Supplementary table I: Revised survey tool characterizing supplement use among perimenopausal and menopausal women in a rural region of Hawai'i, US (available at https://tinyurl.com/Caldwell2018Survey)

1. **What is your...**
   Age? __________
   Height? ________feet _________ inches
   Weight?____________________ pounds

2. **When was your last period?**
   ☐ Less than 1 year ago
   ☐ More than 1 year ago
   ☐ More than 5 years ago
   ☐ More than 10 years ago

3. **What is your race?** (Select **all** that apply)

☐ American Indian ☐ Alaska Native	☐ Hispanic or Latina Central American ☐ Hispanic or Latina Mexican ☐ Hispanic or Latina South American ☐ Puerto Rican ☐ Other Hispanic or Latinx
☐ Chinese ☐ Filipina ☐ Japanese ☐ Okinawan ☐ Korean ☐ Asian Indian ☐ Vietnamese ☐ Hmong ☐ Laotian ☐ Other Asian	☐ Native Hawaiian ☐ Guamanian, Chamorro, or Chamoru ☐ Micronesian ☐ Nauruan ☐ Kiribati ☐ Marshallese ☐ Samoan ☐ Tongan ☐ Fijian ☐ Tahitian ☐ Carolinian ☐ Other Pacific Islander ☐ Middle Eastern
☐ African American ☐ African (Black) ☐ Caribbean (Black) ☐ Other Black	
☐ White/Caucasian	
☐ Other____	

4. **What is your PRIMARY race/ethnicity?** (choose one)

   ____

5. **Please indicate the highest level of education?**
   ☐ Some high school (but no GED or diploma)
   ☐ High school graduate (GED or diploma)
   ☐ Some college courses
   ☐ Associate's or Bachelor's degree
   ☐ Graduate degree

6. **What is your marital status?**
   - ☐ Single
   - ☐ Married
   - ☐ Widowed
   - ☐ Divorced/Separated

7. **Based on the <u>past six months</u>, use the table to estimate your use of each of the following vitamins, minerals, and/or supplements. <u>Mark an X in the appropriate column</u> for each vitamin/mineral/supplement. Write your reason for taking the supplement in the far right column.**

Vitamin & Mineral Supplements	**Estimation of Use**					**Reason for Use**
	Never	Once per Month	Once per week	Few times per week	Daily	
EXAMPLE – B12	X					
EXAMPLE – Green Tea			X			Help lose weight
Multivitamin						
Mega/High potency vitamin						
Combination Antioxidant Supplement						
Individual Vitamins/Minerals	Never	Once per Month	Once per week	Few times per week	Daily	**Reason for Use**
Vitamin A						
Vitamin C						
Vitamin D						
Vitamin E						
Beta-carotene						
B-Complex supplement						
B2 (Riboflavin) alone						
B5 (Pantothenic acid) alone						
B6 (Pyridoxine) alone						
B12 (Cyanocobalamin)						
Calcium						
Chromium						
Folate (Folic acid)						
Iron						
Magnesium						
Phosphate/Phosphorous						
Potassium						
Selenium						
Zinc						

Vitamin & Mineral Supplements	Estimation of Use					Reason for Use
	Never	Once per Month	Once per week	Few times per week	Daily	
EXAMPLE – B12	X					
EXAMPLE – Green Tea			X			Help lose weight
Alpha lipoic acid						
Androstenedione (Andro)						
‘Awa						
‘Awapuhi						
ArginMax						
BCAA (Branch chain AA)						
Bioastin (Hawaiian Astaxanthin)						
Black cohosh (Cimicifuga racemosa)						
Caffeine						
Chaulmoogra						
CoQ 10 (Coenzyme Q10)						
DHEA						
DIM (Diinodolylmethane)						
Dong quai						
Ephedrine/Ephedra						
Evening Primrose Seed Oil						
Fish Oil or Omega 3s						
Garlic						
Ginkgo Biloba						
Ginseng						
Glucosamine/Chondroitin						
Green tea						
Guarana						
Hoodia Gordonii						
Horney goat weed						
Kava						
Ti leaf						
Kalo						
Kukui						
Ko						
Ko’oko’olau						
Koali						
L-Carnitine						
Lycopene						
Meal replacement drinks						
Melatonin						
Noni						
‘Ohia ai						

Vitamin & Mineral Supplements	Estimation of Use					Reason for Use
	Never	Once per Month	Once per week	Few times per week	Daily	
EXAMPLE – B12	X					
EXAMPLE – Green Tea			X			Help lose weight
Pomegranate (Punica granatum)						
Popolo						
Psyllium						
Red clover						
Soy Isoflavone						
Sports Bars (Powerbar, Tiger's Milk)/jelly beans/chews						
Sports drinks (Gatorade, Powerade)						
Synephrine/Bitter Orange						
Tyrosine						
'Uhualoa						
Willow bark						
Chinese Yam						
Yerba mate						
Yohimbe						
Other: _______________						
Other: _______________						

Protein or other related supplement	Estimation of Use					Reason for Use
	Never	Once per Month	Once per week	Few times per week	Daily	
Protein Powder						
Amino Acid Mixture						
Arginine/Nitric Oxide – alone						
Creatine – alone						
Glutamine -alone						

8. **How confident are you that your dietary supplements will do as they claim?** *(Select one box below)*

☐ Not confident at all	☐ Somewhat confident	☐ Very confident	☐ Extremely Confident

9. **How confident are you that your dietary supplements are safe to consume?** *(Select one box below)*

☐ Not confident at all	☐ Somewhat confident	☐ Very confident	☐ Extremely Confident

10. **What is your primary goal for taking supplements?** *(Select ONE)*
    - ☐ Performance enhancer
    - ☐ Promote general health
    - ☐ Give more energy
    - ☐ Increased endurance
    - ☐ Greater muscle strength
    - ☐ Lose weight
    - ☐ Replace things that are missing from my diet
    - ☐ Improve menopause-related symptoms
    - ☐ My healthcare provider told me to
    - ☐ I don't know

11. **If you avoid supplements, why do you avoid them?** *(Please mark all that apply)*
    - ☐ Aggravates medical problems
    - ☐ Upset your stomach
    - ☐ Caused insomnia
    - ☐ Caused or intensifies anxiety
    - ☐ Caused or intensifies feelings of nervousness
    - ☐ Does not boost your energy
    - ☐ Heartburn
    - ☐ Dizziness
    - ☐ Dehydration
    - ☐ Rapid heart rate
    - ☐ Too expensive
    - ☐ Do not like the taste
    - ☐ Other___________________________

12. During the past three months, on average, how much money did you spend per month on dietary supplements?

$________________________________

13. How do you consider your general health *(Select one)*

☐ Poor	☐ Fair	☐ Good	☐ Excellent

14. Have you experienced any of the following negative side effects while consuming dietary supplements? *(Please mark all that apply)*

☐Abnormal or fast heartbeat
☐Stomach pain/diarrhea/nausea/vomiting
☐Dizziness or confusion
☐Tremors or shaking
☐Numbness or tingling of arms or legs
☐Loss of consciousness/pass out
☐Vaginal bleeding
☐Other____________________________

15. What or who is the source of your dietary supplement information?
(Please mark all that apply)

☐ Family members
☐ Friends
☐ A health professional (such as doctor, nurse, dietitian, etc.)
☐ A personal trainer
☐ Magazines
☐ Books
☐ Medical Journals (such as New England Journal of Medicine)
☐ Internet or social media
☐ Store sales person
☐ Television
☐ Other____

Thank you for taking the time to fill out this survey.
Please check over the questions to be sure nothing was missed.