BEGIN HERE. PLEASE USE NO. 2 PENCIL ONLY.

1. Date of Birth

	DAY	YEAR
○ Jan		1
○ Feb		
○ Mar	0 0	0 0
○ Apr	1 1	1 1
○ May	2 2	2 2
○ Jun	3 3	3 3
○ Jul	4	4 4
○ Aug	5	5 5
○ Sep	6	6 6
○ Oct	7	7 7
○ Nov	8	8 8 8
○ Dec	9	9 9 9

2. Sex

○ Female
○ Male

3. Current Marital Status:

○ Single
○ Married
○ Divorced
○ Widowed

4. Social Security Number

0 0 0 0 0 0 0 0 0
1 1 1 1 1 1 1 1 1
2 2 2 2 2 2 2 2 2
3 3 3 3 3 3 3 3 3
4 4 4 4 4 4 4 4 4
5 5 5 5 5 5 5 5 5
6 6 6 6 6 6 6 6 6
7 7 7 7 7 7 7 7 7
8 8 8 8 8 8 8 8 8
9 9 9 9 9 9 9 9 9

5. Height

FEET	INCHES
	0 0
	1 1
	2
3	3
4	4
5	5
6	6
7	7
	8
	9

6. Weight

POUNDS
0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6
7 7
8 8
9 9

7. Race:

○ White/ Non-Hispanic
○ Hispanic
○ African American/Black
○ Asian or Pacific Islander
○ American Indian or Alaskan Native
○ Other or Unknown

8. What is your professional qualification?

○ R.N. ○ L.P.N. or L.V.N. ○ Other
○ MD/MD equivalent ○ DDS/DMD ○ DVM

9. What is the highest level of education you have completed?

○ L.P.N. or L.V.N. training ○ 2-year Associate's degree–R.N. ○ Diploma program (3-year–R.N.)
○ Bachelor's degree or B.S. in nursing ○ Master's degree ○ Doctoral degree (including MD)

10. Are you currently a participant in the Nurses' Health Study, a prospective cohort study of registered nurses that has been ongoing since 1976, or the Nurses' Health Study II, which has been ongoing since 1989?

○ No ○ Yes → **IF YES: YOU ARE NOT ELIGIBLE TO PARTICIPATE IN THE WOMEN'S HEALTH STUDY. PLEASE RETURN THIS FORM. THANK YOU.**
○ Not applicable

11. Have your menstrual periods ceased permanently?

○ No, premenopausal ○ Not sure ○ Yes (Includes those who have reached menopause but now have periods induced by hormones)

IF NO or NOT SURE:

Do you intend to become pregnant at any time in the future?

○ No ○ Yes ○ Not sure

Have you had a tubal ligation?

○ No ○ Yes

a) **At what age did your natural periods cease?** → AGE

b) **For what reason did they cease?**

○ Surgery → If due to surgery, were your ovaries removed?
○ Yes, both ○ Yes, one only ○ No, only uterus removed

○ Radiation or Chemotherapy

○ Natural → If natural menopause (not due to the above), have you had subsequent surgery to remove ovaries or uterus? **(Mark all that apply.)**
○ No ○ One ovary removed
○ Both ovaries removed ○ Uterus removed

AGE
0 0
1 1
2 2
3 3
4 4
5 5
6 6
7 7
8 8
9 9

12. At what age did your menstrual periods begin?

○ 9 or younger ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16 ○ 17 or older

13. Have you *EVER* been pregnant?

○ No ○ Yes **IF YES**

a) **How many pregnancies lasting six months or more have you had?**
○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 or more

b) **How old were you at the end of your first pregnancy lasting six months or more?**
○ Not applicable ○ Less than 15 years ○ 15-19 ○ 20-24 ○ 25-29
○ 30-34 ○ 35-39 ○ 40 or more years

c) **How many pregnancies lasting less than six months (including miscarriages and abortions) have you had?**
○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 or more

Regardless of your decision to participate in the trial, we would be grateful if you completed the entire form.

PLEASE CONTINUE ON NEXT PAGE.

1 2 4 8 P

1 2 3 4 5 6 7 8 9 0 1 2 3 4 5 6 7 8 9 0 a b c d e f g h i j k l m n o

14. Have you *EVER* used oral contraceptives for two months or more for any reason (contraception, acne, menstrual irregularity, etc.)?

○ No ○ Not sure ○ Yes **IF YES: What is the total number of years that you have used oral contraceptives?**

○ Less than 1/2 year ○ 1/2-2 years ○ 3-4 years ○ 5 or more years

15. Have you *EVER* used postmenopausal hormones (e.g., estrogen)?

○ Never ○ Past only ○ Currently

IF used in PAST or CURRENTLY:

a) **For how many TOTAL YEARS?** ○ Less than 1 year ○ 1 year ○ 2 years ○ 3-4 years ○ 5-7 years ○ 8 or more years

b) **Type of hormone used MOST RECENTLY?** ○ Conjugated estrogen **ALONE** (e.g., Premarin) ○ Conjugated estrogen **AND** progesterone ○ Non-conjugated estrogens **ALONE** (e.g., Estrace, Estinyl, Ogen) ○ Non-conjugated estrogens **AND** progesterone ○ Patch estrogen **ALONE** ○ Patch estrogen **AND** progesterone ○ Oral progesterone **ALONE** (e.g., Provera) ○ Vaginal estrogen ○ Other → SPECIFY:

c) **MOST RECENT dose of oral conjugated estrogen (e.g., Premarin):** ○ Not used ○ Dose unknown ○ .30 mg/day or less ○ .625 mg/day ○ .9 mg/day or more

d) **MOST RECENT dose of progesterone (e.g., Provera):** ○ Not used ○ Dose unknown ○ Less than 5 mg/day ○ 5-9 mg/day ○ 10 mg/day ○ More than 10 mg/day

e) **MOST RECENT progesterone use pattern:** ○ Not used ○ Continuous ○ Less than 2 weeks per month

16. As a participant in the trial, you will not be able to use *NON-STUDY* aspirin, medications containing aspirin, nonsteroidal anti-inflammatory agents, or individual supplements of beta-carotene, vitamin A, or vitamin E. Do you *CURRENTLY* take any of the following on a regular basis, i.e., *MORE THAN ONE DAY PER WEEK, ON AVERAGE?* (Please answer *NO* or *YES* on each line.)

a) Aspirin (do not include acetaminophen such as Tylenol)	○ No	○ Yes
b) Medications containing aspirin (e.g., Alka-Seltzer, Sine-Off, Doan's Pills, Darvon, Fiorinal)	○ No	○ Yes
c) Nonsteroidal anti-inflammatory agents (e.g., Motrin, Advil, Naprosyn, Feldene, Nuprin, Mediprin)	○ No	○ Yes
d) Individual supplements of beta-carotene (not including multivitamins)	○ No	○ Yes
e) Individual supplements of vitamin E (not including multivitamins)	○ No	○ Yes
f) Individual supplements of vitamin A (not including multivitamins)	○ No	○ Yes

In addition, do you *CURRENTLY* take either of the following *MORE THAN ONE DAY PER WEEK, ON AVERAGE?*

g) Individual supplements of vitamin C (not including multivitamins)	○ No	○ Yes
h) Acetaminophen (e.g., Tylenol, Datril)	○ No	○ Yes

17. As a participant in the Women's Health Study, would you be willing to forego the use of NON-STUDY aspirin, medications containing aspirin, and nonsteroidal anti-inflammatory agents?

○ No ○ Yes

18. Have you experienced adverse effects to aspirin which you believe are serious enough to prevent you from taking a low dose regularly as part of this study?

○ No ○ Yes

19. Have you *EVER* taken multivitamins on a regular basis? (Include pre-natal and post-natal use)

○ Never ○ Past only ○ Currently → **IF used in PAST or CURRENTLY, for how many total years?**

○ 0-1 years ○ 2-4 years ○ 5-9 years ○ 10-14 years ○ 15-19 years ○ 20 or more years

20. Are you *CURRENTLY* taking any anticoagulants (e.g., Coumadin, Heparin)?

○ No ○ Yes

21. Are you *CURRENTLY* taking any corticosteroids (e.g., Prednisone)? (Include use of inhalers or topical steroids only if used more than 10 times/day)

○ No ○ Yes

22. Have you *EVER* been diagnosed by a physician as having high cholesterol?

○ No ○ Yes → **IF YES: Are you currently being treated with cholesterol-lowering medication?**

○ No ○ Yes

23. Have you *EVER* been diagnosed by a physician as having high blood pressure (hypertension)?

○ No ○ Yes → **IF YES: Are you currently being treated with medication for high blood pressure?**

○ No ○ Yes

24. Please record your average consumption of the following beverages over the *LAST YEAR:*

	Never or Less Than One/Month	1-3 Per Month	1 Per Week	2-4 Per Week	5-6 Per Week	1 Per Day	2-3 Per Day	4-5 Per Day	6+ Per Day
a) Beer (1 glass, bottle, can)	○	○	(W)	○	○	(D)	○	○	○
b) Red wine (include sherry, port) (4 oz. glass)	○	○	(W)	○	○	(D)	○	○	○
c) White wine (4 oz. glass)	○	○	(W)	○	○	(D)	○	○	○
d) Liquor (e.g., vodka, rum, gin, liqueur, brandy) (one drink or shot)	○	○	(W)	○	○	(D)	○	○	○

25. How often do you engage in strenuous (aerobic) physical activity (e.g., swimming, aerobics, cycling, running)?

○ Rarely/never ○ Less than once/week ○ Once/week ○ 2-3 times/week ○ 4-6 times/week ○ Daily

26. Have you *EVER* had any of the following? Please indicate (N) or (Y) for EACH line. If (Y), provide YR of FIRST DX.

	NO	YES	YEAR	
Myocardial infarction (heart attack)	N	Y →		a
Stroke or TIA (transient ischemic attack)	N	Y →		b
Angina pectoris	N	Y →		c
IF YES, confirmed by: angiogram? No Yes				1
IF YES, confirmed by: stress test? No Yes				2
Coronary angioplasty (PTCA)	N	Y →		d
Coronary bypass surgery (CABG)	N	Y →		e
Carotid artery surgery (endarterectomy)	N	Y →		f
Peripheral artery surgery	N	Y →		g
Intermittent claudication	N	Y →		h
Melanoma	N	Y →		i
Non-melanoma skin cancer	N	Y →		j
IF YES, type: basal cell squamous cell unknown				1
Fibrocystic or other benign breast disease	N	Y →		k
IF YES, confirmed by: breast biopsy? No Yes				1
IF YES, confirmed by: aspiration? No Yes				2
Breast cancer	N	Y →		l
Other cancer (non-skin, non-breast)	N	Y →		m
IF YES, SITE:				i
				e
Active or chronic liver disease or cirrhosis	N	Y →		n
Chronic kidney failure	N	Y →		o
Bleeding hemorrhoids	N	Y →		p
Any other gastrointestinal bleeding	N	Y →		q
Ulcer	N	Y →		r
Coagulation disorder (e.g., Von Willebrand's disease)	N	Y →		s
Gout	N	Y →		t
Migraine headaches	N	Y →		u
Diabetes mellitus, diagnosed prior to age 30	N	Y →		v
Diabetes mellitus, diagnosed at 30 or older	N	Y →		w
Colon polyp (benign)	N	Y →		x
Multiple sclerosis	N	Y →		y
Amyotrophic lateral sclerosis (ALS)	N	Y →		z
Systemic lupus erythematosus (SLE)	N	Y →		aa
Rheumatoid arthritis (Dr. diagnosed)	N	Y →		bb
IF YES, Rheumatoid factor: Negative/unknown Positive				1
Other arthritis	N	Y →		cc
Joint pain or joint swelling	N	Y →		dd
Hip replacement	N	Y →		ee
Knee replacement	N	Y →		ff
Osteoporosis	N	Y →		gg
Scleroderma	N	Y →		hh
Dermatomyositis or polymyositis	N	Y →		ii
Sjögren's syndrome	N	Y →		jj
Any other connective tissue disorder (including mixed)	N	Y →		kk
Other major illness	N	Y →		ll
IF YES, SPECIFY MAJOR ILLNESS:				i
				e
				yy

27. Did any of these relatives ever have...

	UNKOWN OR NONE	RELATIVE: MOTHER	ANY SISTER	FATHER	ANY BROTHER	
a) Diabetes?	○	○	○	○	○	a
b) Colon or rectal cancer?	○	○	○	○	○	b
c) Ovarian cancer?	○	○	○			c

28. Did any of these relatives ever have... AGE AT FIRST DIAGNOSIS

a) Myocardial Infarction?	NO or UNKNOWN	YES	BEFORE AGE 40	AGE 40 TO 49	AGE 50 TO 59	AGE 60+	??? AGE	
Mother	○	○ →	○	○	○	○	○	a
Father	○	○ →	○	○	○	○	○	b
b) Breast Cancer?								
Mother	○	○ →	○	○	○	○	○	c
Any sister	○	○ →	○	○	○	○	○	d
Maternal grandmother	○	○ →	○	○	○	○	○	e
Paternal grandmother	○	○ →	○	○	○	○	○	f

29. In the *PAST YEAR*, have you had migraine headaches? ○ No ○ Yes **IF YES:**

a) **What is the approximate frequency of your migraines?**
○ Daily ○ Weekly ○ Monthly ○ Every other month ○ Less than 6 times per year

b) **Do your migraines have any of the following characteristics? *(Mark all that apply.)***
- ○ Aura or any other indication a migraine is coming
- ○ Unilateral location of pain
- ○ Pulsating quality
- ○ Inhibit daily activities
- ○ Nausea and/or vomiting
- ○ Light sensitivity
- ○ Sensitivity to sound
- ○ Tingling or numbness
- ○ Difficulty with speech
- ○ Duration of 4–72 hours
- ○ Aggravation by routine physical activity
- ○ Dizziness or vertigo
- ○ Unilateral weakness in face, arms or legs
- ○ NONE OF THE ABOVE

30. Have you smoked 100 cigarettes or more in your lifetime?
○ No ○ Yes, currently smoke ○ Yes, smoked in past but quit

IF YES, *CURRENTLY* what specific brand and type? (e.g., Marlboro Lights 100's)
SPECIFY:

IF YES, *BUT QUIT*: When did you quit?
○ Less than 1 year ago ○ 1 or more years ago

a) **How many total years have you smoked?**
○ Less than 5 years ○ 5-9 ○ 10-19 ○ 20-29 ○ 30-39 ○ 40-49 ○ 50 or more years

b) **At each age: what was the average number of cigarettes you smoked PER DAY during the time that you smoked?**

AGE	None	1-4	5-14	15-24	25-35	36-44	45+	
<15	○	○	○	○	○	○	○	1
15-19	○	○	○	○	○	○	○	2
20-29	○	○	○	○	○	○	○	3
30-39	○	○	○	○	○	○	○	4
40-49	○	○	○	○	○	○	○	5
50-59	○	○	○	○	○	○	○	6
60-69	○	○	○	○	○	○	○	7
70+	○	○	○	○	○	○	○	8

31. Are you living with a spouse or significant other who *CURRENTLY* smokes cigarettes?
○ No ○ Yes

PLEASE CONTINUE ON NEXT PAGE. →

ID #

32 **32. On average, how many hours *PER WEEK* are you in a room where someone other than yourself is smoking cigarettes?**

◯ None ◯ 1-4 hrs. ◯ 5-8 hrs. ◯ 9-12 hrs. ◯ 13-24 hrs. ◯ 25-36 hrs. ◯ 37-48 hrs. ◯ 49-60 hrs. ◯ 61+ hrs.

33 **33. Have you EVER had any of these procedures or injections? (Please mark (N) or (Y) for each and provide year of FIRST procedure)**

	NO	YES		YEAR	
a) Breast implant	(N)	(Y)	When was YEAR of FIRST breast implant?		a
b) Silicone injection	(N)	(Y)	When was YEAR of FIRST silicone injection?		b
c) Collagen injection	(N)	(Y)	When was YEAR of FIRST collagen injection?		c
d) Paraffin injection	(N)	(Y)	When was YEAR of FIRST paraffin injection?		d

34 **34. Would you be willing to provide a venous blood sample if we sent you a convenient collection kit? This would require assistance in drawing the blood. No centrifugation or processing would be necessary. A postage-paid mailer would be provided to return the specimen. Unwillingness to provide such a sample will not affect your eligibility for the main study.**

◯ No ◯ Yes

OPTIONAL: ***The following assists us in maintaining follow-up.***

35 **35. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail:** HOME: ( ) WORK: ( )

OPTIONAL: ***The following information assists us in classifying our study population.***

36 **36. Which of these income groups represents your total household income in the past year?**

◯ Under $10,000 ◯ $10,000-19,999 ◯ $20,000-29,999 ◯ $30,000-39,999
◯ $40,000-49,999 ◯ $50,000-99,999 ◯ Over $100,000

THANK YOU FOR COMPLETING THIS FORM!

WHETHER OR NOT YOU AGREE TO PARTICIPATE, please complete the consent form below and return it along with the questionnaire in the reply envelope to:

Women's Health Study
900 Commonwealth Avenue East
Boston, MA 02215
1-800-633-6911

CONSENT FORM

Purpose

We would like permission to enroll you as a participant in the Women's Health Study. The purpose of this study is to assess the benefits and risks of taking supplements of beta-carotene and vitamin E, as well as low-dose aspirin, to lower the risks of developing cardiovascular disease and cancer.

Procedures

Your participation would involve:

- taking daily study pills from calendar packs we will mail to you. You will be asked to take on even-numbered days a pill that is either 600 IU of vitamin E or placebo and a pill that is either 100 mg aspirin or placebo. On odd-numbered days, you will be asked to take a pill containing 50 mg beta-carotene or placebo. You will be assigned to your study treatment group at random. You will not know or be able to choose your treatment group;
- completing a brief health questionnaire every six months. The form will ask about your recent health experience and ask for permission to review medical records for relevant illnesses that you report.

The study will continue for approximately five years. When it ends, we will inform you of the results of the study and tell you what your treatment group assignment has been.

DURING THE COURSE OF THE TRIAL, YOU MUST AGREE NOT TO TAKE (APART FROM THE STUDY PILLS WE WILL PROVIDE) ASPIRIN, OR ASPIRIN-CONTAINING COMPOUNDS, AS WELL AS NON-STEROIDAL ANTI-INFLAMMATORY DRUGS THAT HAVE ASPIRIN-LIKE EFFECTS, SUCH AS MOTRIN, ADVIL, AND NAPROSYN. YOU MUST ALSO AGREE NOT TO TAKE INDIVIDUAL BETA-CAROTENE, VITAMIN A, AND VITAMIN E SUPPLEMENTS.

If at any time you have questions or concerns regarding these procedures, you may contact Dr. Julie Buring at (617) 278-0800.

Risks and Discomforts

Although no toxic effects have been documented for either beta-carotene or vitamin E at the dosages we will use in the trial, in larger doses beta-carotene can cause loose stools and yellowing of the skin, both of which disappear when the pills are stopped. There have been anecdotal reports of skin rash and fatigue associated with higher doses of vitamin E, which also cease upon discontinuing the supplement.

In a minority of individuals, aspirin can cause symptoms of stomach upset. It also increases the tendency to bleed, particularly in the gastrointestinal tract, although generally at much higher doses than that used in this study. If you should experience gastrointestinal symptoms, you may request an enteric-coated preparation.

Benefits

If low-dose aspirin, beta-carotene or vitamin E reduce the risks of cardiovascular disease or cancer, those women assigned to the active agents may benefit from participation.

Alternative Procedures

The alternative to participation in this study is to not participate. Participation is voluntary and you may discontinue participation at any time.

Confidential Information

Confidential information contained in your study record may not be furnished to anyone unaffiliated with the Brigham and Women's Hospital without your written consent, except as required by law or regulation.

Compensation Clause

In the rare event that you should experience any adverse effects which seem to be associated with taking your study pills, please contact us and your pill taking may be discontinued. Brigham and Women's Hospital does not provide you with any compensation as the result of such effects.

Withdrawal from Study

You are free to withdraw your consent and discontinue participation in this project at any time.

Inquiries Regarding Study Procedures

If you have any questions about the trial, you may contact us by letter or telephone. You may also request reference material on the possible role of beta-carotene, vitamin E and aspirin in the prevention of cardiovascular disease and cancer. In the event that at any time during the course of this project, you feel you have not been adequately informed as to the risks, benefits, alternative procedures, or your rights as a research subject, or feel under duress to continue against your wishes, the Executive Secretary of the Human Subjects Research Committee at Brigham and Women's Hospital or a representative is available to speak with you during normal working hours (8:00 a.m. to 4:30 p.m. E.T.) at (617) 732-7200. A signed copy of this consent form will be made available to you upon request.

◯ No, I do not wish to participate ◯ Yes, I agree to participate (Please sign below)

In signing this consent form, I agree to participate in the Women's Health Study to evaluate the possible (but unproven) benefits of beta-carotene, vitamin E, and aspirin in healthy women, under the conditions outlined above. I understand that I am free to withdraw my consent at any time, and that if I have questions at any time, they will be answered.

Signed *Date*

DIET

1. Do you CURRENTLY take multi-vitamins? (Please report INDIVIDUAL vitamin supplements in questions 2 and 3.)

○ No ○ Yes

If YES, a) How many do you take per week?

