMTX\_v1r0] Have you ever had treatment for gum disease, such as scaling or root planing, sometimes called "deep cleaning"?

- 1 Yes
- 0 No
- 77 Don't know

46. [SrvMtW\_ANTIBIO\_v1r0] In the **past two months**, have you taken any antibiotic medicine? Common antibiotics include Azithromycin (such as Zithromax®/Z-Paks®), Penicillin (such as

Pfizerpen® or Pen-Vee K®), and Amoxicillin (such as Amoxil®) and are generally used to treat infections.

1 Yes → **GO TO SrvMtW\_ANTIBIOTIME\_v1r0**

0 No → **GO TO END**

77 Don't know → **GO TO END**

**NO RESPONSE → GO TO END**

47. [SrvMtW\_ANTIBIOTIME\_v1r0] When did you last take antibiotic medicine?

0 Within the last 24 hours

1 More than 24 hours ago, but in the past week

2 More than 1 week ago, but in the past 4 weeks

3 More than 4 weeks ago

Closing remark on submit survey screen: "You have answered all of the questions in this survey. To submit your answers, select the "Submit Survey" button."