○ 2 or less ○ 3–5 ○ 6–9 ○ 10 or more

b) Specify exact name: → Specify exact brand and type

2. Not counting multi-vitamins, do you *CURRENTLY* take any of the following supplements:

a) **Vitamin B_6?** ○ No ○ Yes → **If YES,**	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ Less than 10 mg.	○ 10 to 39 mg.	○ 40 to 79 mg.	○ 80 mg. or more	○ Don't know
b) **Vitamin C?** ○ No ○ Yes, seasonal only ○ Yes, most months	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ Less than 400 mg.	○ 400 to 700 mg.	○ 750 to 1250 mg.	○ 1300 mg. or more	○ Don't know
c) **Selenium?** ○ No ○ Yes → **If YES,**	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ Less than 80 mcg.	○ 80 to 130 mcg.	○ 140 to 250 mcg.	○ 260 mcg. or more	○ Don't know
d) **Iron?** ○ No ○ Yes → **If YES,**	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ 50 mg. or less	○ 51 to 200 mg.	○ 201 to 400 mg.	○ 401 mg. or more	○ Don't know
e) **Zinc?** ○ No ○ Yes → **If YES,**	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ Less than 25 mg.	○ 25 to 74 mg.	○ 75 to 100 mg.	○ 101 mg. or more	○ Don't know
f) **Calcium?** (include Calcium in Dolomite and Tums, etc.) ○ No ○ Yes → **If YES,**	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ Less than 400 mg.	○ 400 to 900 mg.	○ 901 to 1300 mg.	○ 1301 mg. or more	○ Don't know

g) **Are there other supplements that you take on a regular basis?** ○ Vitamin D ○ Cod liver oil ○ Other Fish oil ○ Niacin ○ Magnesium ○ B-Complex vitamins ○ Folic acid ○ Brewer's yeast ○ Iodine ○ Other → Please specify

3. Not counting multi-vitamins, have you taken any of the following supplements IN THE PAST:

a) **Vitamin A?** ○ No ○ Yes, seasonal only ○ Yes, most months	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ Less than 8,000 IU	○ 8,000 to 12,000 IU	○ 13,000 to 22,000 IU	○ 23,000 IU or more	○ Don't know
b) **Vitamin E?** ○ No ○ Yes → **If YES,**	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ Less than 100 IU	○ 100 IU to 250 IU	○ 300 IU to 500 IU	○ 600 IU or more	○ Don't know
c) **Beta-carotene?** ○ No ○ Yes → **If YES,**	How many years?	○ 0-1 yr.	○ 2-4 years	○ 5-9 years	○ 10+ years	○ Don't know
	What dose per day?	○ Less than 8,000 IU	○ 8,000 to 12,000 IU	○ 13,000 to 22,000 IU	○ 23,000 IU or more	○ Don't know

4. For each food listed, fill in the circle indicating how often *ON AVERAGE* you have used the amount specified *DURING THE PAST YEAR.*

DAIRY FOODS	NEVER OR LESS THAN ONCE/MONTH	1–3 PER MONTH	1 PER WEEK	2–4 PER WEEK	5–6 PER WEEK	1 PER DAY	2–3 PER DAY	4–5 PER DAY	6+ PER DAY
Skim or low fat milk (8 oz. glass)	○	○	W	○	○	D	○	○	○
Whole milk (8 oz. glass)	○	○	W	○	○	D	○	○	○
Cream, e.g., coffee, whipped (Tbs)	○	○	W	○	○	D	○	○	○
Sour cream (Tbs)	○	○	W	○	○	D	○	○	○
Non-dairy coffee whitener (tsp.)	○	○	W	○	○	D	○	○	○
Sherbet, ice milk or frozen yogurt (1/2 cup)	○	○	W	○	○	D	○	○	○
Ice cream (1/2 cup)	○	○	W	○	○	D	○	○	○
Yogurt (1 cup)	○	○	W	○	○	D	○	○	○
Cottage or ricotta cheese (1/2 cup)	○	○	W	○	○	D	○	○	○
Cream cheese (1 oz.)	○	○	W	○	○	D	○	○	○
Other cheese, e.g., American, cheddar, etc., plain or as part of a dish (1 slice or 1 oz. serving)	○	○	W	○	○	D	○	○	○
Margarine (pat), added to food or bread; exclude use in cooking	○	○	W	○	○	D	○	○	○
Butter (pat), added to food or bread; exclude use in cooking	○	○	W	○	○	D	○	○	○

What form of margarine do you usually use? → What specific brand and type (e.g., Parkay Corn Oil Spread)?

○ None

Form? ○ Stick ○ Tub ○ Squeeze (liquid)

Type? ○ Regular ○ Light ○ Extra Light

PLEASE TURN TO PAGE 2

4. (Continued) Please fill in your ***AVERAGE*** use, ***DURING THE PAST YEAR***, of each specified food.

Please try to average your seasonal use of foods over the entire year. For example, if a food such as cantaloupe is eaten 4 times a week during the approximate 3 months (12 weeks) that it is in season, then the *AVERAGE* use would be once per week.

FRUITS	AVERAGE USE PAST YEAR: NEVER, OR LESS THAN ONCE/MONTH	1–3 PER MONTH	1 PER WEEK	2–4 PER WEEK	5–6 PER WEEK	1 PER DAY	2–3 PER DAY	4–5 PER DAY	6+ PER DAY
Raisins (1 oz. or small pack) or grapes			W			D			
Prunes (7 prunes or 1/2 cup)			W			D			
Bananas (1)			W			D			
Cantaloupe (1/4 melon)			W			D			
Avocado (1/2 fruit or 1/2 cup)			W			D			
Fresh apples or pears (1)			W			D			
Apple juice or cider (small glass)			W			D			
Oranges (1)			W			D			
Orange juice (small glass)			W			D			
Grapefruit (1/2)			W			D			
Grapefruit juice (small glass)			W			D			
Other fruit juices (small glass)			W			D			
Strawberries, fresh, frozen or canned (1/2 cup)			W			D			
Blueberries, fresh, frozen or canned (1/2 cup)			W			D			
Peaches, apricots or plums (1 fresh, or 1/2 cup canned)			W			D			

VEGETABLES	NEVER, OR LESS THAN ONCE/MONTH	1–3 PER MONTH	1 PER WEEK	2–4 PER WEEK	5–6 PER WEEK	1 PER DAY	2–3 PER DAY	4–5 PER DAY	6+ PER DAY
Tomatoes (1)			W			D			
Tomato juice, V8 (small glass)			W			D			
Tomato sauce (1/2 cup) e.g., spaghetti sauce			W			D			
Red chili sauce (1 Tbs)			W			D			
Tofu or soybeans (3–4 oz.)			W			D			
String beans (1/2 cup)			W			D			
Broccoli (1/2 cup)			W			D			
Cabbage or coleslaw (1/2 cup)			W			D			
Cauliflower (1/2 cup)			W			D			
Brussels sprouts (1/2 cup)			W			D			
Carrots, raw (1/2 carrot or 2–4 sticks)			W			D			
Carrots, cooked (1/2 cup) or carrot juice (2–3 oz.)			W			D			
Beets–not greens (1/2 cup)			W			D			
Corn (1 ear or 1/2 cup frozen or canned)			W			D			
Peas or lima beans (1/2 cup fresh, frozen, canned)			W			D			
Mixed vegetables (1/2 cup)			W			D			
Beans or lentils, baked or dried (1/2 cup)			W			D			
Dark orange (winter) squash (1/2 cup)			W			D			
Eggplant, zucchini or other summer squash (1/2 cup)			W			D			
Yams or sweet potatoes (1/2 cup)			W			D			
Spinach, cooked (1/2 cup)			W			D			
Spinach, raw as in salad (serving)			W			D			
Kale, mustard, or chard greens (1/2 cup)			W			D			
Iceberg or head lettuce (serving)			W			D			
Romaine or leaf lettuce (serving)			W			D			
Celery (4" stick)			W			D			
Green peppers (3 slices or 1/4 pepper)			W			D			
Onions as a garnish, or in salad (1 slice)			W			D			
Onions as a vegetable, rings or soup (1 onion)			W			D			

EGGS, MEAT, ETC.	NEVER, OR LESS THAN ONCE/MONTH	1–3 PER MONTH	1 PER WEEK	2–4 PER WEEK	5–6 PER WEEK	1 PER DAY	2–3 PER DAY	4–5 PER DAY	6+ PER DAY
Eggs (1)			W			D			
Chicken with skin (4–6 oz.)			W			D			
Chicken without skin (4–6 oz.)			W			D			
Turkey, including ground (4–6 oz. or 2 turkey dogs)			W			D			
Hot dogs (1)			W			D			
Bacon (2 slices)			W			D			

PLEASE TURN TO PAGE 3

4. (Continued) Please fill in your ***AVERAGE*** use, ***DURING THE PAST YEAR***, of each specified food.

AVERAGE USE PAST YEAR

EGGS, MEAT, ETC. (continued)	NEVER, OR LESS THAN ONCE/MONTH	1–3 PER MONTH	1 PER WEEK	2–4 PER WEEK	5–6 PER WEEK	1 PER DAY	2–3 PER DAY	4–5 PER DAY	6+ PER DAY	
Processed meats, e.g., sausage, salami, bologna, etc. (piece or slice)	○	○	W	○	○	D	○	○	○	a
Hamburger (1 patty)	○	○	W	○	○	D	○	○	○	h
Beef, pork, or lamb as a sandwich or mixed dish, e.g., stew, casserole, lasagna, etc.	○	○	W	○	○	D	○	○	○	j
Pork as a main dish, e.g., ham or chops (4–6 oz.)	○	○	W	○	○	D	○	○	○	j
Beef or lamb as a main dish, e.g., steak, roast (4–6 oz.)	○	○	W	○	○	D	○	○	○	k
Canned tuna fish (3–4 oz.)	○	○	W	○	○	D	○	○	○	l
Dark meat fish, e.g., mackerel, salmon, sardines, bluefish, swordfish (3–5 oz.)	○	○	W	○	○	D	○	○	○	m
Other fish (3–5 oz.)	○	○	W	○	○	D	○	○	○	n
Shrimp, lobster, scallops as a main dish	○	○	W	○	○	D	○	○	○	o

BREADS, CEREALS, STARCHES	NEVER, OR LESS THAN ONCE/MONTH	1–3 PER MONTH	1 PER WEEK	2–4 PER WEEK	5–6 PER WEEK	1 PER DAY	2–3 PER DAY	4–5 PER DAY	6+ PER DAY	
Cold breakfast cereal (1 cup)	○	○	W	○	○	D	○	○	○	a
Cooked oatmeal/cooked oat bran (1 cup)	○	○	W	○	○	D	○	○	○	b
Other cooked breakfast cereal (1 cup)	○	○	W	○	○	D	○	○	○	c
White bread (slice), including pita bread	○	○	W	○	○	D	○	○	○	d
Dark bread (slice), including wheat pita bread	○	○	W	○	○	D	○	○	○	e
English muffins, bagels, or rolls (1)	○	○	W	○	○	D	○	○	○	f
Muffins or biscuits (1)	○	○	W	○	○	D	○	○	○	g
Brown rice (1 cup)	○	○	W	○	○	D	○	○	○	h
White rice (1 cup)	○	○	W	○	○	D	○	○	○	i
Pasta, e.g., spaghetti, noodles, etc. (1 cup)	○	○	W	○	○	D	○	○	○	j
Tortillas (1)	○	○	W	○	○	D	○	○	○	k
Other grains, e.g., bulgur, kasha, couscous, etc. (1 cup)	○	○	W	○	○	D	○	○	○	l
Pancakes or waffles (serving)	○	○	W	○	○	D	○	○	○	m
French fried potatoes (4 oz.)	○	○	W	○	○	D	○	○	○	n
Potatoes, baked, boiled (1) or mashed (1 cup)	○	○	W	○	○	D	○	○	○	o
Potato chips or corn chips (small bag or 1 oz.)	○	○	W	○	○	D	○	○	○	p
Crackers, Triscuits, Wheat Thins (5)	○	○	W	○	○	D	○	○	○	q
Pizza (2 slices)	○	○	W	○	○	D	○	○	○	r

BEVERAGES		NEVER, OR LESS THAN ONCE/MONTH	1–3 PER MONTH	1 PER WEEK	2–4 PER WEEK	5–6 PER WEEK	1 PER DAY	2–3 PER DAY	4–5 PER DAY	6+ PER DAY	
CARBONATED BEVERAGES Consider the serving size as 1 glass, bottle or can for these carbonated beverages.	**LOW-CALORIE** (sugar free) **TYPES**										
	Low-calorie cola, e.g., Diet Coke with caffeine	○	○	W	○	○	D	○	○	○	a
	Low-calorie caffeine-free cola	○	○	W	○	○	D	○	○	○	b
	Other low-calorie carbonated beverage, e.g., Fresca, Diet 7-Up, diet ginger ale	○	○	W	○	○	D	○	○	○	c
	REGULAR TYPES (not sugar-free)										
	Coke, Pepsi, or other cola with sugar	○	○	W	○	○	D	○	○	○	d
	Caffeine Free Coke, Pepsi, or other cola with sugar	○	○	W	○	○	D	○	○	○	e
	Other carbonated beverage with sugar, e.g., 7-Up	○	○	W	○	○	D	○	○	○	f
OTHER BEVERAGES	Hawaiian Punch, lemonade, or other non-carbonated fruit drinks (1 glass, bottle, can)	○	○	W	○	○	D	○	○	○	g
	Regular beer (1 glass, bottle, can)	○	○	W	○	○	D	○	○	○	h
	Light beer, e.g., Bud Light (1 glass, bottle, can)	○	○	W	○	○	D	○	○	○	i
	Red wine (4 oz. glass)	○	○	W	○	○	D	○	○	○	j
	White wine (4 oz. glass)	○	○	W	○	○	D	○	○	○	k
	Liquor, e.g., whiskey, gin, etc. (1 drink or shot)	○	○	W	○	○	D	○	○	○	l
	Plain water, bottled or tap (1 cup or glass)	○	○	W	○	○	D	○	○	○	m
	Tea (1 cup), not herbal tea	○	○	W	○	○	D	○	○	○	n
	Decaffeinated coffee (1 cup)	○	○	W	○	○	D	○	○	○	o
	Coffee with caffeine (1 cup)	○	○	W	○	○	D	○	○	○	p

Usual method of preparing coffee

Decaffeinated: ○ Mainly filtered ○ Mainly instant ○ Mainly espresso or perc. ○ No usual method/don't know/don't use q

Caffeinated: ○ Mainly filtered ○ Mainly instant ○ Mainly espresso or perc. ○ No usual method/don't know/don't use r

0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | a b c d e f g h i j k l m n o

4. **(Continued) Please fill in your *AVERAGE* use, *DURING THE PAST YEAR*, of each specified food.**

SWEETS, BAKED GOODS, MISC.	NEVER, OR LESS THAN ONCE/MONTH	1–3 PER MONTH	1 PER WEEK	2–4 PER WEEK	5–6 PER WEEK	1 PER DAY	2–3 PER DAY	4–5 PER DAY	6+ PER DAY	
Chocolate (bar or packet) e..g., Hershey's, M & M's	○	○	W	○	○	D	○	○	○	
Candy bars, e.g., Snickers, Milky Way, Reeses	○	○	W	○	○	D	○	○	○	b
Candy without chocolate (1 oz.)	○	○	W	○	○	D	○	○	○	c
Cookies, home baked (1)	○	○	W	○	○	D	○	○	○	d
Cookies, ready made (1)	○	○	W	○	○	D	○	○	○	e
Brownies (1)	○	○	W	○	○	D	○	○	○	f
Doughnuts (1)	○	○	W	○	○	D	○	○	○	g
Cake, home baked (slice)	○	○	W	○	○	D	○	○	○	h
Cake, ready made (slice)	○	○	W	○	○	D	○	○	○	i
Pie, homemade (slice)	○	○	W	○	○	D	○	○	○	j
Pie, ready made (slice)	○	○	W	○	○	D	○	○	○	k
Sweet roll, coffee cake or other pastry, home baked (serving)	○	○	W	○	○	D	○	○	○	l
Sweet roll, coffee cake or other pastry, ready made (serving)	○	○	W	○	○	D	○	○	○	m
Jams, jellies, preserves, syrup, or honey (1 Tbs)	○	○	W	○	○	D	○	○	○	n
Peanut butter (1 Tbs)	○	○	W	○	○	D	○	○	○	o
Popcorn (1 cup)	○	○	W	○	○	D	○	○	○	p
Peanuts (small packet or 1 oz.)	○	○	W	○	○	D	○	○	○	q
Other nuts (small packet or 1 oz.)	○	○	W	○	○	D	○	○	○	r
Oat bran, added to food (1 Tbs)	○	○	W	○	○	D	○	○	○	s
Other bran, added to food (1 Tbs)	○	○	W	○	○	D	○	○	○	t
Wheat germ (1 Tbs)	○	○	W	○	○	D	○	○	○	u
Chowder or cream soup (1 cup)	○	○	W	○	○	D	○	○	○	v
Olive oil salad dressings (1 Tbs)	○	○	W	○	○	D	○	○	○	w
Other oil and vinegar dressing, e.g., Italian (1 Tbs)	○	○	W	○	○	D	○	○	○	x
Mayonnaise or other creamy salad dressing (1 Tbs)	○	○	W	○	○	D	○	○	○	y
Salt added at table (1 shake)	○	○	W	○	○	D	○	○	○	z
Garlic (1 clove or 4 shakes)	○	○	W	○	○	D	○	○	○	a

5. **Liver: beef, calf or pork (4 oz.)** ○ Never ○ Less than 1/mo. ○ 1/mo. ○ 2–3 mo. ○ 1/week or more a

Liver: chicken or turkey (1 oz.) ○ Never ○ Less than 1/mo. ○ 1/mo. ○ 2–3 mo. ○ 1/week or more b

6. **Which *COLD* breakfast cereal do you usually eat?** → Specify brand and type (e.g., Kellog's Nutrigrain Nuggets) 6

○ Don't eat cold breakfast cereal

7. **How many teaspoons of sugar do you add to your beverages or food each day?** ○ 1 tsp ○ 2 tsp ○ 3 tsp ○ 4 tsp ○ 5 tsp ○ 6 tsp ○ 7 tsp ○ 8 tsp ○ 9 tsp ○ 10 tsp ○ 11 tsp ○ 12 tsp ○ 13 tsp or more 7

8. **When you have beef or lamb as a main dish, how well done is the meat cooked?** 8

○ Rare ○ Medium rare ○ Medium ○ Medium well ○ Well ○ Don't know/not eaten

9. **How often do you eat meat that was charred during cooking? (e.g., during barbecueing or broiling)** 9

○ Never ○ Less than 1/mo. ○ 1/mo. ○ 2–3 mo. ○ 1/week ○ 2+/week

10. **How much of the visible fat on your beef, pork or lamb do you remove before eating?** 10

○ Remove all visible fat ○ Remove most ○ Remove small part of fat ○ Remove none ○ Don't eat meat

11. **What kind of fat do you usually use for frying and sautéing at home? (Exclude "Pam"-type spray)** 11

○ Real butter ○ Margarine ○ Vegetable oil ○ Vegetable shortening ○ Lard ○ Don't use

12. **What kind of fat do you usually use for baking at home?** 12

○ Real butter ○ Margarine ○ Vegetable oil ○ Vegetable shortening ○ Lard ○ Don't use

13. **How often do you eat food that is fried at home? (Exclude "Pam"-type spray)** 13

○ Never ○ Less than once a week ○ 1–3 times per week ○ 4–6 times per week ○ Daily

14. **How often do you eat fried food away from home? (e.g., french fries, fried chicken, fried fish)** 14

○ Never ○ Less than once a week ○ 1–3 times per week ○ 4–6 times per week ○ Daily

15. **What type of cooking oil do you usually use at home (e.g., Mazola Corn Oil)?** → Specify brand and type

16. **How does your current diet compare to your usual diet over the past five years?** 16

○ Almost the same ○ Slightly changed ○ Moderately changed ○ Greatly changed

Thank You! Please return this form in the enclosed postage-paid envelope to:

Women's Health Study • 900 Commonwealth Ave. East Boston, MA 02215-1204

Runin

1. *DURING THE PAST MONTH,* on how many *DAYS* did you *MISS* taking your study pills?

◯ 0 days missed ◯ 1-5 days missed ◯ 6-10 days missed
◯ 11-15 days missed ◯ 16-29 days missed ◯ Took none

If you *missed* days, was it due to:

◯ Lost/misplaced calendar packs ◯ Vacation
◯ Side effects ◯ Difficulty remembering ◯ Other reasons

2. Are you willing to continue taking the study pills?

◯ Yes
◯ No → SPECIFY REASON:

3. *SINCE YOU STARTED TAKING YOUR STUDY PILLS,* have you been diagnosed as having any of the following?

Please indicate N or Y on each line.	NO	YES
Myocardial infarction (heart attack)	N	Y
Stroke or TIA (transient ischemic attack)	N	Y
Angina pectoris	N	Y
IF YES, confirmed by: angiogram? No Yes; stress test? No Yes		
Coronary angioplasty (PTCA)	N	Y
Coronary bypass surgery (CABG)	N	Y
Carotid artery surgery (endarterectomy)	N	Y
Peripheral artery surgery	N	Y
Melanoma	N	Y
Non-melanoma skin cancer	N	Y
IF YES, type: basal cell squamous cell unknown		
Fibrocystic or other benign breast disease	N	Y
IF YES, confirmed by: breast biopsy No Yes; aspiration No Yes		
Breast cancer	N	Y
Other cancer (non-skin, non-breast)	N	Y
IF YES, SITE:		
Active or chronic liver disease or cirrhosis	N	Y
Chronic kidney failure	N	Y
Bleeding hemorrhoids	N	Y
Any other gastrointestinal bleeding	N	Y
Ulcer	N	Y
Coagulation disorder (e.g., Von Willebrand's disease)	N	Y
Gout	N	Y
Systemic lupus erythematosus	N	Y
Hypertension (physician diagnosed) rhighchol	N	Y
Elevated cholesterol (physician diagnosed)	N	Y
Other major illness	N	Y
IF YES, SPECIFY MAJOR ILLNESS:		

4. Are you *CURRENTLY* taking anti-coagulants (e.g., Coumadin, Heparin)?

◯ No ◯ Yes

5. Are you *CURRENTLY* taking any corticosteroids (e.g., Prednisone)? (*Include use of inhalers or topical steroids ONLY IF used more than 10 times per day.*)

◯ No ◯ Yes

6. *SINCE YOU STARTED TAKING YOUR STUDY PILLS,* have you experienced any of the following?

Please indicate N or Y on each line.	NO	YES
Symptoms suggestive of gastric upset	N	Y
Symptoms suggestive of peptic ulcer	N	Y
Nausea	N	Y
Constipation	N	Y
Diarrhea	N	Y
Skin discoloration	N	Y
Blood in urine (hematuria)	N	Y
Easy bruising	N	Y
Nose bleed (epistaxis)	N	Y
Other bleeding	N	Y
Skin rash	N	Y
Fatigue	N	Y

7. Have you *EVER* had any of the following?

	NO	YES
Atrial fibrillation	N	Y
Deep vein thrombosis	N	Y
Pulmonary embolism	N	Y
Osteoporosis	N	Y
Fracture of hip or forearm after age 40	N	Y
Periodontal disease	N	Y
Gallstones	N	Y
Gallbladder or gallstones removal	N	Y

8. When was your *LAST* eye exam?

◯ Within past year ◯ 1-2 years ago ◯ 3-5 years ago
◯ More than 5 years ago ◯ Never had an eye exam

9. Have you *EVER* had macular degeneration diagnosed:

In your RIGHT eye? ◯ No ◯ Yes ◯ Not sure
In your LEFT eye? ◯ No ◯ Yes ◯ Not sure

10. Have you *EVER* had a cataract diagnosed?

In your RIGHT eye? ◯ No ◯ Yes ◯ Not sure
In your LEFT eye? ◯ No ◯ Yes ◯ Not sure

11. Regarding *YOUR* infancy:

a) **Were you breast fed?**
◯ No ◯ Yes → **Number of months?** ◯ Unknown ◯ 3 or less ◯ 4-8 months ◯ 9+ months
◯ Not sure

b) **What was your birthweight in pounds:**
◯ Unknown ◯ ≤ 5 lbs. 8 ozs.
◯ 5 lbs. 9 ozs.-6 lbs. 15 ozs. ◯ 7 lbs.-8 lbs. 8 ozs.
◯ 8 lbs. 9 ozs.-9 lbs. 15 ozs. ◯ 10+ lbs.

c) **Were you:**
◯ Full term ◯ 2 or more weeks premature ◯ Don't know

d) **Were you a twin, triplet or other multiple birth?**
◯ No ◯ Yes

12. In the *PAST YEAR,* how many colds have you had?

◯ None ◯ 1-2 ◯ 3-5 ◯ 6-10 ◯ More than 10 colds

For a typical cold in the past year:

a) **For how many days were symptoms usually present?**
◯ 1-3 days ◯ 4-7 days ◯ More than a week

b) **For how many days were you usually confined to home?**
◯ None ◯ 1-3 days ◯ 4-7 days ◯ More than a week

PLEASE CONTINUE ON BACK.

13. *DURING THE PAST MONTH*, on approximately how many *days* did you take any of the following (do *not* count your study pills): Please respond on each line:

	DAYS IN THE PAST MONTH 0	1-3	4-10	11-20	21+
Acetaminophen (e.g., Tylenol, Datril)	○	○	○	○	○
Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin)	○	○	○	○	○
Medications containing aspirin (e.g., Alka-Seltzer, Sine-Off, Doan's Pills, Darvon, Fiorinal)	○	○	○	○	○
Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Mediprin)	○	○	○	○	○
Multivitamins	○	○	○	○	○
Individual supplements of beta-carotene (not including multivitamins)	○	○	○	○	○
Individual supplements of vitamin E (not including multivitamins)	○	○	○	○	○
Individual supplements of vitamin A (not including multivitamins)	○	○	○	○	○
Other vitamin preparations containing vitamin A, C, E, or beta-carotene — Specify EXACT BRAND and TYPE:	○	○	○	○	○

14. *DURING THE PAST YEAR*, what was your average *time per week* spent at each of the following recreational activities?

	TIME PER WEEK Zero	1-19 Min.	20-59 Min.	One Hr.	1.5 Hr.	2-3 Hr.	4-6 Hr.	7+ Hr.
Walking or hiking outdoors (include walking to work)	○	○	○	○	○	○	○	○
Jogging (slower than 10 minute miles)	○	○	○	○	○	○	○	○
Running (10 minute miles or faster)	○	○	○	○	○	○	○	○
Bicycling (include stationary machine)	○	○	○	○	○	○	○	○
Aerobic exercise/aerobic dance/exercise machines	○	○	○	○	○	○	○	○
Lower intensity exercise/yoga/stretching/toning	○	○	○	○	○	○	○	○
Tennis, squash, or racquetball	○	○	○	○	○	○	○	○
Lap swimming	○	○	○	○	○	○	○	○

15. What is your usual walking pace outdoors?

○ Don't walk regularly ○ Easy, casual (less than 2 mph) ○ Normal, average (2-2.9 mph) ○ Brisk pace (3-3.9 mph) ○ Very brisk/striding (4 mph or faster)

16. On average, how many *flights* of stairs (not individual steps) do you climb *DAILY*?

○ None ○ 1-2 flights ○ 3-4 flights ○ 5-9 flights ○ 10-14 flights ○ 15 or more flights

17. What is your *CURRENT* level of blood pressure (if checked within the last 2 years):

a) **Systolic** (mmHg): ○ <110 ○ 110-119 ○ 120-129 ○ 130-139 ○ 140-149 ○ 150-159 ○ 160-169 ○ 170-179 ○ 180+ ○ Unknown/not checked within 2 years

b) **Diastolic** (mmHg): ○ <65 ○ 65-74 ○ 75-84 ○ 85-89 ○ 90-94 ○ 95-104 ○ 105+ ○ Unknown/not checked within 2 years

18. What is your *CURRENT* serum cholesterol level (if checked within 5 years):

○ <140 mg/dl ○ 140-159 ○ 160-179 ○ 180-199 ○ 200-219 ○ 220-239 ○ 240-249 ○ 250-259 ○ 260-269 ○ 270-279 ○ 280-299 ○ 300-329 ○ 330+ ○ Unknown/not checked within 5 years

19. Have you *EVER* had a mammogram? ○ No ○ Yes

20. Have you *EVER* used fertility drugs (e.g., Clomid)? ○ No ○ Yes

21. In the *PAST YEAR*, have you noticed any change in your memory?

○ No change ○ Memory improved ○ Memory worse

22. For identification and validation purposes, please provide us again with:

a) **Your birthdate:** MONTH ☐☐ DAY ☐☐ YEAR ☐☐

b) **Your Social Security Number:** ☐☐☐ ☐☐ ☐☐☐☐

23. Please indicate the name, address and phone number of someone at a *DIFFERENT PERMANENT ADDRESS* whom we might contact if we are unable to contact you:

NAME: _____

ADDRESS: _____

STATE/ZIP: _____ PHONE NO.: ( ) _____

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THANK YOU. PLEASE RETURN THIS FORM IN THE PRE-PAID ENVELOPE PROVIDED TO:

Women's Health Study
900 Commonwealth Avenue East
Boston, MA 02215
(617) 278-0800

6 MONTH

WOMEN'S HEALTH STUDY ■ ■ ■ HARVARD MEDICAL SCHOOL

Please complete and return this form in the reply envelope provided. It is important that we receive a *RESPONSE FROM EACH SUBJECT,* even though you may be encountering no difficulty in complying with the protocol.

***INSTRUCTIONS*: Use a #2 pencil; please completely darken the response circle; erase cleanly; make no stray marks; and keep handwriting within the response boxes.**

FOR EACH* of the *THREE* study agents (white pill; red capsule; amber capsule), please indicate below the percentage of pills you have *TAKEN* over the *PAST SIX MONTHS.

For each agent, indicate the percentage of pills *TAKEN* over the past six months.	WHITE PILL	RED CAPS	AMBER CAPS
Took 100%, or missed none	○	○	○
Took 93 - 99%, or missed only a few	○	○	○
Took 75 - 92%, or missed between 2 - 6 weeks	○	○	○
Took 67 - 74%, or missed between 6 - 8 weeks	○	○	○
Took 50 - 66%, or missed between 2 - 3 months	○	○	○
Took 33 - 49%, or missed between 3 - 4 months	○	○	○
Took less than 33%, or missed more than 4 months	○	○	○

IF YOU MISSED TAKING YOUR PILLS, WHAT WAS THE MAIN REASON? →

2. *SINCE WE LAST CONTACTED YOU* (about 6 months ago), have you experienced any of the following?

	NO	YES
a. Symptoms suggestive of gastric upset ✓	○	○
b. Symptoms suggestive of peptic ulcer ✓	○	○
c. Nausea ✓	○	○
d. Constipation ✓	○	○
e. Diarrhea ✓	○	○
f. Skin discoloration ✓	○	○
g. Blood in urine (hematuria) ✓	○	○
h. Easy bruising ✓	○	○
i. Nose bleed (epistaxis) ✓	○	○
j. Skin rash ✓	○	○
k. Fatigue	○	○
l. Headache	○	○

3. *SINCE WE LAST CONTACTED YOU* (about 6 months ago), have you had any of the following? (Darken in *NO* or *YES* to each item. If *YES,* please provide the month and year of diagnosis and complete the consent form below.)

	NO	YES	DX MO/YR
a. Myocardial infarction	○	○ →	/
b. Stroke or TIA	○	○ →	/
c. Angina pectoris	○	○ →	/
d. Coronary angioplasty (PTCA)	○	○ →	/
e. Coronary bypass surgery (CABG)	○	○ →	/
f. Pulmonary embolism (PE)	○	○ →	/
g. Deep vein thrombosis (DVT)	○	○ →	/
h. Colon polyps	○	○ →	/
i. Melanoma	○	○ →	/
j. Non-melanoma skin cancer	○	○ →	/
k. Breast cancer	○	○ →	/
l. Other cancer: site	○	○ →	/
m. Peptic ulcer	○	○ →	/
n. Bleeding hemorrhoids	○	○ →	/
o. Any other gastrointestinal bleeding	○	○ →	/

4. Please indicate the *IMPORTANCE* of each of the following reasons for your decision to participate in the WHS.

	Most Important	Very Important	Somewhat Important	Slightly Important	Not Important
a. I may be less likely to get heart disease/ cancer in the future.	○	○	○	○	○
b. A family member or friend had heart disease/cancer.	○	○	○	○	○
c. Taking the daily study pills may make me feel healthier.	○	○	○	○	○
d. I want to contribute to understanding ways to prevent disease.	○	○	○	○	○
e. Other: specify	○	○	○	○	○

CONSENT FORM

If you responded *YES* to any of the items in *QUESTION #3,* please *COMPLETE* and *SIGN* the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest professional confidence.

I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION/TREATMENT:** _____

Name of hospital/physician: _____

Address of hospital/physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____

Signed *Date*

12 month

Please complete and return this form in the reply envelope provided. It is important that we receive a *RESPONSE FROM EACH SUBJECT,* even though you may be encountering no difficulty in complying with the protocol.

INSTRUCTIONS: **Use a #2 pencil; please completely darken the response circle; erase cleanly; make no stray marks; and keep handwriting within the response boxes.**

1. *FOR EACH* of the *THREE* study agents (white pill; red capsule; amber capsule), please indicate below the percentage of pills you have *TAKEN* over the *PAST SIX MONTHS.*

	WHITE PILL	RED CAPS	AMBER CAPS	
Took 100%, or missed none	○	○	○	1
Took 93–99%, or missed only a few	○	○	○	W
Took 75–92%, or missed between 2–6 weeks	○	○	○	R
Took 67–74%, or missed between 6–8 weeks	○	○	○	A
Took 50–66%, or missed between 2–3 months	○	○	○	
Took 33–49%, or missed between 3–4 months	○	○	○	
Took less than 33%, or missed more than 4 months	○	○	○	

IF YOU MISSED TAKING YOUR PILLS, WHAT WAS THE MAIN REASON? → [ ] 2

2. *IN THE PAST YEAR,* have you experienced any of the following?

	NO	YES	
a. Symptoms suggestive of gastric upset	○	○	a
b. Symptoms suggestive of peptic ulcer	○	○	b
c. Nausea	○	○	c
d. Constipation	○	○	d
e. Diarrhea	○	○	e
f. Skin discoloration	○	○	f
g. Blood in urine (hematuria)	○	○	g
h. Easy bruising	○	○	h
i. Nose bleed (epistaxis)	○	○	i
j. Skin rash	○	○	j
k. Fatigue	○	○	k
l. Drowsiness	○	○	l
m. Headache	○	○	m

3. *IN THE PAST YEAR,* have you had:

	NO	YES, for symptoms	YES, for screening	
a. A physical exam	○	○	○	a
b. Blood pressure check	○	○	○	b
c. Blood cholesterol check	○	○	○	c
d. Rectal exam	○	○	○	d
e. Stool occult blood test	○	○	○	e
f. Colonoscopy or sigmoidoscopy	○	○	○	f
g. Pelvic exam	○	○	○	g
h. Breast exam by doctor	○	○	○	h
i. Mammogram	○	○	○	i
j. Breast self-exam	○	○	○	j

IF YES, in how many months?
○ 1 month ○ 2–3 months ○ 4–6 months
○ 7–11 months ○ 12 months

4. What is your *CURRENT* level of blood pressure? 4

a) **Systolic** (mmHg): ○ <110 ○ 110–119 ○ 120–129 ○ 130–139 ○ 140–149 ○ 150–159 ○ 160–169 ○ 170–179 ○ 180+ ○ Unknown — a

b) **Diastolic** (mmHg): ○ <65 ○ 65–74 ○ 75–84 ○ 85–89 ○ 90–94 ○ 95–104 ○ 105+ ○ Unknown — b

c) ***IN THE PAST YEAR,* have you been diagnosed by a physician as having high blood pressure (hypertension)?** ○ No ○ Yes — c

d) **Are you *CURRENTLY* being treated with medication for high blood pressure?** ○ No ○ Yes — d

5. What is your *CURRENT* blood cholesterol level? 5

a) ○ <140 mg/dl ○ 140–159 ○ 160–179 ○ 180–199 ○ 200–219 ○ 220–239 ○ 240–249 ○ 250–259 ○ 260–269 ○ 270–279 ○ 280–299 ○ 300–329 ○ 330+ ○ Unknown — a

b) ***IN THE PAST YEAR,* have you been diagnosed by a physician as having high cholesterol?** ○ No ○ Yes — b

c) **Are you *CURRENTLY* being treated with cholesterol-lowering medication?** ○ No ○ Yes — c

6. Do you *CURRENTLY* smoke cigarettes? 6

○ No ○ Yes

IF YES: On average, number of cigarettes you smoke EACH DAY? — a
○ 1–4 cigs. ○ 5–14 cigs. ○ 15–24 cigs. ○ 25–35 cigs. ○ 36–44 cigs. ○ 45+ cigs.

7. In the *PAST YEAR,* how many colds have you had? 7

○ None ○ 1–2 ○ 3–5 ○ 6–10 ○ More than 10 colds

For a typical cold in the past year:

a) **For how many days were symptoms usually present?** ○ 1–3 days ○ 4–7 days ○ More than a week — a

b) **For how many days were you usually confined to home?** ○ None ○ 1–3 days ○ 4–7 days ○ More than a week — b

8. Have you *EVER* been diagnosed by a physician as having any of the following? If yes, provide YEAR of FIRST diagnosis. 8

	NO	YES	YR of DX	
a. Parkinson's disease	N	Y →		a
b. Asthma	N	Y →		b
c. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	N	Y →		c

9. *IN THE PAST YEAR,* have you had any of the following? Darken in *NO* or *YES* for each item. If *YES,* please provide the month and year of diagnosis and complete the consent form at the bottom of this page.

	NO	YES	DX MO/YR	9
Myocardial infarction (heart attack)	N	Y	/	a
Stroke	N	Y	/	b
TIA (transient ischemic attack)	N	Y	/	c
Angina pectoris	N	Y	/	d
IF YES, confirmed by: **angiogram?** ○ No ○ Yes **stress test?** ○ No ○ Yes				
Coronary angioplasty (PTCA)	N	Y	/	e
Coronary bypass surgery (CABG)	N	Y	/	f
Carotid artery surgery (endarterectomy)	N	Y	/	g
Peripheral artery surgery	N	Y	/	h
Intermittent claudication	N	Y	/	i
Pulmonary embolism (PE)	N	Y	/	j
Deep vein thrombosis (DVT)	N	Y	/	k
Melanoma	N	Y	/	l
Non-melanoma skin cancer	N	Y	/	m
IF YES, type: ○ basal cell ○ squamous cell ○ unknown				
Fibrocystic or other benign breast disease	N	Y	/	n
IF YES, confirmed by: **breast biopsy?** ○ No ○ Yes **aspiration?** ○ No ○ Yes				
Breast cancer	N	Y	/	o
Lung cancer	N	Y	/	p
Colon cancer	N	Y	/	q
Other cancer	N	Y	/	r
IF YES, SITE:				
Active or chronic liver disease or cirrhosis	N	Y	/	s
Chronic kidney failure	N	Y	/	t
Migraine headaches	N	Y	/	u
Bleeding hemorrhoids	N	Y	/	v
Any other gastrointestinal bleeding	N	Y	/	w
Coagulation disorder	N	Y	/	x

	NO	YES	DX MO/YR	
Peptic ulcer	N	Y	/	y
Gout	N	Y	/	z
Diabetes mellitus	N	Y	/	aa
Colon polyp	N	Y	/	bb
Osteoporosis	N	Y	/	cc
Fractures	N	Y	/	dd
IF YES, **hip** N Y **foot** N Y **arm** N Y **wrist** N Y **other** N Y Specify:				
Macular degeneration RIGHT eye	N	Y	/	ee
Macular degeneration LEFT eye	N	Y	/	ff
Cataract RIGHT eye	N	Y	/	gg
Cataract LEFT eye	N	Y	/	hh
Multiple sclerosis	N	Y	/	ii
Amyotrophic lateral sclerosis (ALS)	N	Y	/	jj
Systemic lupus erythematosus (SLE)	N	Y	/	kk
Rheumatoid arthritis (Dr. diagnosed)	N	Y	/	ll
IF YES, Rheumatoid factor: ○ Negative/unknown ○ Positive				
Other arthritis	N	Y	/	mm
Joint pain or joint swelling	N	Y	/	nn
Hip replacement	N	Y	/	oo
Knee replacement	N	Y	/	pp
Scleroderma	N	Y	/	qq
Dermatomyositis or polymyositis	N	Y	/	rr
Sjögren's syndrome	N	Y	/	ss
Any other connective tissue disorder (including mixed)	N	Y	/	tt
Other major illness	N	Y	/	uu
IF YES, SPECIFY MAJOR ILLNESS:				

CONSENT FORM

IF YES TO ANY ITEM ABOVE, PLEASE COMPLETE THIS CONSENT FORM. OTHERWISE, *PLEASE CONTINUE ON BACK PAGE.*

If you responded *YES* to any of the items above, please *COMPLETE* and *SIGN* the consent from below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.

I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION/TREATMENT:** _____

Name of hospital/physician: _____

Address of hospital/physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____

Signed ***Date***

ID#:

10. *DURING THE PAST MONTH*, on approximately how many *days* did you take any of the following (do *not* count your study pills): Please respond on each line:

	DAYS IN THE PAST MONTH 0	1–3	4–10	11–20	21+	
Acetaminophen (e.g., Tylenol, Datril)	◯	◯	◯	◯	◯	a
Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin)	◯	◯	◯	◯	◯	c
Medications containing aspirin (e.g., Alka-Seltzer, Sine-Off, Doan's Pills, Darvon, Fiorinal)	◯	◯	◯	◯	◯	d
Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Mediprin)	◯	◯	◯	◯	◯	e
Multivitamins — Specify EXACT BRAND and TYPE: ◯ i ◯ e	◯	◯	◯	◯	◯	f
Individual supplements of vitamin C (not including multivitamins)	◯	◯	◯	◯	◯	g
Individual supplements of beta-carotene (not including multivitamins)	◯	◯	◯	◯	◯	h
Individual supplements of vitamin E (not including multivitamins)	◯	◯	◯	◯	◯	i
Individual supplements of vitamin A (not including multivitamins)	◯	◯	◯	◯	◯	j
Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) — Specify EXACT BRAND and TYPE: ◯ i ◯ e	◯	◯	◯	◯	◯	10

11. Have you *EVER* used DES (diethylstilbestrol) during any pregnancy? 11

◯ No ◯ Yes ➡ a) **Counting ALL pregnancies, TOTAL DURATION OF USE (in months):** ____ **TOTAL MONTHS** a

b) **YEAR of FIRST use:** ____ b

c) **YEAR of LAST use:** ____ c

12. Have your menstrual periods ceased PERMANENTLY? 12

◯ No: Premenopausal

◯ Yes: No menstrual periods ➡ a) **Age natural periods ceased?** a

◯ Yes: Had menopause but now have periods induced by hormones

◯ Not sure

AGE	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
	7
	8
	9

b) **For what reason did your periods cease?** b

◯ SURGERY: If due to surgery, were your ovaries and/or uterus removed? (Mark **ALL** that apply) s

◯ Both ovaries removed

◯ One ovary removed n

◯ Uterus removed

◯ RADIATION or CHEMOTHERAPY

◯ NATURAL: If natural (non-surgical) menopause, have you had subsequent surgery to remove ovaries or uterus? (Mark **ALL** that apply)

◯ No ◯ One ovary removed

◯ Uterus removed ◯ Both ovaries removed

13. *IN THE PAST YEAR*, have you used female replacement hormones (other than oral contraceptives)**?** 13

◯ No

◯ Yes, currently ➡ a) **How many months have you used them?** a

◯ 1–2 mo. ◯ 7–8 mo.

◯ 3–4 mo. ◯ 9–10 mo.

◯ 5–6 mo. ◯ 11–12 mo.

◯ Yes, discontinued

b) **Mark the types of hormones you have used the longest during this period.** b

Estrogen: ◯ Oral Premarin ◯ Estrace ◯ Ogen ◯ Patch Estrogen ◯ Vaginal Estrogen ◯ Other Estrogen

Progesterone/Progestin (e.g., Provera, Cycrin): ◯ Oral ◯ Vaginal ◯ Other (specify below)

Other type of hormones used, please specify: ➡ ____

c) **If you used oral conjugated estrogen (e.g., Premarin) what dose did you usually take?** c

◯ .30 mg/day or less (Green) ◯ .625 mg/day (Brown) ◯ .9 mg/day (White) ◯ 1.25 mg/day (Yellow)

◯ More than 1.25 mg/day ◯ Dose unknown ◯ Did not take oral conjugated estrogen

d) **If you used oral Medroxy Progesterone (e.g., Provera, Cycrin), what dose did you usually take?** d

◯ < 5 mg ◯ 5–9 mg ◯ 10 mg ◯ More than 10 mg ◯ Dose unknown ◯ Not used

e) **What was your pattern of hormone use (Days per Month)?** e

Oral or Patch Estrogen: **Days per Month** ◯ Not used ◯ <1 day/mo ◯ 1–8 days ◯ 9–18 ◯ 19–26 ◯ 27+ days/mo 1

Progesterone: **Days per Month** ◯ Not used ◯ <1 day/mo ◯ 1–8 days ◯ 9–18 ◯ 19–26 ◯ 27+ days/mo 2

14. For identification and validation purposes, please provide us again with: 14

a) **Your birthdate:** MONTH ____ DAY ____ YEAR ____ m

b) **Your Social Security Number:** ____ ____ ____ ____ ____ ____ ____ ____ ____ n a m b n

THANK YOU. PLEASE RETURN THIS FORM IN THE PRE-PAID ENVELOPE PROVIDED TO:

Women's Health Study
900 Commonwealth Avenue East
Boston, MA 02215
(800) 633-6911

1 1 1 1 1 1 1 1 1
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1a. Are you CURRENTLY taking your WHS pills?

☐ No ☐ Yes

FOR EACH of the *TWO* study agents (white pill; amber capsule), please indicate below the percentage of pills you have *TAKEN* over the *PAST YEAR.*

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐
If you missed taking your pills, what was the main reason? _____		

2. IN THE PAST YEAR, have you experienced any of the following?

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

3. *IN THE PAST YEAR,* were you newly diagnosed with any of the following? Check *NO* or *YES* for each item. If YES, please provide the month and year of diagnosis and complete the consent form at the bottom of this page.

	NO	YES	Dx MO/YR
a. Myocardial infarction (heart attack)	☐	☐ ➡	_____ (a)
b. Angina pectoris	☐	☐ ➡	_____ (b)

IF YES, confirmed by:

angiogram? ☐ No ☐ Yes

stress test? ☐ No ☐ Yes

PLEASE GO TO NEXT COLUMN

	NO	YES	Dx MO/YR
c. Coronary angioplasty (PTCA)	☐	☐ ➡	_____ (c)
d. Coronary bypass surgery (CABG)	☐	☐ ➡	_____ (d)
e. Stroke	☐	☐ ➡	_____ (e)
f. TIA (transient ischemic attack)	☐	☐ ➡	_____ (f)
g. Carotid artery surgery (endarterectomy)	☐	☐ ➡	_____ (g)
h. Peripheral artery surgery	☐	☐ ➡	_____ (h)
i. Intermittent claudication	☐	☐ ➡	_____ (i)
j. Pulmonary embolism (PE)	☐	☐ ➡	_____ (j)
k. Deep vein thrombosis (DVT)	☐	☐ ➡	_____ (k)
l. Melanoma	☐	☐ ➡	_____ (l)
m. Non-melanoma skin cancer	☐	☐ ➡	_____ (m)
IF YES, type: ☐ basal cell ☐ squamous cell ☐ unknown			
n. Breast cancer	☐	☐ ➡	_____ (n)
o. Lung cancer	☐	☐ ➡	_____ (o)
p. Colon cancer	☐	☐ ➡	_____ (p)
q. Other cancer (non-skin)	☐	☐ ➡	_____ (q)
IF YES, SPECIFY SITE: _____			
r. Peptic ulcer	☐	☐ ➡	_____ (r)
s. Gout	☐	☐ ➡	_____ (s)
t. Diabetes mellitus	☐	☐ ➡	_____ (t)
u. Colon polyp	☐	☐ ➡	_____ (u)
v. Active or chronic liver disease or cirrhosis	☐	☐ ➡	_____ (v)
w. Chronic kidney failure	☐	☐ ➡	_____ (w)
x. Migraine headaches	☐	☐ ➡	_____ (x)
y. Bleeding hemorrhoids	☐	☐ ➡	_____ (y)
z. Any other gastrointestinal bleeding	☐	☐ ➡	_____ (z)
aa. Coagulation disorder	☐	☐ ➡	_____ (aa)
bb. Fibrocystic or other benign breast disease	☐	☐ ➡	_____ (bb)
IF YES, confirmed by: **breast biopsy?** ☐ No ☐ Yes **aspiration?** ☐ No ☐ Yes			
cc. Macular degeneration RIGHT eye	☐	☐ ➡	_____ (cc)
dd. Macular degeneration LEFT eye	☐	☐ ➡	_____ (dd)
ee. Cataract RIGHT eye	☐	☐ ➡	_____ (ee)
ff. Cataract LEFT eye	☐	☐ ➡	_____ (ff)
gg. Cataract extraction RIGHT eye	☐	☐ ➡	_____ (gg)
hh. Cataract extraction LEFT eye	☐	☐ ➡	_____ (hh)
ii. Multiple sclerosis	☐	☐ ➡	_____ (ii)
jj. Other major illness	☐	☐ ➡	_____ (jj)
IF YES, SPECIFY MAJOR ILLNESS: _____			

CONSENT FORM

If you responded *YES* to any of the items above, please *COMPLETE* and *SIGN* the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.

I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION/TREATMENT:** _____

Name of hospital/physician: _____ **Phone #:** _____

Address of hospital/physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____

Signed Date

PLEASE TURN THE PAGE ➡

4. DURING THE PAST MONTH, on approximately how many DAYS did you take any of the following (do not count your study pills)? Please respond for each item:

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21+
Acetaminophen (e.g., Tylenol, Datril)	☐	☐	☐	☐	☐
Aspirin, (e.g., Bayer, Bufferin, Anacin, Excedrin)	☐	☐	☐	☐	☐
Medications containing aspirin (e.g., Alka-Seltzer, Sine-Off, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Mediprin)	☐	☐	☐	☐	☐
Multivitamins: Specify brand name: _____ Specify: contains Vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content _____ IU contains Vitamin E? ☐ No ☐ Yes ➡ content _____ IU	☐	☐	☐	☐	☐
Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	☐
Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐

5. Do you CURRENTLY smoke cigarettes?
☐ No ☐ Yes ➡ IF YES, on average, how many cigarettes do you smoke EACH DAY?
☐ 1-4 cigs. ☐ 5-14 cigs. ☐ 15-24 cigs. ☐ 25-35 cigs. ☐ 36-44 cigs. ☐ 45+ cigs.

6. Did you EVER breast-feed?
☐ No ☐ Yes ➡ IF YES, age you FIRST breast-fed? _____ years old
age you ENDED breast feeding? _____ years old
TOTAL DURATION (in months) you breast-fed (for all pregnancies): _____ TOTAL MONTHS

7. How often did you participate in strenuous (aerobic) physical activity or sports at least twice per week (e.g. swimming, aerobics, field hockey, basketball, cycling, running)?

During high school (please average): ☐ Never ☐ 1-3 months/yr ☐ 4-6 months/yr ☐ 7-9 months/yr ☐ 10-12 months/yr
During ages 18-22 (please average): ☐ Never ☐ 1-3 months/yr ☐ 4-6 months/yr ☐ 7-9 months/yr ☐ 10-12 months/yr

8. a. Between the AGES OF 18 AND 30 (excluding illness and pregnancy-related changes):
What was your: Minimum weight _____ lbs. ➡ AND Maximum weight _____ lbs.

b. Between the AGES OF 18 AND 30, how many times did you lose EACH of the following amounts of weight on purpose (excluding illness and pregnancy-related changes)?

5-9 lbs:	☐ 0 times	☐ 1-2 times	☐ 3-4 times	☐ 5-6 times	☐ 7+ times	☐ Don't know
10-19 lbs:	☐ 0 times	☐ 1-2 times	☐ 3-4 times	☐ 5-6 times	☐ 7+ times	☐ Don't know
20-49 lbs:	☐ 0 times	☐ 1-2 times	☐ 3-4 times	☐ 5-6 times	☐ 7+ times	☐ Don't know
50 + lbs:	☐ 0 times	☐ 1-2 times	☐ 3-4 times	☐ 5-6 times	☐ 7+ times	☐ Don't know

c. What is your CURRENT weight? _____ lbs.

9. Have you EVER used permanent hair dyes? (Do not count dyes that rinse out with washing.)
☐ No ☐ Yes ➡ IF YES, ANSWER (a) and (b) below:

a. How often at EACH AGE?	Not Used	Every 2-4 weeks	Every 5-7 weeks	Every 8-12 weeks	Every 13+ weeks
Prior to age 40	☐	☐	☐	☐	☐
Ages 40-49	☐	☐	☐	☐	☐
Ages 50-59	☐	☐	☐	☐	☐
Ages 60+	☐	☐	☐	☐	☐

b. TOTAL DURATION (in years) of permanent hair dye use? _____ TOTAL YEARS

10. The following assists us in maintaining follow-up:

a. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail:
HOME: ( ) _____ WORK: ( ) _____

b. Please indicate the name, address and phone number of *SOMEONE AT A DIFFERENT PERMANENT ADDRESS* whom we might contact if we are unable to contact you:
NAME: _____ PHONE NO.: ( ) _____
ADDRESS: _____ STATE/ZIP: _____

11. For identification and validation purposes, please provide us again with:
a) Your birthdate: ☐☐ (MO) ☐☐ (DAY) ☐☐ (YR) AND ➡ b) Your Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐

1a. Are you CURRENTLY taking ANY of your WHS pills? ☐ No ☐ Yes

b. *FOR EACH* of the *TWO* study agents (white pill; amber capsule), please indicate below the percentage of pills you have *TAKEN* over the *PAST YEAR*.

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐

If you missed taking your pills, what was the main reason?
_____

2. IN THE PAST YEAR, have you experienced the following?

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

3. *IN THE PAST YEAR*, were you newly diagnosed with any of the following? Check *NO* or *YES* for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form at the bottom of this page.

	NO	YES	Dx MO/YR
a. Active or chronic liver disease or cirrhosis	☐	☐ ➡	_____ (a)
b. Chronic kidney failure	☐	☐ ➡	_____ (b)
c. Migraine headaches	☐	☐ ➡	_____ (c)
d. Bleeding hemorrhoids	☐	☐ ➡	_____ (d)
e. Any other gastrointestinal bleeding	☐	☐ ➡	_____ (e)
f. Coagulation disorder	☐	☐ ➡	_____ (f)

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	NO	YES	Dx MO/YR
g. Myocardial infarction (heart attack)	☐	☐ ➡	_____ (g)
h. Angina pectoris	☐	☐ ➡	_____ (h)
IF YES, confirmed by:	NO	YES	
angiogram/cardiac cath?	☐	☐	
stress test?	☐	☐	
i. Coronary angioplasty (PTCA)	☐	☐ ➡	_____ (i)
IF YES, # of vessels _____			
j. Coronary bypass surgery (CABG)	☐	☐ ➡	_____ (j)
IF YES, # of vessels _____			
k. Stroke	☐	☐ ➡	_____ (k)
l. TIA (transient ischemic attack)	☐	☐ ➡	_____ (l)
m. Carotid artery surgery (endarterectomy)	☐	☐ ➡	_____ (m)
n. Peripheral artery surgery (not varicose veins)	☐	☐ ➡	_____ (n)
o. Intermittent claudication	☐	☐ ➡	_____ (o)
p. Pulmonary embolism (PE)	☐	☐ ➡	_____ (p)
q. Deep vein thrombosis (DVT)	☐	☐ ➡	_____ (q)
r. Melanoma	☐	☐ ➡	_____ (r)
s. Non-melanoma skin cancer	☐	☐ ➡	_____ (s)
IF YES, type: ☐ **basal cell** ☐ **squamous cell** ☐ **unknown**			
t. Breast cancer	☐	☐ ➡	_____ (t)
u. Lung cancer	☐	☐ ➡	_____ (u)
v. Colon cancer	☐	☐ ➡	_____ (v)
w. Other cancer (non-skin)	☐	☐ ➡	_____ (w)
IF YES, SPECIFY SITE: _____			
x. Peptic ulcer	☐	☐ ➡	_____ (x)
y. Gout	☐	☐ ➡	_____ (y)
z. Diabetes mellitus	☐	☐ ➡	_____ (z)
aa. Colon polyp	☐	☐ ➡	_____ (aa)
bb. Fibrocystic or other benign breast disease	☐	☐ ➡	_____ (bb)
IF YES, confirmed by:	NO	YES	
breast biopsy?	☐	☐	
aspiration?	☐	☐	
cc. Macular degeneration RIGHT eye	☐	☐ ➡	_____ (cc)
dd. Macular degeneration LEFT eye	☐	☐ ➡	_____ (dd)
ee. Cataract RIGHT eye	☐	☐ ➡	_____ (ee)
ff. Cataract LEFT eye	☐	☐ ➡	_____ (ff)
gg. Cataract extraction RIGHT eye	☐	☐ ➡	_____ (gg)
hh. Cataract extraction LEFT eye	☐	☐ ➡	_____ (hh)
ii. Other major illness	☐	☐ ➡	_____ (ii)

IF YES, SPECIFY: _____

CONSENT FORM

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I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION / TREATMENT:** _____

Name of hospital / physician: _____ **Phone #:** _____

Address of hospital/physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____
Signed

Date

PLEASE CONTINUE ON NEXT PAGE ➡

4. SINCE YOU STARTED THE TRIAL (about 3 years ago), have you had any of the following? IF YES, please provide the month and year of diagnosis.

	NO	YES	DX MO/YR
a. Gallstones **IF YES,** Did you have symptoms? ☐ No ☐ Yes How was this diagnosed? ☐ X-ray/ultrasound ☐ Other	☐	☐ ➡	
b. Gallbladder removal	☐	☐ ➡	
c. Periodontal disease (specify number of teeth lost: _____)	☐	☐ ➡	
d. Kidney disease (NOT kidney stones): specify type:	☐	☐ ➡	
e. Elevated cholesterol (diagnosed by a clinician)	☐	☐ ➡	
f. Hypertension (diagnosed by a clinician)	☐	☐ ➡	
g. Asthma	☐	☐ ➡	
h. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	☐	☐ ➡	

5. Are you CURRENTLY being treated with:

	NO	YES	
a. Oral medication for diabetes?	☐	☐	
b. Insulin injection?	☐	☐	
c. Cholesterol-lowering medication(s)?	☐	☐ ➡	Specify Med(s):
d. Anti-hypertensive medication(s)?	☐	☐ ➡	Specify Med(s):

6. DURING THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do not include your study pills. Please respond for each item.

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21 +
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	☐	☐	☐	☐	☐
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	☐	☐	☐	☐	☐
c. Medications containing aspirin (e.g., Alka-Seltzer, Sine-Off, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
d. Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Aleve)	☐	☐	☐	☐	☐
e. Multivitamins: Specify brand name: _____ Specify: Does multivitamin contain vitamin E? ☐ No ☐ Yes ➡ content _____ IU Contain vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content _____ IU	☐	☐	☐	☐	☐
f. Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
g. Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
h. Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	☐
i. Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
j. Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐

7. What is your CURRENT weight? _____ pounds.

8. DURING THE PAST YEAR, what was your approximate average time per week spent at each of the following recreational activities?

	TIME PER WEEK							
	Zero	1-19 Min.	20-59 Min.	One Hr.	1½ Hr.	2-3 Hr.	4-6 Hr.	7 + Hr.
a. Walking for exercise (include walking to work, hiking, treadmill)	☐	☐	☐	☐	☐	☐	☐	☐
b. Jogging (slower than 10 minute miles)	☐	☐	☐	☐	☐	☐	☐	☐
c. Running (10 minute miles or faster)	☐	☐	☐	☐	☐	☐	☐	☐
d. Bicycling (include stationary machine)	☐	☐	☐	☐	☐	☐	☐	☐
e. Aerobic exercise/aerobic dance/exercise machines	☐	☐	☐	☐	☐	☐	☐	☐
f. Lower intensity exercise/yoga/stretching/toning	☐	☐	☐	☐	☐	☐	☐	☐
g. Tennis, squash, or racquetball	☐	☐	☐	☐	☐	☐	☐	☐
h. Lap Swimming	☐	☐	☐	☐	☐	☐	☐	☐
i. Other: Please specify activity:	☐	☐	☐	☐	☐	☐	☐	☐

PLEASE CONTINUE ON NEXT PAGE ➡

9. Have your menstrual periods ceased PERMANENTLY?
- ☐ Yes: No menstrual periods
- ☐ Yes: Had menopause, but now have periods induced by hormones
- ☐ No: Premenopausal
- ☐ Not Sure

a. At what AGE did your periods cease? _____

b. For what REASON did your periods cease?
- ☐ SURGERY: If due to surgery, were your ovaries and/or uterus removed? (Mark **ALL** that apply)
  - ☐ Uterus removed
  - ☐ One ovary removed
  - ☐ Both ovaries removed
- ☐ RADIATION or CHEMOTHERAPY
- ☐ NATURAL: If natural (non-surgical) menopause, have you had subsequent surgery to remove ovaries or uterus? (Mark **ALL** that apply)
  - ☐ No, did not have surgery
  - ☐ One ovary removed
  - ☐ Uterus removed
  - ☐ Both ovaries removed

10. *IN THE PAST YEAR*, have you used female replacement hormones (other than oral contraceptives)?
☐ No ☐ Yes, currently ☐ Yes, discontinued

a. ESTROGEN: Did you use ESTROGEN in the PAST YEAR?
☐ No ☐ Yes ➡

1. In the PAST YEAR, for how many months have you used ESTROGEN?
☐ 1-2 mo. ☐ 3-4 mo. ☐ 5-6 mo. ☐ 7-8 mo. ☐ 9-10 mo. ☐ 11-12 mo.
2. What type of ESTROGEN have you used the longest in the PAST YEAR?
☐ Oral Premarin ☐ Oral Estrace ☐ Patch Estrogen
☐ Vaginal Estrogen ☐ Oral Ogen ☐ Other Estrogen: please specify _____
3. If you used ORAL CONJUGATED ESTROGEN (e.g., Premarin), what dose did you usually take?
☐ DID NOT USE ORAL CONJUGATED ESTROGEN
☐ .30 mg/day or less (green) ☐ .9 mg/day (white) ☐ More than 1.25 mg/day
☐ .625 mg/day (brown) ☐ 1.25 mg/day (yellow) ☐ Dose unknown
4. If you used ORAL or PATCH ESTROGEN, what was your pattern of use (days per month)?
☐ DID NOT USE ORAL OR PATCH ESTROGEN
☐ < 1 day/mo. ☐ 1-8 days/mo. ☐ 9-18 days/mo. ☐ 19-26 days/mo. ☐ 27+ days/mo.

b. PROGESTERONE/PROGESTIN: Did you use PROGESTERONE/PROGESTIN (e.g., Provera, Cycrin) in the PAST YEAR?
☐ No ☐ Yes ➡

1. In the PAST YEAR, for how many months have you used PROGESTERONE/PROGESTIN?
☐ 1-2 mo. ☐ 3-4 mo. ☐ 5-6 mo. ☐ 7-8 mo. ☐ 9-10 mo. ☐ 11-12 mo.
2. What type of PROGESTERONE/PROGESTIN have you used the longest in the PAST YEAR?
☐ Oral ☐ Vaginal ☐ Other: please specify _____
3. If you used ORAL MEDROXY PROGESTERONE (e.g., Provera, Cycrin), what dose did you usually take?
☐ DID NOT USE ORAL MEDROXY PROGESTERONE
☐ < 5 mg ☐ 5-9 mg ☐ 10 mg ☐ > 10 mg ☐ Dose unknown
4. If you used ORAL PROGESTERONE, what was your pattern of use (days per month)?
☐ DID NOT USE ORAL PROGESTERONE
☐ < 1 day/mo. ☐ 1-8 days/mo. ☐ 9-18 days/mo. ☐ 19-26 days/mo. ☐ 27+ days/mo.

11. Have you EVER used PERMANENT hair dye (do NOT include dyes that rinse out)? ☐ Don't Remember ☐ No ☐ Yes
IF YES: Please indicate below the color(s) and years of use for each.

DYE COLOR	USED? Don't Remember	No	Yes	IF YES, NUMBER OF YEARS USED (APPROXIMATELY) < 1 YR	1-5 YRS	6-10 YRS	11-15 YRS	16-20 YRS	21-25 YRS	> 25 YRS
a. Blonde	☐	☐	☐➡	☐	☐	☐	☐	☐	☐	☐
b. Red/Auburn	☐	☐	☐➡	☐	☐	☐	☐	☐	☐	☐
c. Light Brown	☐	☐	☐➡	☐	☐	☐	☐	☐	☐	☐
d. Medium Brown	☐	☐	☐➡	☐	☐	☐	☐	☐	☐	☐
e. Dark Brown	☐	☐	☐➡	☐	☐	☐	☐	☐	☐	☐
f. Black	☐	☐	☐➡	☐	☐	☐	☐	☐	☐	☐
g. Silver Gray	☐	☐	☐➡	☐	☐	☐	☐	☐	☐	☐
h. Other Color	☐	☐	☐➡	☐	☐	☐	☐	☐	☐	☐

12. Did either of YOUR PARENTS EVER have macular degeneration of the retina?

	Unknown	No	Yes	If Yes: what age? before age 60	age 60+	age unknown
a. Mother	☐	☐	☐➡	☐	☐	☐
b. Father	☐	☐	☐➡	☐	☐	☐

THANK YOU! PLEASE CALL (800) 633-6911 IF YOU HAVE ANY QUESTIONS

1a. Are you **CURRENTLY** taking the WHITE PILLS? ☐ No ☐ Yes
Are you **CURRENTLY** taking the AMBER CAPS? ☐ No ☐ Yes

b. For EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have TAKEN over the PAST YEAR.

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐

If you missed taking your pills, what was the main reason?

_____

2. IN THE PAST YEAR have you experienced the following? Please check NO or YES for EACH item.

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

3. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please check NO or YES for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form on the next page.

	NO	YES	Dx MO/YR	
a. Myocardial infarction (heart attack)	☐	☐	_____	(a)
b. Angina pectoris	☐	☐	_____	(b)
IF YES, confirmed by: angiogram/cardiac cath?	☐	☐		
IF YES, confirmed by: stress test?	☐	☐		
c. Coronary angioplasty (PTCA)	☐	☐	_____	(c)
IF YES, # of vessels _____				
d. Coronary bypass surgery (CABG)	☐	☐	_____	(d)
IF YES, # of vessels _____				
e. Stroke	☐	☐	_____	(e)
f. TIA (transient ischemic attack)	☐	☐	_____	(f)
Carotid artery surgery (endarterectomy)	☐	☐	_____	(g)
h. Peripheral artery surgery (not varicose veins)	☐	☐	_____	(h)
i. Intermittent claudication	☐	☐	_____	(i)
j. Pulmonary embolism (PE)	☐	☐	_____	(j)
k. Deep vein thrombosis (DVT)	☐	☐	_____	(k)

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NEWLY DIAGNOSED IN PAST YEAR?	NO	YES	Dx MO/YR	
l. Asthma	☐	☐	_____	(l)
m. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	☐	☐	_____	(m)
n. Elevated cholesterol (dx by clinician)	☐	☐	_____	(n)
o. Hypertension (dx by clinician)	☐	☐	_____	(o)
p. Melanoma	☐	☐	_____	(p)
q. Non-melanoma skin cancer	☐	☐	_____	(q)
IF YES, type: ☐ basal cell ☐ squamous cell ☐ unknown				
r. Breast cancer	☐	☐	_____	(r)
s. Lung cancer	☐	☐	_____	(s)
t. Colon cancer	☐	☐	_____	(t)
u. Other cancer (non-skin)	☐	☐	_____	(u)
IF YES, SPECIFY SITE: _____				
v. Colon polyp	☐	☐	_____	(v)
w. Fibrocystic or other benign breast disease	☐	☐	_____	(w)
IF YES, confirmed by: breast biopsy?	☐	☐		
IF YES, confirmed by: aspiration?	☐	☐		
x. Diabetes mellitus	☐	☐	_____	(x)
y. Gout	☐	☐	_____	(y)
z. Peptic ulcer	☐	☐	_____	(z)
aa. Gallstones	☐	☐	_____	(aa)
IF YES, how diagnosed? ☐ x-ray, ultrasound ☐ other				
bb. Gallbladder removal	☐	☐	_____	(bb)
cc. Active or chronic liver disease or cirrhosis	☐	☐	_____	(cc)
dd. Kidney disease (NOT kidney stones)	☐	☐	_____	(dd)
IF YES, specify type: _____				
ee. Chronic kidney failure	☐	☐	_____	(ee)
ff. Migraine headaches	☐	☐	_____	(ff)
gg. Bleeding hemorrhoids	☐	☐	_____	(gg)
hh. Any other gastrointestinal bleeding	☐	☐	_____	(hh)
ii. Coagulation disorder	☐	☐	_____	(ii)
jj. Periodontal disease	☐	☐	_____	(jj)
IF YES, # teeth lost: _____				
kk. Macular degeneration RIGHT eye	☐	☐	_____	(kk)
ll. Macular degeneration LEFT eye	☐	☐	_____	(ll)
mm. Cataract RIGHT eye	☐	☐	_____	(mm)
nn. Cataract LEFT eye	☐	☐	_____	(nn)
oo. Cataract extraction RIGHT eye	☐	☐	_____	(oo)
pp. Cataract extraction LEFT eye	☐	☐	_____	(pp)
qq. Other major illness	☐	☐	_____	(qq)
IF YES, SPECIFY: _____				

IF YES TO ANY OF THE ITEMS IN QUESTION # 3, PLEASE COMPLETE THE CONSENT FORM AT THE TOP OF THE NEXT PAGE. OTHERWISE PLEASE CONTINUE WITH # 4.

CONSENT FORM **If you responded YES to any of the items in question # 3, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.**

I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION/TREATMENT:** _____

Name of hospital/physician: _____ **Phone # :** _____

Address of hospital/physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____
Signed **Date**

4. DURING THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do NOT include your study pills. Please respond for each item.

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21 +
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	☐	☐	☐	☐	☐
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	☐	☐	☐	☐	☐
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
d. Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Aleve)	☐	☐	☐	☐	☐
e. Multivitamins: Specify brand name: _____ Specify: Does multivitamin contain vitamin E? ☐ No ☐ Yes ➡ content _____ IU Contain vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content _____ IU	☐	☐	☐	☐	☐
f. Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
g. Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
h. Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	
i. Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
j. Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐

5. Please record your average consumption of the following beverages over the LAST YEAR:

	Never or Less Than One/Month	1-3 Per Month	1 Per Week	2-4 Per Week	5-6 Per Week	1 Per Day	2-3 Per Day	4-5 Per Day	6+ Per Day
a. Beer (1 glass, bottle, can)	☐	☐	W	☐	☐	D	☐	☐	☐
b. Red wine (include sherry, port) (4 oz. glass)	☐	☐	W	☐	☐	D	☐	☐	☐
c. White wine (4 oz. glass)	☐	☐	W	☐	☐	D	☐	☐	☐
d. Liquor (e.g., vodka, rum, gin, liqueur, brandy) (one drink or shot)	☐	☐	W	☐	☐	D	☐	☐	☐

6. Do you CURRENTLY smoke cigarettes?

☐ No ☐ Yes ➡ IF YES, on average, how many cigarettes do you smoke EACH DAY?

☐ 1-4 cigs. ☐ 5-14 cigs. ☐ 15-24 cigs. ☐ 25-35 cigs. ☐ 36-44 cigs. ☐ 45 + cigs.

7. Have you EVER been diagnosed with any of the following conditions? IF YES, please provide month and year of diagnosis.

	NO	YES	Dx MO/YR
a. Congestive heart failure	☐	☐ ➡	_____
b. Left ventricular hypertrophy	☐	☐ ➡	_____
c. Ventricular tachycardia	☐	☐ ➡	_____
d. Atrial fibrillation	☐	☐ ➡	_____
e. Bradycardia	☐	☐ ➡	_____
f. Urinary incontinence	☐	☐ ➡	_____
g. Depression	☐	☐ ➡	_____
h. Fluid retention	☐	☐ ➡	_____
i. Leg swelling	☐	☐ ➡	_____
j. Dry eye syndrome (dx by clinician)	☐	☐ ➡	_____

8. How often are your eyes dry (not wet enough)? Would you say: ☐ Constantly ☐ Often ☐ Sometimes ☐ Never

9. How often are your eyes irritated? Would you say: ☐ Constantly ☐ Often ☐ Sometimes ☐ Never

Please continue on next page ⟶

10. What is your CURRENT blood pressure? _____ / _____ mmHg ☐ don't know

11. Are you CURRENTLY being treated with any medications SPECIFICALLY for hypertension?

☐ No ☐ Yes ➡ IF YES, please specify below (PLEASE WRITE CLEARLY):

	Brand Name of Drug	Dose (each pill)	# Pills/Week	Date Began (mo/yr)
a.				
b.				
c.				
d.				

12. When was your TOTAL blood cholesterol level last checked?

☐ within the past year ☐ 1-2 years ago ☐ 3-5 years ago ☐ more than 5 years ago/never ☐ don't remember

If checked within the past 5 years, what is your most recent TOTAL cholesterol level? _____ mg/100 ml ☐ don't know

13. When was your HDL cholesterol level last checked?

☐ within the past year ☐ 1-2 years ago ☐ 3-5 years ago ☐ more than 5 years ago/never ☐ don't remember

If checked within the past 5 years, what is your most recent HDL cholesterol level? _____ mg/100 ml ☐ don't know

14. Are you CURRENTLY being treated with any cholesterol-lowering medications?

☐ No ☐ Yes ➡ IF YES, please specify below (PLEASE WRITE CLEARLY):

	Brand Name of Drug	Dose (each pill)	# Pills/Week	Date Began (mo/yr)
a.				
b.				

15. IN THE PAST TWO WEEKS, have you taken any OTHER medications (either prescription or over-the-counter, including pills, creams, inhalers, patches, etc.)?

☐ No ☐ Yes ➡ IF YES, please specify below, including the reason for taking the drug (PLEASE WRITE CLEARLY):

PRESCRIPTION:

	Brand Name of Drug	Dose (each pill or application)	# Pills/Week (or applications)	Date Began (mo/yr)	Reason for Taking
a.					
b.					
c.					
d.					

OVER THE COUNTER:

a.					
b.					
c.					
d.					

16. ONE YEAR AGO were you taking any ADDITIONAL prescription medications that you **ARE NO LONGER** taking now?

☐ No ☐ Yes ➡ IF YES, please specify below, including the reason for taking and reason for discontinuation (PLEASE WRITE CLEARLY):

	Brand Name of Drug	Reason for Taking	Reason for Discontinuation
a.			
b.			
c.			
d.			
e.			
f.			

THANK YOU! PLEASE CALL (800) 633-6911 IF YOU HAVE ANY QUESTIONS.

1a. Are you CURRENTLY taking the WHITE PILLS? ☐ No ☐ Yes
Are you CURRENTLY taking the AMBER CAPS? ☐ No ☐ Yes

b. For EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have TAKEN over the PAST YEAR.

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐

If you missed taking your pills, what was the main reason?
_____

2. IN THE PAST YEAR, have you experienced the following? Please check NO or YES for EACH item.

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

3. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please check NO or YES for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form on the next page.

	NO	YES	Dx MO/YR	
a. Myocardial infarction (heart attack)	☐	☐ ➡	_____	(a)
b. Angina pectoris	☐	☐ ➡	_____	(b)
IF YES, confirmed by: **angiogram/cardiac cath?**	NO ☐	YES ☐		
stress test?	☐	☐		
c. Coronary angioplasty (PTCA)	☐	☐ ➡	_____	(c)
IF YES, # of vessels: _____				
d. Coronary bypass surgery (CABG)	☐	☐ ➡	_____	(d)
IF YES, # of vessels: _____				
e. Congestive heart failure	☐	☐ ➡	_____	(e)
f. Ventricular tachycardia	☐	☐ ➡	_____	(f)
g. Atrial fibrillation	☐	☐ ➡	_____	(g)
h. Intermittent claudication	☐	☐ ➡	_____	(h)
i. Pulmonary embolism (PE)	☐	☐ ➡	_____	(i)
j. Deep vein thrombosis (DVT)	☐	☐ ➡	_____	(j)

PLEASE GO TO THE TOP OF THE NEXT COLUMN

NEWLY DIAGNOSED IN PAST YEAR?

		NO	YES	Dx MO/YR	
k.	Stroke	☐	☐ ➡	_____	(k)
l.	TIA (transient ischemic attack)	☐	☐ ➡	_____	(l)
m.	Carotid artery surgery (endarterectomy)	☐	☐ ➡	_____	(m)
n.	Peripheral artery surgery (not varicose veins)	☐	☐ ➡	_____	(n)
o.	Asthma	☐	☐ ➡	_____	(o)
p.	Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	☐	☐ ➡	_____	(p)
q.	Elevated cholesterol (dx by clinician)	☐	☐ ➡	_____	(q)
r.	Hypertension (dx by clinician)	☐	☐ ➡	_____	(r)
s.	Melanoma	☐	☐ ➡	_____	(s)
t.	Non-melanoma skin cancer	☐	☐ ➡	_____	(t)
IF YES, type:	☐ **basal cell** ☐ **squamous cell** ☐ **unknown**				
u.	Breast cancer	☐	☐ ➡	_____	(u)
v.	Lung cancer	☐	☐ ➡	_____	(v)
w.	Colon cancer	☐	☐ ➡	_____	(w)
x.	Other cancer (non-skin)	☐	☐ ➡	_____	(x)
IF YES, SPECIFY SITE: _____					
y.	Colon polyp	☐	☐ ➡	_____	(y)
z.	Fibrocystic or other benign breast disease	☐	☐ ➡	_____	(z)
IF YES, confirmed by:		NO	YES		
breast biopsy?		☐	☐		
aspiration?		☐	☐		
aa.	Diabetes mellitus	☐	☐ ➡	_____	(aa)
bb.	Gout	☐	☐ ➡	_____	(bb)
cc.	Peptic ulcer	☐	☐ ➡	_____	(cc)
dd.	Gallstones	☐	☐ ➡	_____	(dd)
IF YES, how diagnosed? ☐ **x-ray, ultrasound** ☐ **other**					
ee.	Gallbladder removal	☐	☐ ➡	_____	(ee)
ff.	Active or chronic liver disease or cirrhosis	☐	☐ ➡	_____	(ff)
gg.	Kidney disease (NOT kidney stones)	☐	☐ ➡	_____	(gg)
IF YES, specify type: _____					
hh.	Chronic kidney failure	☐	☐ ➡	_____	(hh)
ii.	Migraine headaches	☐	☐ ➡	_____	(ii)
jj.	Bleeding hemorrhoids	☐	☐ ➡	_____	(jj)
kk.	Any other gastrointestinal bleeding	☐	☐ ➡	_____	(kk)
ll.	Coagulation disorder	☐	☐ ➡	_____	(ll)
mm.	Periodontal disease	☐	☐ ➡	_____	(mm)
IF YES, # teeth lost: _____					
nn.	Macular degeneration RIGHT eye	☐	☐ ➡	_____	(nn)
oo.	Macular degeneration LEFT eye	☐	☐ ➡	_____	(oo)
pp.	Cataract RIGHT eye	☐	☐ ➡	_____	(pp)
qq.	Cataract LEFT eye	☐	☐ ➡	_____	(qq)
rr.	Cataract extraction RIGHT eye	☐	☐ ➡	_____	(rr)
ss.	Cataract extraction LEFT eye	☐	☐ ➡	_____	(ss)
tt.	Other major illness	☐	☐ ➡	_____	(tt)
IF YES, SPECIFY: _____					

IF "YES" IN QUESTION # 3, PLEASE COMPLETE THE CONSENT FORM ON PAGE 2.

CONSENT FORM **If you responded YES to any of the items in question # 3, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.**

I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION/TREATMENT:** _____

Name of hospital/physician: _____ **Phone # :** _____

Address of hospital/physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____
Signed **Date**

4. DURING THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do NOT include your study pills. Please respond for each item.

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21 +
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	☐	☐	☐	☐	☐
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	☐	☐	☐	☐	☐
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
d. Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Aleve)	☐	☐	☐	☐	☐
e. Multivitamins: Specify brand name: _____ Specify: Does multivitamin contain vitamin E? ☐ No ☐ Yes ➡ content _____ IU Contain vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content _____ IU	☐	☐	☐	☐	☐
f. Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
g. Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
h. Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	☐
i. Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
j. Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐

5. Please indicate the number of times you have had each of the following IN THE PAST YEAR. Please provide a response on each line.

	TIMES IN PAST YEAR				
	None	1-2X	3-5X	6-10X	>10X
a. Common cold	☐	☐	☐	☐	☐
b. Acute bronchitis	☐	☐	☐	☐	☐
c. Sinusitis	☐	☐	☐	☐	☐
d. Pneumonia	☐	☐	☐	☐	☐
e. Skin and/or soft tissue infection	☐	☐	☐	☐	☐
f. Urinary infection	☐	☐	☐	☐	☐
g. Any OTHER infection	☐	☐	☐	☐	☐

6. IN THE PAST YEAR, have you used antibiotics?
☐ No ☐ Yes ➡ IF YES, on approximately how many TOTAL DAYS? ☐ 1-7 days ☐ 8-14 days ☐ 15-30 days ☐ 31-60 days ☐ >60 days

7. What is your CURRENT weight? _____ pounds.

8. Have your menstrual periods ceased PERMANENTLY?
☐ Yes: No menstrual periods
☐ Yes: Had menopause, but now have periods induced by hormones
☐ No: Premenopausal
☐ Not Sure

IF YES . . .

a. At what AGE did your periods cease? _____

b. For what REASON did your periods cease?
☐ SURGERY: If due to surgery, were your ovaries and/or uterus removed? (Mark **ALL** that apply)
☐ Uterus removed
☐ One ovary removed
☐ Both ovaries removed
☐ RADIATION or CHEMOTHERAPY
☐ NATURAL: If natural (non-surgical) menopause, have you had subsequent surgery to remove ovaries or uterus)? (Mark **ALL** that apply)
☐ No, did not have surgery ☐ One ovary removed
☐ Uterus removed ☐ Both ovaries removed

PLEASE CONTINUE ON THE BACK

9. IN THE PAST YEAR, have you used female replacement hormones (other than oral contraceptives)? (including estrogen, progesterone, or the new hormones such as Raloxifene)

☐ No ☐ Yes, currently ☐ Yes, discontinued

a. ESTROGEN: Did you use ESTROGEN in the PAST YEAR?

☐ No ☐ Yes ➡

1. In the PAST YEAR, for how many months have you used ESTROGEN?
   ☐ 1-2 mo. ☐ 3-4 mo. ☐ 5-6 mo. ☐ 7-8 mo. ☐ 9-10 mo. ☐ 11-12 mo.
2. What type of ESTROGEN have you used the **longest** in the PAST YEAR?
   ☐ Oral Premarin ☐ Oral Estrace ☐ Patch Estrogen
   ☐ Vaginal Estrogen ☐ Oral Ogen ☐ Other Estrogen: please specify _____
3. If you used ORAL CONJUGATED ESTROGEN (e.g., Premarin), what **dose** did you usually take?
   ☐ DID NOT USE ORAL CONJUGATED ESTROGEN
   ☐ .30 mg/day or less (green) ☐ .9 mg/day (white) ☐ More than 1.25 mg/day
   ☐ .625 mg/day (brown) ☐ 1.25 mg/day (yellow) ☐ Dose unknown
4. If you used either ORAL CONJUGATED ESTROGEN (e.g., Premarin) or a PATCH ESTROGEN, what was your **pattern of use** (days per month)?
   ☐ DID NOT USE EITHER ORAL OR PATCH ESTROGEN
   ☐ < 1 day/mo. ☐ 1-8 days/mo. ☐ 9-18 days/mo. ☐ 19-26 days/mo. ☐ 27 + days/mo.

b. PROGESTERONE/PROGESTIN: Did you use PROGESTERONE/PROGESTIN (e.g., Provera, Cycrin) in the PAST YEAR?

☐ No ☐ Yes ➡

1. In the PAST YEAR, for how many months have you used PROGESTERONE/PROGESTIN?
   ☐ 1-2 mo. ☐ 3-4 mo. ☐ 5-6 mo. ☐ 7-8 mo. ☐ 9-10 mo. ☐ 11-12 mo.
2. What type of PROGESTERONE/PROGESTIN have you used the **longest** in the PAST YEAR?
   ☐ Oral ☐ Vaginal ☐ Other: please specify _____
3. If you used ORAL MEDROXY PROGESTERONE (e.g., Provera, Cycrin), what **dose** did you usually take?
   ☐ DID NOT USE ORAL MEDROXY PROGESTERONE
   ☐ < 5 mg ☐ 5-9 mg ☐ 10 mg ☐ > 10 mg ☐ Dose unknown
4. If you used ORAL PROGESTERONE, what was your **pattern of use** (days per month)?
   ☐ DID NOT USE ORAL PROGESTERONE
   ☐ < 1 day/mo. ☐ 1-8 days/mo. ☐ 9-18 days/mo. ☐ 19-26 days/mo. ☐ 27 + days/mo.

10. How often did you participate in strenuous (aerobic) physical activity or sports at least twice per week (e.g. swimming, aerobics, field hockey, basketball, cycling, running) . . .

a. During high school? (please average) ☐ Never ☐ 1-3 months/yr ☐ 4-6 months/yr ☐ 7-9 months/yr ☐ 10-12 months/yr

b. During ages 18-22? (please average) ☐ Never ☐ 1-3 months/yr ☐ 4-6 months/yr ☐ 7-9 months/yr ☐ 10-12 months/yr

11.

THE INFORMATION BELOW IS IMPORTANT FOR VERIFICATION PURPOSES AND ASSISTS US IN MAINTAINING HIGH RATES OF FOLLOW-UP.

A. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail:

HOME: ( ) _____ WORK: ( ) _____

B. Please indicate the name, address and phone number of *SOMEONE AT A DIFFERENT PERMANENT ADDRESS* whom we might contact if we are unable to contact you. Please indicate if: ☐ friend ☐ neighbor ☐ relative

NAME: _____ PHONE NO.: ( ) _____

ADDRESS: _____ STATE/ZIP: _____

C. Your birthdate: ☐☐ MO ☐☐ DAY ☐☐ YR AND ➡ D. LAST 6-digits of Social Security Number: XXX-☐☐-☐☐☐☐ (OPTIONAL)

D. Your Maiden Name: (LAST NAME ONLY) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PLEASE CONTINUE ON THE NEXT PAGE. THANK YOU. ➡

12. IN THE PAST TWO WEEKS, have you taken any medications (either prescription or over-the-counter, including pills, creams, inhalers, patches, etc.)? Please include medications/vitamins which you may have reported elsewhere on this form.

☐ No ☐ Yes ➡ IF YES, please specify below, including the reason for taking the drug (PLEASE WRITE CLEARLY):

Brand name of drug	Dose (each pill) or application	# Pills/week (or applications)	Date began (mo/yr)	Reason for taking
PRESCRIPTION:				
a.				
b.				
c.				
d.				
OVER THE COUNTER:				
a.				
b.				
c.				
d.				

13. ONE YEAR AGO were you taking any ADDITIONAL prescription medications that you **ARE NO LONGER TAKING NOW?**

☐ No ☐ Yes ➡ IF YES, please specify below, including the reason for taking and reason for discontinuation (PLEASE WRITE CLEARLY):

Brand name of drug	Reason for taking	Reason for discontinuation
a.		
b.		
c.		
d.		
e.		
f.		

14. The following items are about activities you might do during a typical day.
Does your health now limit you in these activities? If so, how much?

Please mark one response on each line.

	No, not limited at all	Yes, limited a little	Yes, limited a lot
a. *Vigorous activities,* such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b. *Moderate activities,* such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing *several* flights of stairs	☐	☐	☐
e. Climbing *one* flight of stairs	☐	☐	☐
f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking *more than a mile*	☐	☐	☐
h. Walking *several blocks*	☐	☐	☐
i. Walking *one* block	☐	☐	☐
j. Bathing or dressing yourself	☐	☐	☐

PLEASE CONTINUE ON THE BACK.

15. Which best describes your current employment status (including self-employment)?

☐ Employed full-time ☐ Employed part-time ☐ Full-time homemaker ☐ Retired ☐ Not employed ☐ Disabled

16. If you have been employed within the past 2 years, the following questions relate to your current or most recent job:

☐ Not employed in past 2 years

Please choose the answer which best describes the degree to which you agree or disagree with each of the following statements.	Strongly disagree	Disagree	Agree	Strongly agree
a. My job requires that I learn new things	☐	☐	☐	☐
b. My job involves a lot of repetitive work	☐	☐	☐	☐
c. My job requires me to be creative	☐	☐	☐	☐
d. My job allows me to make a lot of decisions on my own	☐	☐	☐	☐
e. My job requires a high level of skill	☐	☐	☐	☐
f. On my job, I have very little freedom to decide how I do my work	☐	☐	☐	☐
g. I get to do a variety of different things on my job	☐	☐	☐	☐
h. I have a lot of say about what happens on my job	☐	☐	☐	☐
i. I have an opportunity to develop my own special abilities	☐	☐	☐	☐
j. My job requires working very fast	☐	☐	☐	☐
k. My job requires working very hard	☐	☐	☐	☐
l. My job requires lots of physical effort	☐	☐	☐	☐
m. I am not asked to do an excessive amount of work	☐	☐	☐	☐
n. I have enough time to get the job done	☐	☐	☐	☐
o. My job security is good	☐	☐	☐	☐
p. I am free from conflicting demands that others make	☐	☐	☐	☐

17. These questions are about how you feel and how things have been with you *during the past 4 weeks.*
For each question, please give the one answer that comes closest to the way you have been feeling.
How much of the time during the *past 4 weeks* . . .

Please mark one response on each line.	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you been a very nervous person?	☐	☐	☐	☐	☐	☐
b. Have you felt so down in the dumps nothing could cheer you up?	☐	☐	☐	☐	☐	☐
c. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
d. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐
e. Have you been a happy person?	☐	☐	☐	☐	☐	☐

18. Is there anyone special you know that you feel close to; someone you feel you can share confidences and feelings with?

☐ No ☐ Yes ➡ IF YES, How often do you talk?

☐ Daily ☐ Weekly ☐ Monthly ☐ Several times a year ☐ Once a year or less

19. In general, compared to other persons your age, would you say your health is

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

THANK YOU!

PLEASE RETURN THE ENTIRE FORM IN THE PRE-PAID ENVELOPE TO . . .

WOMEN'S HEALTH STUDY
900 COMMONWEALTH AVENUE EAST
BOSTON, MA 02215

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR TOLL-FREE NUMBER

1-800-633-6911

72 MONTH

1a. Are you CURRENTLY taking the WHITE PILLS? ☐ No ☐ Yes

Are you CURRENTLY taking the AMBER CAPS? ☐ No ☐ Yes

b. For EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have TAKEN over the PAST YEAR.

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐

If you missed taking your pills, what was the main reason?

_____

2. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please check NO or YES for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form on the next page.

	NO	YES	Dx MO/YR	
a. Myocardial infarction (heart attack)	☐	☐	➡ _____	(a)
b. Angina pectoris	☐	☐	➡ _____	(b)
IF YES, confirmed by:	NO	YES		
angiogram/cardiac cath?	☐	☐		
stress test?	☐	☐		
c. Coronary angioplasty (PTCA)	☐	☐	➡ _____	(c)
IF YES, # of vessels: _____				
d. Coronary bypass surgery (CABG)	☐	☐	➡ _____	(d)
IF YES, # of vessels: _____				
e. Congestive heart failure	☐	☐	➡ _____	(e)
f. Ventricular tachycardia	☐	☐	➡ _____	(f)
g. Atrial fibrillation	☐	☐	➡ _____	(g)
h. Intermittent claudication	☐	☐	➡ _____	(h)
i. Pulmonary embolism (PE)	☐	☐	➡ _____	(i)
j. Deep vein thrombosis (DVT)	☐	☐	➡ _____	(j)
k. Stroke	☐	☐	➡ _____	(k)
l. TIA (transient ischemic attack)	☐	☐	➡ _____	(l)
m. Carotid artery surgery (endarterectomy)	☐	☐	➡ _____	(m)
n. Peripheral artery surgery (not varicose veins)	☐	☐	➡ _____	(n)
o. Asthma	☐	☐	➡ _____	(o)
p. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	☐	☐	➡ _____	(p)

PLEASE GO TO THE TOP OF THE NEXT COLUMN

NEWLY DIAGNOSED IN PAST YEAR?	NO	YES	Dx MO/YR	
q. Elevated cholesterol (dx by clinician)	☐	☐	➡ _____	(q)
r. Hypertension (dx by clinician)	☐	☐	➡ _____	(r)
s. Melanoma	☐	☐	➡ _____	(s)
t. Non-melanoma skin cancer	☐	☐	➡ _____	(t)
IF YES, type: ☐ **basal cell** ☐ **squamous cell** ☐ **unknown**				
u. Breast cancer	☐	☐	➡ _____	(u)
v. Lung cancer	☐	☐	➡ _____	(v)
w. Colon cancer	☐	☐	➡ _____	(w)
x. Other cancer (non-skin)	☐	☐	➡ _____	(x)
IF YES, SPECIFY SITE: _____				
y. Colon polyp	☐	☐	➡ _____	(y)
z. Fibrocystic or other benign breast disease	☐	☐	➡ _____	(z)
IF YES, confirmed by:	NO	YES		
breast biopsy?	☐	☐		
aspiration?	☐	☐		
aa. Diabetes mellitus	☐	☐	➡ _____	(aa)
bb. Gout	☐	☐	➡ _____	(bb)
cc. Peptic ulcer	☐	☐	➡ _____	(cc)
dd. Gallstones	☐	☐	➡ _____	(dd)
IF YES, how diagnosed? ☐ **x-ray, ultrasound** ☐ **other**				
ee. Gallbladder removal	☐	☐	➡ _____	(ee)
ff. Active or chronic liver disease or cirrhosis	☐	☐	➡ _____	(ff)
gg. Kidney disease (NOT kidney stones)	☐	☐	➡ _____	(gg)
IF YES, specify type: _____				
hh. Chronic kidney failure	☐	☐	➡ _____	(hh)
ii. Migraine headaches	☐	☐	➡ _____	(ii)
jj. Bleeding hemorrhoids	☐	☐	➡ _____	(jj)
kk. Any other gastrointestinal bleeding	☐	☐	➡ _____	(kk)
ll. Coagulation disorder	☐	☐	➡ _____	(ll)
mm. Periodontal disease	☐	☐	➡ _____	(mm)
IF YES, # teeth lost: _____				
nn. Macular degeneration RIGHT eye	☐	☐	➡ _____	(nn)
oo. Macular degeneration LEFT eye	☐	☐	➡ _____	(oo)
pp. Cataract RIGHT eye	☐	☐	➡ _____	(pp)
qq. Cataract LEFT eye	☐	☐	➡ _____	(qq)
rr. Cataract extraction RIGHT eye	☐	☐	➡ _____	(rr)
ss. Cataract extraction LEFT eye	☐	☐	➡ _____	(ss)
tt. Other major illness	☐	☐	➡ _____	(tt)
IF YES, SPECIFY: _____				

IF "YES" IN QUESTION # 2, PLEASE COMPLETE THE CONSENT FORM ON PAGE 2.

CONSENT FORM **If you responded YES to any of the items in question # 2, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.**

I hereby grant permission to Drs. Julie Buring and Charles H. Hennekens, Professors, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION/TREATMENT:** _____

Name of hospital/physician: _____ **Phone # :** _____

Address of hospital/physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____
Signed Date

COPY VALID AS ORIGINAL

3. IN THE PAST YEAR, have you experienced any of the following? Please check NO or YES for EACH item.

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐

NEXT COLUMN

	NO	YES
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

4. DURING THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do NOT include your study pills. Please respond for each item.

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21 +
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	☐	☐	☐	☐	☐
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	☐	☐	☐	☐	☐
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
d. Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Aleve)	☐	☐	☐	☐	☐
e. Multivitamins: Specify brand name: _____ Specify: Does multivitamin contain vitamin E? ☐ No ☐ Yes ➡ content _____ IU Contain vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content _____ IU	☐	☐	☐	☐	☐
f. Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
g. Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
h. Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	☐
i. Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
j. Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐

5. Do you CURRENTLY smoke cigarettes?
☐ No ☐ Yes ➡ IF YES: On average, how many cigarettes do you smoke EACH DAY?
☐ 1-4 cigs. ☐ 5-14 cigs. ☐ 15-24 cigs. ☐ 25-35 cigs. ☐ 36-44 cigs. ☐ 45 + cigs.

6. Have you EVER been diagnosed **by a physician** as having rheumatoid arthritis?
☐ No ☐ Yes ➡ IF YES: a. When were you diagnosed (month/year)? _____ / _____
b. Rheumatoid factor: ☐ negative / unknown ☐ positive

7. Have you EVER had shingles (Varicella-zoster virus)? ☐ No ☐ Yes ➡ IF YES: What YEAR were you initially diagnosed with shingles? _____

8. What is your CURRENT weight and height? Weight: _____ pounds AND Height: _____ ft. _____ in.

PLEASE CONTINUE ON BACK ⟹

9. Using the instructions found on the cover letter, please record the following measurements to the nearest quarter inch:

	inches	fraction		inches	fraction
WAIST:	_____	_____ /4	HIPS:	_____	_____ /4

10. During the PAST 6 YEARS (since the study began), what is the difference between your highest and lowest weight (excluding illness)?

☐ No change ☐ 2-4 lbs ☐ 5-9 lbs ☐ 10-14 lbs ☐ 15-29 lbs ☐ 30-49 lbs ☐ 50 + lbs

11. During the PAST 6 YEARS (since the study began), have you had unintentional weight loss (e.g., due to illness, unusual stress, depression)?

☐ No ☐ Yes ➡ IF YES: How many lbs.? ☐ 2-4 lbs ☐ 5-9 lbs ☐ 10-14 lbs ☐ 15-29 lbs ☐ 30-49 lbs ☐ 50 + lbs

12. During the PAST 6 YEARS (since the study began), what primary methods have you used to control your weight? PLEASE CHECK ALL THAT APPLY.

☐ None ☐ Diet pills/over-the-counter ☐ Crash diet/fasting
☐ Exercise ☐ Diet pills/prescription ☐ Cigarette smoking
☐ Calorie restriction ☐ Commercial diet program (e.g., Weight Watchers) ☐ Gastric surgery
☐ Low-fat diet ☐ Commercial diet supplement (e.g., Slim-Fast) ☐ Other

13. DURING THE PAST YEAR, what was your approximate average time per week spent at each of the following recreational activities?

	TIME PER WEEK							
	Zero	1-19 Min.	20-59 Min.	One Hr.	1½ Hr.	2-3 Hr.	4-6 Hr.	7 + Hr.
a. Walking for exercise (including walking to work, hiking, treadmill)	☐	☐	☐	☐	☐	☐	☐	☐
b. Jogging (slower than 10 minute miles)	☐	☐	☐	☐	☐	☐	☐	☐
c. Running (10 minute miles or faster)	☐	☐	☐	☐	☐	☐	☐	☐
d. Bicycling (include stationary machine)	☐	☐	☐	☐	☐	☐	☐	☐
e. Aerobic exercise/aerobic dance/exercise machines	☐	☐	☐	☐	☐	☐	☐	☐
f. Lower intensity exercise/yoga/stretching/toning	☐	☐	☐	☐	☐	☐	☐	☐
g. Tennis, squash, or racquetball	☐	☐	☐	☐	☐	☐	☐	☐
h. Lap swimming	☐	☐	☐	☐	☐	☐	☐	☐
i. Other: Please specify activity:	☐	☐	☐	☐	☐	☐	☐	☐

14.

THE INFORMATION BELOW IS IMPORTANT FOR VERIFICATION PURPOSES AND ASSISTS US IN MAINTAINING HIGH RATES OF FOLLOW-UP.

A. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail:

HOME: ( ) _____ WORK: ( ) _____

B. Please indicate the name, address and phone number of *SOMEONE AT A DIFFERENT PERMANENT ADDRESS* whom we might contact if we are unable to contact you. Please indicate if: ☐ friend ☐ neighbor ☐ relative

NAME: _____ PHONE NO.: ( ) _____

ADDRESS: _____ STATE/ZIP: _____

C. Your birthdate: ☐☐ ☐☐ ☐☐ AND ➡ D. LAST 6-digits of Social Security Number: XXX-☐☐-☐☐☐☐
MO DAY YR (OPTIONAL)

E. Your Maiden Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
(LAST NAME ONLY)

THANK YOU!

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR TOLL-FREE NUMBER

1-800-633-6911

84 MONTH QQ

1a. Are you CURRENTLY taking the WHITE PILLS? ☐ No ☐ Yes
Are you CURRENTLY taking the AMBER PILLS? ☐ No ☐ Yes

b. For EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have TAKEN over the PAST YEAR.

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐

If you missed taking your pills, what was the main reason? _____

2. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please check NO or YES for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form on the next page.

	NO	YES	Dx MO/YR
a. Myocardial infarction (heart attack)	☐	☐ ➡	_____ (a)
b. Angina pectoris	☐	☐ ➡	_____ (b)
IF YES, confirmed by: **angiogram/cardiac cath?**	☐	☐	
stress test?	☐	☐	
c. Coronary angioplasty (PTCA)	☐	☐ ➡	_____ (c)
IF YES, # of vessels: _____			
d. Coronary bypass surgery (CABG)	☐	☐ ➡	_____ (d)
IF YES, # of vessels: _____			
e. Congestive heart failure	☐	☐ ➡	_____ (e)
f. Ventricular tachycardia	☐	☐ ➡	_____ (f)
g. Atrial fibrillation	☐	☐ ➡	_____ (g)
h. Intermittent claudication	☐	☐ ➡	_____ (h)
i. Pulmonary embolism (PE)	☐	☐ ➡	_____ (i)
j. Deep vein thrombosis (DVT)	☐	☐ ➡	_____ (j)
k. Stroke	☐	☐ ➡	_____ (k)
l. TIA (transient ischemic attack)	☐	☐ ➡	_____ (l)
m. Carotid artery surgery (endarterectomy)	☐	☐ ➡	_____ (m)
n. Peripheral artery surgery (not varicose veins)	☐	☐ ➡	_____ (n)
o. Asthma	☐	☐ ➡	_____ (o)
p. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	☐	☐ ➡	_____ (p)

NEWLY DIAGNOSED IN PAST YEAR?	NO	YES	Dx MO/YR
q. Elevated cholesterol (dx by clinician)	☐	☐ ➡	_____ (q)
r. Hypertension (dx by clinician)	☐	☐ ➡	_____ (r)
s. Melanoma	☐	☐ ➡	_____ (s)
t. Non-melanoma skin cancer	☐	☐ ➡	_____ (t)
IF YES, TYPE: ☐ **basal cell** ☐ **squamous cell** ☐ **unknown**			
u. Breast cancer	☐	☐ ➡	_____ (u)
v. Lung cancer	☐	☐ ➡	_____ (v)
w. Colon cancer	☐	☐ ➡	_____ (w)
x. Other cancer (non-skin)	☐	☐ ➡	_____ (x)
IF YES, SPECIFY SITE: _____			
y. Colon polyp	☐	☐ ➡	_____ (y)
z. Fibrocystic or other benign breast disease	☐	☐ ➡	_____ (z)
IF YES, confirmed by: **breast biopsy?**	NO ☐	YES ☐	
aspiration?	☐	☐	
aa. Diabetes mellitus	☐	☐ ➡	_____ (aa)
bb. Gout	☐	☐ ➡	_____ (bb)
cc. Peptic ulcer	☐	☐ ➡	_____ (cc)
dd. Gallstones	☐	☐ ➡	_____ (dd)
IF YES, how diagnosed? ☐ **x-ray, ultrasound** ☐ **other**			
ee. Gallbladder removal	☐	☐ ➡	_____ (ee)
ff. Active or chronic liver disease or cirrhosis	☐	☐ ➡	_____ (ff)
gg. Kidney disease (NOT kidney stones)	☐	☐ ➡	_____ (gg)
IF YES, specify type: _____			
hh. Chronic kidney failure	☐	☐ ➡	_____ (hh)
ii. Migraine headaches	☐	☐ ➡	_____ (ii)
jj. Bleeding hemorrhoids	☐	☐ ➡	_____ (jj)
kk. Any other gastrointestinal bleeding	☐	☐ ➡	_____ (kk)
ll. Coagulation disorder	☐	☐ ➡	_____ (ll)
mm. Periodontal disease	☐	☐ ➡	_____ (mm)
IF YES, # of teeth lost. _____			
nn. Macular degeneration RIGHT eye	☐	☐ ➡	_____ (nn)
oo. Macular degeneration LEFT eye	☐	☐ ➡	_____ (oo)
pp. Cataract RIGHT eye	☐	☐ ➡	_____ (pp)
qq. Cataract LEFT eye	☐	☐ ➡	_____ (qq)
rr. Cataract extraction RIGHT eye	☐	☐ ➡	_____ (rr)
ss. Cataract extraction LEFT eye	☐	☐ ➡	_____ (ss)
tt. Shingles (Varicella-zoster virus)	☐	☐ ➡	_____ (tt)
uu. Rheumatoid arthritis	☐	☐ ➡	_____ (uu)
IF YES, rheumatoid factor: ☐ negative / unknown ☐ positive			
vv. Other major illnesses	☐	☐ ➡	_____ (vv)
IF YES, SPECIFY: _____			

PLEASE GO TO THE TOP OF THE NEXT COLUMN

IF "YES" IN QUESTION #2, PLEASE COMPLETE THE CONSENT FORM ON PAGE 2.

CONSENT FORM **If you responded YES to any of the items in question #2, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.**

I hereby grant permission to Dr. Julie Buring, Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION / TREATMENT:** _____

Name of hospital / physician: _____ **Phone # :** _____

Address of hospital / physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____

Signed **Date**

COPY VALID AS ORIGINAL

3. IN THE PAST YEAR, have you experienced any of the following? Please check NO or YES for EACH item.

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐

NEXT COLUMN

	NO	YES
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

4. DURING THE PAST MONTH, on approximately how many days did you take any of the following? Do NOT include your study pills. Please respond for each item.

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	☐	☐	☐	☐	☐
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	☐	☐	☐	☐	☐
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
d. Traditional nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Aleve)	☐	☐	☐	☐	☐
e. New NSAIDs (Cox-2 inhibitors, e.g., Celebrex, Vioxx)	☐	☐	☐	☐	☐
f. Multivitamins: Specify brand name: _____ Specify: Does multivitamin contain vitamin E? ☐ No ☐ Yes ➡ content _____ IU Contain vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content _____ IU	☐	☐	☐	☐	☐
g. Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
h. Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
i. Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	☐
j. Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
k. Other vitamin preparations containing beta-carotene, vitamins E or A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐

5. THE INFORMATION BELOW ASSISTS US IN MAINTAINING HIGH RATES OF FOLLOW-UP.

A. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail:
HOME: ( ) _____ WORK: ( ) _____

B. Please indicate the name, address and phone number of *SOMEONE AT A DIFFERENT PERMANENT ADDRESS* whom we might contact if we are unable to contact you. Please indicate if: ☐ friend ☐ neighbor ☐ relative
NAME: _____ PHONE NO.: ( ) _____
ADDRESS: _____ STATE / ZIP: _____

C. Your birthdate: ☐☐ ☐☐ ☐☐ (MO DAY YR) AND ➡ D. LAST 6-digits of Social Security Number: XXX-☐☐-☐☐☐☐ (OPTIONAL)

E. Your Maiden Name: (LAST NAME ONLY) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

1a. Are you CURRENTLY taking the WHITE PILLS? ☐ No ☐ Yes
Are you CURRENTLY taking the AMBER PILLS? ☐ No ☐ Yes

b. For EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have TAKEN over the PAST YEAR.

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐

If you missed taking your pills, what was the main reason?
_____

2. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please check NO or YES for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form on the next page.

	NO	YES	Dx MO/YR
a. Myocardial infarction (heart attack)	☐	☐ ➡	_____ (a)
b. Angina pectoris	☐	☐ ➡	_____ (b)
IF YES, confirmed by: angiogram/cardiac cath?	☐	☐	
stress test?	☐	☐	
c. Coronary angioplasty (PTCA)	☐	☐ ➡	_____ (c)
IF YES, # of vessels: _____			
d. Coronary bypass surgery (CABG)	☐	☐ ➡	_____ (d)
IF YES, # of vessels: _____			
e. Congestive heart failure	☐	☐ ➡	_____ (e)
f. Ventricular tachycardia	☐	☐ ➡	_____ (f)
g. Atrial fibrillation	☐	☐ ➡	_____ (g)
h. Intermittent claudication	☐	☐ ➡	_____ (h)
i. Pulmonary embolism (PE)	☐	☐ ➡	_____ (i)
j. Deep vein thrombosis (DVT)	☐	☐ ➡	_____ (j)
k. Stroke	☐	☐ ➡	_____ (k)
l. TIA (transient ischemic attack)	☐	☐ ➡	_____ (l)
m. Carotid artery surgery (endarterectomy)	☐	☐ ➡	_____ (m)
n. Peripheral artery surgery (not varicose veins)	☐	☐ ➡	_____ (n)
o. Asthma	☐	☐ ➡	_____ (o)
p. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	☐	☐ ➡	_____ (p)

PLEASE GO TO THE TOP OF THE NEXT COLUMN

NEWLY DIAGNOSED IN PAST YEAR?	NO	YES	Dx MO/YR
q. Elevated cholesterol (dx by clinician)	☐	☐ ➡	_____ (q)
r. Hypertension (dx by clinician)	☐	☐ ➡	_____ (r)
s. Melanoma	☐	☐ ➡	_____ (s)
t. Non-melanoma skin cancer	☐	☐ ➡	_____ (t)
IF YES, TYPE: ☐ basal cell ☐ squamous cell ☐ unknown			
u. Breast cancer	☐	☐ ➡	_____ (u)
v. Lung cancer	☐	☐ ➡	_____ (v)
w. Colon cancer	☐	☐ ➡	_____ (w)
x. Other cancer (non-skin)	☐	☐ ➡	_____ (x)
IF YES, SPECIFY SITE: _____			
y. Colon polyp	☐	☐ ➡	_____ (y)
z. Fibrocystic or other benign breast disease	☐	☐ ➡	_____ (z)
IF YES, confirmed by: breast biopsy?	☐	☐	
aspiration?	☐	☐	
aa. Diabetes mellitus	☐	☐ ➡	_____ (aa)
bb. Gout	☐	☐ ➡	_____ (bb)
cc. Peptic ulcer	☐	☐ ➡	_____ (cc)
dd. Gallstones	☐	☐ ➡	_____ (dd)
IF YES, how diagnosed? ☐ x-ray, ultrasound ☐ other			
ee. Gallbladder removal	☐	☐ ➡	_____ (ee)
ff. Active or chronic liver disease or cirrhosis	☐	☐ ➡	_____ (ff)
gg. Kidney disease (NOT kidney stones)	☐	☐ ➡	_____ (gg)
IF YES, specify type: _____			
hh. Chronic kidney failure	☐	☐ ➡	_____ (hh)
ii. Migraine headaches	☐	☐ ➡	_____ (ii)
jj. Bleeding hemorrhoids	☐	☐ ➡	_____ (jj)
kk. Any other gastrointestinal bleeding	☐	☐ ➡	_____ (kk)
ll. Coagulation disorder	☐	☐ ➡	_____ (ll)
mm. Periodontal disease	☐	☐ ➡	_____ (mm)
IF YES, # of teeth lost: _____			
nn. Macular degeneration RIGHT eye	☐	☐ ➡	_____ (nn)
oo. Macular degeneration LEFT eye	☐	☐ ➡	_____ (oo)
pp. Cataract RIGHT eye	☐	☐ ➡	_____ (pp)
qq. Cataract LEFT eye	☐	☐ ➡	_____ (qq)
rr. Cataract extraction RIGHT eye	☐	☐ ➡	_____ (rr)
ss. Cataract extraction LEFT eye	☐	☐ ➡	_____ (ss)
tt. Shingles (Varicella-zoster virus)	☐	☐ ➡	_____ (tt)
uu. Rheumatoid arthritis	☐	☐ ➡	_____ (uu)
IF YES, rheumatoid factor: ☐ negative / unknown ☐ positive			
vv. Other major illnesses	☐	☐ ➡	_____ (vv)
IF YES, SPECIFY: _____			

IF "YES" IN QUESTION #2, PLEASE COMPLETE THE CONSENT FORM ON PAGE 2.

CONSENT FORM **If you responded YES to any of the items in question #2, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence. I hereby grant permission to Dr. Julie Buring, Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:**

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION / TREATMENT:** _____

Name of hospital / physician: _____ **Phone # :** _____

Address of hospital / physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____ **Date:** _____

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3. IN THE PAST YEAR, have you experienced any of the following? Please check NO or YES for EACH item.

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐

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	NO	YES
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

4. DURING THE PAST MONTH, on approximately how many days did you take any of the following? Do NOT include your study pills. Please respond for each item.

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	☐	☐	☐	☐	☐
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	☐	☐	☐	☐	☐
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
d. Traditional nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Aleve)	☐	☐	☐	☐	☐
e. New NSAIDs (Cox-2 inhibitors, e.g., Celebrex, Vioxx)	☐	☐	☐	☐	☐
f. Multivitamins: Specify brand name: _____ Specify: Does multivitamin contain vitamin E? ☐ No ☐ Yes ➡ content _____ IU Contain vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content _____ IU	☐	☐	☐	☐	☐
g. Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
h. Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
i. Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	☐
j. Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
k. Other vitamin preparations containing beta-carotene, vitamins E or A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐

5. DURING THE PAST YEAR, what was your approximate average time per week spent at each of the following recreational activities?

	AVERAGE TIME PER WEEK							
	Zero	1-19 Min.	20-59 Min.	One Hr.	1½ Hr.	2-3 Hr.	4-6 Hr.	7 + Hr.
a. Walking or hiking (include walking to work)	☐	☐	☐	☐	☐	☐	☐	☐
b. Jogging (slower than 10 minute miles)	☐	☐	☐	☐	☐	☐	☐	☐
c. Running (10 minute miles or faster)	☐	☐	☐	☐	☐	☐	☐	☐
d. Bicycling (include stationary machine)	☐	☐	☐	☐	☐	☐	☐	☐
e. Aerobic exercise / aerobic dance / exercise machines	☐	☐	☐	☐	☐	☐	☐	☐
f. Lower intensity exercise / yoga / stretching / toning	☐	☐	☐	☐	☐	☐	☐	☐
g. Tennis, squash, or racquetball	☐	☐	☐	☐	☐	☐	☐	☐
h. Lap swimming	☐	☐	☐	☐	☐	☐	☐	☐
i. Weight lifting / strength training	☐	☐	☐	☐	☐	☐	☐	☐
j. Other: Please specify activity	☐	☐	☐	☐	☐	☐	☐	☐

6. On average, how many *flights* of stairs (not individual steps) do you climb *DAILY*?

☐ None ☐ 1-2 flights ☐ 3-4 flights ☐ 5-9 flights ☐ 10-14 flights ☐ 15 or more flights

7. What is your usual walking pace outdoors? ☐ Don't walk regularly ☐ Easy, casual (less than 2 mph) ☐ Normal, average (2-2.9 mph) ☐ Brisk pace (3-3.9 mph) ☐ Very brisk/striding (4 mph or faster)

8. Have your menstrual periods ceased PERMANENTLY?
- ☐ Yes: No menstrual periods
- ☐ Yes: Had menopause, but now have periods induced by hormones
- ☐ No: Premenopausal
- ☐ Not sure

a. At what AGE did your periods cease? _____

b. For what REASON did your periods cease?
- ☐ SURGERY: If due to surgery, were your ovaries and/or uterus removed? Mark ALL that apply)
  - ☐ Uterus removed
  - ☐ One ovary removed
  - ☐ Both ovaries removed
- ☐ RADIATION or CHEMOTHERAPY
- ☐ NATURAL: If natural (non-surgical) menopause, have you had subsequent surgery to remove ovaries or uterus? (Mark ALL that apply)
  - ☐ No, did not have surgery ☐ One ovary removed
  - ☐ Uterus removed ☐ Both ovaries removed

9. Have you EVER taken SERMS such as raloxifene (Evista) or tamoxifen?
☐ No ☐ Yes, currently ☐ Yes, past

IF YES, what is the total amount of time you used it?
☐ < 6 mo ☐ 6-12 mo ☐ 13-24 mo ☐ 25-36 mo ☐ > 36 mo

10. Have you used female hormones (other than oral contraceptives) in the PAST THREE YEARS?

☐ No ☐ Yes

a) Of the PAST 3 YEARS, how many TOTAL YEARS have you used them?
☐ <1 year ☐ 1 year ☐ 2 years ☐ 3 years

b) Are you currently using them? ☐ No ☐ Yes

c) Mark the types of hormones you have used the longest:
Estrogen: ☐ Oral Premarin ☐ Oral Prempro ☐ Oral Premphase ☐ Oral Estrace/Ogen ☐ Vaginal estrogen ☐ Patch estrogen ☐ Other estrogen, specify: _____
Progesterone: ☐ Oral ☐ Vaginal ☐ Other, specify: _____

d) If you used conjugated estrogens (e.g., Premarin, Prempro or Premphase) what dose did you usually take?
☐ ≤0.3 mg ☐ 0.625 mg ☐ 0.9 mg ☐ 1.25 mg ☐ >1.25 mg ☐ dose unknown ☐ did not take conjugated estrogens

e) If you used medroxy progesterone (e.g., Provera, Cycrin, Prempro or Premphase) what dose did you usually take?
☐ <5 mg ☐ 5-9 mg ☐ 10 mg ☐ ≥10 mg ☐ unknown ☐ not used

f) What was your pattern of hormone use? (Days/month)

Oral or patch estrogen	☐ not used	☐ <1	☐ 1-8	☐ 9-18	☐ 19-26	☐ 27+ days/month
Progesterone	☐ not used	☐ <1	☐ 1-8	☐ 9-18	☐ 19-26	☐ 27+ days/month

11. Do you CURRENTLY smoke cigarettes?
☐ No ☐ Yes

IF YES: On average, how many cigarettes do you smoke EACH DAY?
☐ 1-4 cigs. ☐ 5-14 cigs. ☐ 15-24 cigs. ☐ 25-35 cigs. ☐ 36-44 cigs. ☐ 45 + cigs.

12. THE INFORMATION BELOW ASSISTS US IN MAINTAINING HIGH RATES OF FOLLOW-UP.

A. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail:
HOME: ( ) _____ WORK: ( ) _____

B. Please indicate the name, address and phone number of *SOMEONE AT A DIFFERENT PERMANENT ADDRESS* whom we might contact if we are unable to contact you. Please indicate if: ☐ friend ☐ neighbor ☐ relative
NAME: _____ PHONE NO.: ( ) _____
ADDRESS: _____ STATE / ZIP: _____

C. Your birthdate: ☐☐ MO ☐☐ DAY ☐☐ YR AND ➡ D. LAST 6-digits of Social Security Number: XXX-☐☐-☐☐☐☐ (OPTIONAL)

E. Your Maiden Name: (LAST NAME ONLY) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

F. e-mail address: _____

1a. Are you CURRENTLY taking the WHITE PILLS? ☐ No ☐ Yes
Are you CURRENTLY taking the AMBER PILLS? ☐ No ☐ Yes

b. For EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have taken IN THE PAST YEAR.

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	☐	☐
Took 93-99%, or missed only a few	☐	☐
Took 75-92%, or missed between 1-3 months	☐	☐
Took 67-74%, or missed between 3-4 months	☐	☐
Took 50-66%, or missed between 4-6 months	☐	☐
Took 33-49%, or missed between 6-8 months	☐	☐
Took less than 33%, or missed more than 8 months	☐	☐
Took none, or missed all	☐	☐

If you missed taking your pills, what was the main reason?
_____

2. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please check NO or YES for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form on the next page.

	NO	YES	Dx MO/YR
a. Myocardial infarction (heart attack)	☐	☐ ➡	_____ (a)
b. Angina pectoris	☐	☐ ➡	_____ (b)
IF YES, confirmed by: NO YES angiogram/cardiac cath? ☐ ☐ stress test? ☐ ☐			
c. Coronary angioplasty (PTCA)	☐	☐ ➡	_____ (c)
IF YES, # of vessels: _____			
d. Coronary bypass surgery (CABG)	☐	☐ ➡	_____ (d)
IF YES, # of vessels: _____			
e. Congestive heart failure	☐	☐ ➡	_____ (e)
f. Ventricular tachycardia	☐	☐ ➡	_____ (f)
g. Atrial fibrillation	☐	☐ ➡	_____ (g)
h. Intermittent claudication	☐	☐ ➡	_____ (h)
i. Pulmonary embolism (PE)	☐	☐ ➡	_____ (i)
j. Deep vein thrombosis (DVT)	☐	☐ ➡	_____ (j)
k. Stroke	☐	☐ ➡	_____ (k)
l. TIA (transient ischemic attack)	☐	☐ ➡	_____ (l)
m. Carotid artery surgery (endarterectomy)	☐	☐ ➡	_____ (m)
n. Peripheral artery surgery (not varicose veins)	☐	☐ ➡	_____ (n)
o. Asthma	☐	☐ ➡	_____ (o)
p. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis)	☐	☐ ➡	_____ (p)

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NEWLY DIAGNOSED IN PAST YEAR?	NO	YES	Dx MO/YR
q. Elevated cholesterol (dx by clinician)	☐	☐ ➡	_____ (q)
r. Hypertension (dx by clinician)	☐	☐ ➡	_____ (r)
s. Melanoma	☐	☐ ➡	_____ (s)
t. Non-melanoma skin cancer	☐	☐ ➡	_____ (t)
IF YES, TYPE: ☐ basal cell ☐ squamous cell ☐ unknown			
u. Breast cancer	☐	☐ ➡	_____ (u)
v. Lung cancer	☐	☐ ➡	_____ (v)
w. Colon cancer	☐	☐ ➡	_____ (w)
x. Other cancer (non-skin)	☐	☐ ➡	_____ (x)
IF YES, SPECIFY SITE: _____			
y. Colon polyp	☐	☐ ➡	_____ (y)
z. Fibrocystic or other benign breast disease	☐	☐ ➡	_____ (z)
IF YES, confirmed by: NO YES breast biopsy? ☐ ☐ aspiration? ☐ ☐			
aa. Diabetes mellitus	☐	☐ ➡	_____ (aa)
bb. Gout	☐	☐ ➡	_____ (bb)
cc. Peptic ulcer	☐	☐ ➡	_____ (cc)
dd. Gallstones	☐	☐ ➡	_____ (dd)
IF YES, how diagnosed? ☐ x-ray, ultrasound ☐ other			
ee. Gallbladder removal	☐	☐ ➡	_____ (ee)
ff. Active or chronic liver disease or cirrhosis	☐	☐ ➡	_____ (ff)
gg. Kidney disease (NOT kidney stones)	☐	☐ ➡	_____ (gg)
IF YES, specify type: _____			
hh. Chronic kidney failure	☐	☐ ➡	_____ (hh)
ii. Migraine headaches	☐	☐ ➡	_____ (ii)
jj. Bleeding hemorrhoids	☐	☐ ➡	_____ (jj)
kk. Any other gastrointestinal bleeding	☐	☐ ➡	_____ (kk)
ll. Coagulation disorder	☐	☐ ➡	_____ (ll)
mm. Periodontal disease	☐	☐ ➡	_____ (mm)
IF YES, # of teeth lost: _____			
nn. Macular degeneration RIGHT eye	☐	☐ ➡	_____ (nn)
oo. Macular degeneration LEFT eye	☐	☐ ➡	_____ (oo)
pp. Cataract RIGHT eye	☐	☐ ➡	_____ (pp)
qq. Cataract LEFT eye	☐	☐ ➡	_____ (qq)
rr. Cataract extraction RIGHT eye	☐	☐ ➡	_____ (rr)
ss. Cataract extraction LEFT eye	☐	☐ ➡	_____ (ss)
tt. Shingles (Varicella-zoster virus)	☐	☐ ➡	_____ (tt)
uu. Rheumatoid arthritis	☐	☐ ➡	_____ (uu)
IF YES, rheumatoid factor: ☐ negative / unknown ☐ positive			
vv. Other major illnesses	☐	☐ ➡	_____ (vv)
IF YES, SPECIFY: _____			

IF "YES" IN QUESTION #2, PLEASE COMPLETE THE CONSENT FORM ON PAGE 2.

CONSENT FORM **If you responded YES to any of the items in question #2, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence. I hereby grant permission to Dr. Julie Buring, Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:**

DIAGNOSIS: _____ **DATES OF HOSPITALIZATION / TREATMENT:** _____

Name of hospital / physician: _____ **Phone # :** _____

Address of hospital / physician: _____

City: _____ **State:** _____ **Zip:** _____

YOUR FULL NAME AT TIME OF DIAGNOSIS: _____

YOUR SIGNATURE: _____

Signed **Date**

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3. Have you EVER been diagnosed with Parkinson's disease? ☐ No ☐ Yes ➡ Dx date (MO/YR): _____ / _____

IF YES: Please specify below, any medications which you are CURRENTLY taking for this condition:

BRAND NAME OF MED	DOSE EACH PILL	NUMBER PILLS/WEEK	DATE BEGAN (MO/YR)
a.			
b.			

4. Have you EVER been diagnosed (by a clinician) with depression? ☐ No ☐ Yes ➡ Dx date (MO/YR): _____ / _____

IF YES: Please specify below, any medications which you are CURRENTLY taking for this condition:

BRAND NAME OF MED	DOSE EACH PILL	NUMBER PILLS/WEEK	DATE BEGAN (MO/YR)
a.			
b.			
c.			

5. Do you have unpleasant leg sensations (like crawling, paraesthesias, or pain) combined with a motor restlessness and an urge to move?

☐ No ☐ Yes ➡ IF YES: **a.** Do these symptoms occur only at rest and does moving improve them? ☐ No ☐ Yes ☐ Don't know
☐ Don't know **b.** Are these symptoms worse in the evening/night compared with the morning? ☐ No ☐ Yes ☐ Don't know

6. Have you EVER been diagnosed (by a clinician) with restless legs syndrome ? ☐ No ☐ Yes ➡ Dx date (MO/YR): ____ / _____

7. How often are your eyes dry (not wet enough)? Would you say: ☐ constantly ☐ often ☐ sometimes ☐ never

8. How often are your eyes irritated? Would you say: ☐ constantly ☐ often ☐ sometimes ☐ never

9. In the past 5 years, have you been diagnosed (by a clinician) as having dry eye syndrome? ☐ No ☐ Yes ➡ Dx date (MO/YR): ____/____

10. SINCE THE STUDY BEGAN, have you had any of the following procedures or exams? Was the procedure/exam done because of SYMPTOMS or as a matter of ROUTINE SCREENING? When was it last done?

		IF YES: WHY?		IF YES: WHEN?				
	NO	For Symptoms	For Screening	Within the past year	1-2 years ago	3-5 years ago	>5 years ago	DON'T REMEMBER
a. A physical exam	☐	☐	☐	☐	☐	☐	☐	☐
b. Blood pressure check	☐	☐	☐	☐	☐	☐	☐	☐
c. Blood cholesterol check	☐	☐	☐	☐	☐	☐	☐	☐
d. Fasting blood sugar	☐	☐	☐	☐	☐	☐	☐	☐
e. Rectal exam	☐	☐	☐	☐	☐	☐	☐	☐
f. Stool occult blood test	☐	☐	☐	☐	☐	☐	☐	☐
g. Colonoscopy or sigmoidoscopy	☐	☐	☐	☐	☐	☐	☐	☐
h. Pelvic exam	☐	☐	☐	☐	☐	☐	☐	☐
i. Mammogram	☐	☐	☐	☐	☐	☐	☐	☐
j. Breast exam by doctor	☐	☐	☐	☐	☐	☐	☐	☐
k. Breast self-exam	☐	☐	☐	☐	☐	☐	☐	☐
l. Eye exam	☐	☐	☐	☐	☐	☐	☐	☐

11. IN THE PAST YEAR, have you experienced any of the following? Please check NO or YES for EACH item.

	NO	YES
a. Symptoms suggestive of gastric upset	☐	☐
b. Symptoms suggestive of peptic ulcer	☐	☐
c. Nausea	☐	☐
d. Constipation	☐	☐
e. Diarrhea	☐	☐
f. Skin discoloration	☐	☐
g. Blood in urine (hematuria)	☐	☐

	NO	YES
h. Easy bruising	☐	☐
i. Nose bleed (epistaxis)	☐	☐
j. Skin rash	☐	☐
k. Fatigue	☐	☐
l. Drowsiness	☐	☐
m. Headache	☐	☐

PLEASE GO TO THE NEXT COLUMN

12. DURING THE PAST MONTH, on approximately how many days did you take any of the following? Do NOT include your study pills. Please respond for each item.

	DAYS IN THE PAST MONTH				
	0	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	☐	☐	☐	☐	☐
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	☐	☐	☐	☐	☐
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	☐	☐	☐	☐	☐
d. COX-2 inhibitors (e.g., Celebrex, Vioxx)	☐	☐	☐	☐	☐
e. Other nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve, Ibuprofen)	☐	☐	☐	☐	☐
f. Statins (e.g., Mevacor, Lipitor, Pravachol, Zocor)	☐	☐	☐	☐	☐
g. Multivitamins: Specify brand name: _____ Specify: Does multivitamin contain vitamin E? ☐ No ☐ Yes ➡ content_____IU Contain vitamin A (including beta-carotene)? ☐ No ☐ Yes ➡ content_____IU	☐	☐	☐	☐	☐
h. Individual supplements of vitamin C (not including multivitamins)	☐	☐	☐	☐	☐
i. Individual supplements of beta-carotene (not including multivitamins)	☐	☐	☐	☐	☐
j. Individual supplements of vitamin E (not including multivitamins)	☐	☐	☐	☐	☐
k. Individual supplements of vitamin A (not including multivitamins)	☐	☐	☐	☐	☐
l. Other vitamin preparations containing beta-carotene, vitamins E or A (not including multivitamins) Specify EXACT BRAND and TYPE: _____	☐	☐	☐	☐	☐
m. Individual supplements of folic acid (not including multivitamins)	☐	☐	☐	☐	☐
n. Individual supplements of zinc (not including multivitamins)	☐	☐	☐	☐	☐
o. Individual supplements of chromium (not including multivitamins)	☐	☐	☐	☐	☐

13. Please record your average consumption of the following beverages over the LAST YEAR:

	Never or Less Than One/Month	1-3 Per Month	1 Per Week	2-4 Per Week	5-6 Per Week	1 Per Day	2-3 Per Day	4-5 Per Day	6+ Per Day
a. Beer (1 glass, bottle, can)	☐	☐	W	☐	☐	D	☐	☐	☐
b. Red wine (include sherry, port) (4 oz. glass)	☐	☐	W	☐	☐	D	☐	☐	☐
c. White wine (4 oz. glass)	☐	☐	W	☐	☐	D	☐	☐	☐
d. Liquor (e.g., vodka, rum, gin, liqueur, brandy) (one drink or shot)	☐	☐	W	☐	☐	D	☐	☐	☐

14. What is your CURRENT weight and height?

Weight: _____ pounds AND Height: _____ ft. _____ in.

15. Did any of these relatives ever have...

	RELATIVE				
	UNKNOWN OR NONE	MOTHER	ANY SISTER	FATHER	ANY BROTHER
a. Diabetes?	☐	☐	☐	☐	☐
b. Colon or rectal cancer?	☐	☐	☐	☐	☐
c. Ovarian cancer?	☐	☐	☐		

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16. Did any of these relatives ever have...

		AGE AT FIRST DIAGNOSIS					
a) Myocardial Infarction?	NO or UNKNOWN	YES	BEFORE AGE 40	AGE 40 TO 49	AGE 50 TO 59	AGE 60+	??? AGE
Mother	☐	☐ ➡	☐	☐	☐	☐	☐
Father	☐	☐ ➡	☐	☐	☐	☐	☐
b) Breast Cancer?							
Mother	☐	☐ ➡	☐	☐	☐	☐	☐
Any sister	☐	☐ ➡	☐	☐	☐	☐	☐
Maternal grandmother	☐	☐ ➡	☐	☐	☐	☐	☐
Paternal grandmother	☐	☐ ➡	☐	☐	☐	☐	☐

Questions 17-23* ask for your views about your health. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

17. In general, would you say your health is: **Excellent** ☐ **Very good** ☐ **Good** ☐ **Fair** ☐ **Poor** ☐

18. The following items are about activities you might do during a typical day. Does your health now limit you in these activities?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b. Climbing **several** flights of stairs	☐	☐	☐

19. During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
a. **Accomplished less** than you would like	☐	☐
b. Were limited in the **kind** of work or other activities	☐	☐

20. During the **past 4 weeks,** have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
a. **Accomplished less** than you would like	☐	☐
b. Didn't do work or other activities as **carefully** as usual	☐	☐

21. During the **past 4 weeks** how much did pain interfere with your normal work (including both work outside the home and housework)?
Not at all ☐ **A little bit** ☐ **Moderately** ☐ **Quite a bit** ☐ **Extremely** ☐

22. These questions are about how you feel and how things have been with you **during the past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks:**

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
c. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

23. During the **past 4 weeks,** how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
All of the time ☐ **Most of the time** ☐ **Some of the time** ☐ **A little of the time** ☐ **None of the time** ☐

THE INFORMATION BELOW ASSISTS US IN MAINTAINING HIGH RATES OF FOLLOW-UP.

A. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail:
HOME: ( ) _____ WORK: ( ) _____

B. Please indicate the name, address and phone number of *SOMEONE AT A DIFFERENT PERMANENT ADDRESS* whom we might contact if we are unable to contact you. Please indicate if: ☐ friend ☐ neighbor ☐ relative
NAME: _____ PHONE NO.: ( ) _____
ADDRESS: _____ STATE / ZIP: _____

C. Your birthdate: ☐☐ MO ☐☐ DAY ☐☐ YR AND ➡ D. LAST 6-digits of Social Security Number: XXX-☐☐-☐☐☐☐ (OPTIONAL)

E. Your Maiden Name: (LAST NAME ONLY) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ F. e-mail address: _____

Thank you! Please call (800) 633-6911 if you have any questions.

*Question nos. 17-23 are the SF-12® Health Survey (Medical Outcomes Trust) © QualityMetric Incorporated

WOMEN'S HEALTH STUDY

1. Are you CURRENTLY taking the white pills?

O No O Yes

Are you CURRENTLY taking the amber capsules?

O No O Yes

For each of the TWO study agents (white and amber), please indicate below the % of pills you have taken over the PAST YEAR:

	WHITE PILL	AMBER CAPS
Took 100%, or missed none	O	O
Took 93-99%, or missed only a few	O	O
Took 75-92%, or missed between 1-3 months	O	O
Took 67-74%, or missed between 3-4 months	O	O
Took 50-66%, or missed between 4-6 months	O	O
Took 33-49%, or missed between 6-8 months	O	O
Took less than 33% or missed more than 8 months	O	O
Took none, or missed all	O	O

If you missed taking your pills, what was the main reason?

2. IN THE PAST YEAR, have you experienced any of the following? Please fill NO or YES for each item.

a. Symptoms suggestive of gastric upset	O No	O Yes
b. Symptoms suggestive of peptic ulcer	O No	O Yes
c. Nausea	O No	O Yes
d. Constipation	O No	O Yes
e. Diarrhea	O No	O Yes
f. Skin Discoloration	O No	O Yes
g. Blood in urine (hematuria)	O No	O Yes
h. Easy bruising	O No	O Yes
i. Nose bleed (epistaxis)	O No	O Yes
j. Skin rash	O No	O Yes
k. Fatigue	O No	O Yes
l. Drowsiness	O No	O Yes
m. Headache	O No	O Yes

3. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please fill NO or YES for each item. If YES, please provide the month and year of the diagnosis or procedure. Also, IF YES, please complete the consent form at the end of this question, on page 4.

a. Myocardial infarction (heart attack)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐ (mo / yr)
b. Angina pectoris	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐ (mo / yr)
If YES, confirmed by: angiogram/cardiac cath?	O No	O Yes	stress test?	O No O Yes
c. Coronary angioplasty (PTCA)	O No	O Yes	→	MO/YR of procedure: ☐☐ / ☐☐ (mo / yr)
d. Coronary bypass surgery (CABG)	O No	O Yes	→	MO/YR of procedure: ☐☐ / ☐☐ (mo / yr)
e. Congestive heart failure	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐ (mo / yr)
f. Ventricular tachycardia	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐ (mo / yr)
g. Atrial fibrillation	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐ (mo / yr)
h. Intermittent claudication	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐ (mo / yr)

WOMEN'S HEALTH STUDY / FORM 120

i. Pulmonary embolism (PE)	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
j. Deep vein thrombosis (DVT)	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
k. Stroke	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
l. TIA (transient ischemic attack)	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
m. Carotid artery surgery (endarterectomy)	O No	O Yes	→ MO/YR of procedure:	mo / yr
n. Peripheral artery surgery (not varicose veins)	O No	O Yes	→ MO/YR of procedure:	mo / yr
o. Parkinson's disease	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
p. Asthma	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
q. Other chronic lung disease (e.g., emphysema, chronic bronchitis)	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
r. Elevated cholesterol (dx by a clinician)	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
s. Hypertension (dx by a clinician)	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
t. Melanoma	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
u. Non-melanoma skin cancer	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
If YES, what type? O basal cell O squamous cell O unknown				
v. Breast cancer	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
w. Lung cancer	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
x. Colon cancer	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
y. Other cancer (non-skin) SITE:	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
z. Colon polyp	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
aa. Fibrocystic or other benign breast disease	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
If YES, confirmed by: breast biopsy? O No O Yes aspiration? O No O Yes				
bb. Diabetes mellitus	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
cc. Gout	O No	O Yes	→ MO/YR of diagnosis:	mo / yr
dd. Peptic ulcer	O No	O Yes	→ MO/YR of diagnosis:	mo / yr

WOMEN'S HEALTH STUDY

ee. Gallstones	O No	O Yes →	MO/YR of diagnosis:	mo / yr
If YES, how was it diagnosed?	O x-ray, ultrasound	O other		
ff. Gallbladder removal	O No	O Yes →	MO/YR of procedure:	mo / yr
gg. Active or chronic liver disease	O No	O Yes →	MO/YR of diagnosis:	mo / yr
hh. Kidney disease (other than kidney stones)	O No	O Yes →	MO/YR of diagnosis:	mo / yr
If YES, specify type of disease:				
ii. Chronic kidney failure	O No	O Yes →	MO/YR of diagnosis:	mo / yr
jj. Migraine headaches	O No	O Yes →	MO/YR of diagnosis:	mo / yr
kk. Depression (dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	mo / yr
ll. Bleeding hemorrhoids	O No	O Yes →	MO/YR of diagnosis:	mo / yr
mm. Any other gastrointestinal bleeding	O No	O Yes →	MO/YR of diagnosis:	mo / yr
nn. Coagulation disorder	O No	O Yes →	MO/YR of diagnosis:	mo / yr
oo. Periodontal disease Number of teeth lost : ___	O No	O Yes →	MO/YR of diagnosis:	mo / yr
pp. Macular degeneration **RIGHT** eye	O No	O Yes →	MO/YR of diagnosis:	mo / yr
qq. Macular degeneration **LEFT** eye	O No	O Yes →	MO/YR of diagnosis:	mo / yr
rr. Cataract **RIGHT** eye	O No	O Yes →	MO/YR of diagnosis:	mo / yr
ss. Cataract **LEFT** eye	O No	O Yes →	MO/YR of diagnosis:	mo / yr
tt. Cataract extraction **RIGHT** eye	O No	O Yes →	MO/YR of procedure:	mo / yr
uu. Cataract extraction **LEFT** eye	O No	O Yes →	MO/YR of procedure:	mo / yr
vv. Shingles (Varicella-zoster virus)	O No	O Yes →	MO/YR of diagnosis:	mo / yr
ww. Rheumatoid arthritis	O No	O Yes →	MO/YR of diagnosis:	mo / yr
IF YES, was rheumatoid factor	O negative / unknown	O positive		

xx. If you have had OTHER MAJOR ILLNESSES, not included in the above, please list them in the box below:

	OTHER ILLNESS	MO/YR OF DIAGNOSIS
OTHER ILLNESS 1:		
OTHER ILLNESS 2:		
OTHER ILLNESS 3:		

WOMEN'S HEALTH STUDY / FORM 120

CONSENT FORM: If you responded YES to any of the items in question #3, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.
I grant permission to Dr. Julie Buring, Professor, Harvard Medical School, 900 Commonwealth Ave., Boston, MA 02215, to review a copy of records of my hospitalization/treatment for:

DIAGNOSIS / PROCEDURE:_____ **DATE OF HOSPITALIZATION / TREATMENT:** _____.

Name of hospital/physician:_____ Phone #: _____

Address of hospital/physician: _____

City: _____ State: _____ Zip code: _____

YOUR FULL NAME AT TIME OF DIAGNOSIS:_____

_____ _____
Your Signature **(COPY VALID AS ORIGINAL)** Date

4. **DURING THE PAST MONTH, on approximately how many days did you take any of the following? Do not include your study pills. Please respond on each line.**

	DAYS USED IN THE PAST MONTH				
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
d. COX-2 inhibitors(e.g., Celebrex, Vioxx)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
f. Statins (e.g., Mevacor, Lipitor, Pravachol, Zocor)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
g. Multivitamins (provide BRAND, vits. E and A/beta-carotene contents below)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
BRAND NAME OF MULTIVITAMIN / VITAMIN E CONTENTS (IU) / VITAMIN A/BETA-CAROTENE CONTENTS (IU)					
h. Individual supplements of vitamin C (not including multivitamins)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
i. Individual supplements of beta-carotene (not including multivitamins)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
j. Individual supplements of vitamin E (not including multivitamins)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
k. Individual supplements of vitamin A (not including multivitamins)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
l. Other, NON-multivitamins, containing beta-carotene, vitamins E or A	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
Specify EXACT BRAND and type:					
m. Individual supplements of folic acid (not including multivitamins)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
n. Individual supplements of zinc (not including multivitamins)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days
o. Individual supplements of chromium (not including multivitamins)	O 0	O 1-3 days	O 4-10 days	O 11-20 days	O 21+ days

5. THE INFORMATION BELOW ASSISTS US IN FOLLOW-UP AND ASSURES PROPER IDENTIFICATION OF DATA

PHONE NUMBERS: (☐☐☐) - ☐☐☐ - ☐☐☐☐ (☐☐☐) - ☐☐☐ - ☐☐☐☐
HOME PHONE NUMBER WORK PHONE NUMBER

BIRTH DATE: ☐☐ / ☐☐ / ☐☐ (MO / DY / YR) LAST 6 DIGITS OF SSN: (OPTIONAL) X X X - ☐☐ - ☐☐☐☐

Please provide the name, address and phone number of SOMEONE AT A DIFFERENT ADDRESS THAN YOU whom we can contact if we are unable to reach you:

NAME: _____ PHONE NUMBER: _____

STREET:_____

CITY: _____ STATE: _____ ZIP CODE:_____

YOU LAST RETURNED A QUESTIONNAIRE IN:

WHS HEALTH HISTORY FORM

[ ][ ] - [ ][ ][ ][ ][ ][ ] - [ ] / [ ][ ][ ]

1. For each of the TWO study agents, please indicate below the % of pills you have taken SINCE YOU LAST RETURNED A QUESTIONNAIRE.

(see above for date of last return)	WHITE PILL	AMBER CAPS
Took 100%, or missed none	O	O
Took 93-99%, or missed only a few	O	O
Took 75-92%	O	O
Took 67-74%	O	O
Took 50-66%	O	O
Took 33-49%	O	O
Took less than 33%	O	O
Took none, or missed all	O	O

PLEASE CONTINUE WITH ITEM #2 IN NEXT COLUMN

2. SINCE YOU LAST RETURNED A QUESTIONNAIRE (see above), have you experienced any of the following?

a. Symptoms suggestive of gastric upset	O No	O Yes
b. Symptoms suggestive of peptic ulcer	O No	O Yes
c. Nausea	O No	O Yes
d. Constipation	O No	O Yes
e. Diarrhea	O No	O Yes
f. Headache	O No	O Yes
g. Blood in urine (hematuria)	O No	O Yes
h. Easy bruising	O No	O Yes
i. Nose bleed (epistaxis)	O No	O Yes
j. Skin rash	O No	O Yes
k. Fatigue	O No	O Yes
l. Drowsiness	O No	O Yes

3. SINCE YOU LAST RETURNED A QUESTIONNAIRE (see above), have you been NEWLY DIAGNOSED with any of the following? Please fill NO/ YES for each item. If YES, please provide the month/ year of the diagnosis or procedure.

a. Myocardial infarction (heart attack)	O No	O Yes	→	MO/YR of diagnosis: [ ][ ] / [ ][ ]
b. Angina pectoris	O No	O Yes	→	MO/YR of diagnosis: [ ][ ] / [ ][ ]
If YES, confirmed by: angiogram/cardiac cath?	O No	O Yes	stress test?	O No O Yes
c. Coronary angioplasty (PTCA)	O No	O Yes	→	MO/YR of procedure: [ ][ ] / [ ][ ]
d. Coronary bypass surgery (CABG)	O No	O Yes	→	MO/YR of procedure: [ ][ ] / [ ][ ]
e. Congestive heart failure	O No	O Yes	→	MO/YR of diagnosis: [ ][ ] / [ ][ ]
f. Ventricular tachycardia	O No	O Yes	→	MO/YR of diagnosis: [ ][ ] / [ ][ ]
g. Atrial fibrillation	O No	O Yes	→	MO/YR of diagnosis: [ ][ ] / [ ][ ]
h. Intermittent claudication	O No	O Yes	→	MO/YR of diagnosis: [ ][ ] / [ ][ ]
i. Peripheral artery surgery (not varicose veins)	O No	O Yes	→	MO/YR of procedure: [ ][ ] / [ ][ ]
j. Pulmonary embolism (PE)	O No	O Yes	→	MO/YR of diagnosis: [ ][ ] / [ ][ ]

(OVER)

k. Deep vein thrombosis (DVT)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
l. Stroke	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	O No	O Yes	→	MO/YR of procedure: ☐☐ / ☐☐
o. Elevated cholesterol (dx by a clinician)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
p. Hypertension (dx by a clinician)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
q. Bleeding hemorrhoids	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
r. Any other gastrointestinal bleeding	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
s. Coagulation disorder	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
t. Periodontal disease Number of teeth lost : ☐☐	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
u. Asthma	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
v. Other chronic lung disease (e.g., emphysema, chronic bronchitis)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
w. Melanoma	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
x. Non-melanoma skin cancer	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
If YES, what type? O basal cell O squamous cell O unknown				
y. Breast cancer	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
z. Lung cancer	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
aa. Colon cancer	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
bb. Other cancer SITE:	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
cc. Colon polyp	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
dd. Fibrocystic or other benign breast disease	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
If YES, confirmed by: breast biopsy? O No O Yes aspiration? O No O Yes				
ee. Diabetes mellitus	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
ff. Gout	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
gg. Peptic ulcer	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
hh. Gallstones	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
If YES, how was it diagnosed? O x-ray, ultrasound O other				

PLEASE GO TO THE TOP OF THE NEXT PAGE

ii. Gallbladder removal	O No	O Yes	→	MO/YR of procedure: ☐☐ / ☐☐
jj. Active or chronic liver disease	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
kk. Kidney disease (other than kid. stones)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
ll. Chronic kidney failure	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
mm. Migraine headaches	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
nn. Depression (dx by a clinician)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
oo. Macular degeneration: **RIGHT** eye	O No	O Yes	→	MO/YR of diagnosis (R): ☐☐ / ☐☐
LEFT eye	O No	O Yes	→	MO/YR of diagnosis (L): ☐☐ / ☐☐
pp. Cataract: **RIGHT** eye	O No	O Yes	→	MO/YR of diagnosis (R): ☐☐ / ☐☐
LEFT eye	O No	O Yes	→	MO/YR of diagnosis (L): ☐☐ / ☐☐
qq. Cataract extraction: **RIGHT** eye	O No	O Yes	→	MO/YR of procedure (R): ☐☐ / ☐☐
LEFT eye	O No	O Yes	→	MO/YR of procedure (L): ☐☐ / ☐☐
rr. Shingles (Varicella-zoster virus)	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
ss. Rheumatoid arthritis	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐

4. Have you EVER been HOSPITALIZED with acute coronary syndrome or unstable angina?

O No O Yes → MO/YR of hospitalization: ☐☐ / ☐☐

5. Have you EVER been diagnosed with:

a. Parkinson's disease? O No O Yes → MO/YR of diagnosis: ☐☐ / ☐☐

b. Restless legs syndrome (by a clinician)? O No O Yes → MO/YR of diagnosis: ☐☐ / ☐☐

6. Do you have unpleasant leg sensations (crawling, paraesthesias, or pain) combined with motor restlessness and an urge to move? O No O Yes O Don't know

IF YES, Do these symptoms occur only at rest and does moving improve them? O No O Yes O Don't know

Are these symptoms worse in the evening/night compared to the morning? O No O Yes O Don't know

7. What is your current blood pressure? ☐☐☐ / ☐☐☐ **mmHg** O Don't know

systolic diastolic

Are you currently being treated with medications for high blood pressure? O No O Yes

If you responded YES to any of the items in question #3 (starting on page 1), #4 or #5, please complete the section below. We may wish to contact you for additional information. If more than 2 diagnoses or procedures, please use an additional sheet of paper to provide hospital/physician information. Thank you.

DIAGNOSIS #1: _____ Date of hospitalization/treatment: _____

Name of hospital/physician: _____ Phone no. of physician: _____

Address of hospital/physician: _____

DIAGNOSIS #2: _____ Date of hospitalization/treatment _____

Name of hospital/physician: _____ Phone no. of physician: _____

Address of hospital/physician: _____

(OVER)

8. If you have had another MAJOR ILLNESS SINCE YOU LAST RETURNED A QUESTIONNAIRE (see above date) and it is not included in #3, 4 or 5 above, please list it below and provide the month/year of diagnosis:

OTHER MAJOR ILLNESS: MO/YR OF DIAGNOSIS:

a. _____

b. _____

c. _____

FOR OFFICE USE ONLY

				.							
				.							
				.							
				.							

9. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do not include your study pills. Please answer on each line.

	DAYS USED IN THE PAST MONTH				
	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex, Vioxx)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
f. Statins (e.g., Mevacor, Lipitor, Pravachol, Zocor)	O	O	O	O	O
g. Multivitamins (please provide BRAND and contents below) Specify BRAND name: _____ Vitamin E contents:_____IU Combined vitamin A/beta-carotene contents:_____ IU	O	O Office use: O el	O O in	O O unk/bl	O
h. Individual supplements of vitamin C (not including multivitamins)	O	O	O	O	O
i. Individual supplements of beta-carotene (not including multivitamins)	O	O	O	O	O
j. Individual supplements of vitamin E (not including multivitamins)	O	O	O	O	O
k. Individual supplements of vitamin A (not including multivitamins)	O	O	O	O	O
l. Other, NON-multivitamins, containing vitamin A , vitamin E or beta-carotene Specify EXACT BRAND and type: _____	O	O Office use: O el	O O in	O O unk/bl	O
m. Individual supplements of folic acid (not including multivitamins)	O	O	O	O	O

10. THE INFORMATION BELOW ASSISTS US IN ASSURING PROPER IDENTIFICATION OF DATA

PHONE NUMBERS: ( ) - - HOME PHONE NUMBER ( ) - - WORK PHONE NUMBER

BIRTH DATE: MO / DY / YR LAST 6 DIGITS OF SSN: (OPTIONAL) X X X - -

Please provide the name, address and phone number of SOMEONE AT A DIFFERENT ADDRESS THAN YOU whom we can contact if we are unable to reach you:

NAME: _____ PHONE NUMBER: _____

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

WOMEN'S HEALTH STUDY
RISK FACTOR FORM

☐☐ - ☐☐☐☐☐☐ - ☐ / ☐☐☐

1. What is your date of birth? ☐☐ / ☐☐ / ☐☐ (month / day / year)

2. In the space to the right, please provide your current weight and height.

WEIGHT: ☐☐☐ pounds

HEIGHT: ☐ feet ☐☐ inches

3. What is your usual walking pace outdoors?

O Don't walk regularly O Easy, casual (less than 2 mph) O Normal, average (2-2.9mph)

O Brisk pace (3-3.9 mph) O Very brisk/striding (4 mph or faster)

4. DURING THE PAST YEAR, what was your approximate average time per week spent at each of the following recreational activities?

	AVERAGE TIME PER WEEK							
	zero	1-19 min.	20-59 min.	1 hour	1.5 hours	2-3 hours	4-6 hours	7+ hours
a. Walking or hiking (include walking to work)	O	O	O	O	O	O	O	O
b. Jogging (slower than 10 minute miles)	O	O	O	O	O	O	O	O
c. Running (10 minute miles or faster)	O	O	O	O	O	O	O	O
d. Bicycling (include stationary bike)	O	O	O	O	O	O	O	O
e. Aerobic exercise / aerobic dance / exercise machines	O	O	O	O	O	O	O	O
f. Lower intensity exercise / yoga / stretching / toning	O	O	O	O	O	O	O	O
g. Tennis, squash, or raquetball	O	O	O	O	O	O	O	O
h. Lap swimming	O	O	O	O	O	O	O	O
i. Weight lifting / strength training	O	O	O	O	O	O	O	O
j. Other: Please specify activity: _____	O	O	O	O	O	O	O	O

5. ON AVERAGE, how many flights of stairs (not individual steps) do you climb DAILY?

O None O 1-2 flights O 3-4 flights O 5-9 flights O 10-14 flights O 15 or more flights

6. SINCE THE STUDY BEGAN, have you had any of the following procedures or exams?
If YES, for the MOST RECENT procedure/exam, please indicate why it was done (whether because of SYMPTOMS or as a matter of ROUTINE SCREENING) and when it was done (how many years ago).

PROCEDURE/EXAM DONE SINCE THE STUDY BEGAN?	No	Yes	Most recent, why done?		Most recent, how many years ago?				
			Result of symptoms	Routine screening	<1 yr	1-2 years	3-5 years	>5 years	Don't recall
a. Stool occult blood test	O	O	O	O	O	O	O	O	O
b. Sigmoidoscopy	O	O	O	O	O	O	O	O	O
c. Colonoscopy	O	O	O	O	O	O	O	O	O
d. Pap smear	O	O	O	O	O	O	O	O	O
e. Mammogram	O	O	O	O	O	O	O	O	O
f. A physical exam	O	O	O	O	O	O	O	O	O
g. Fasting blood sugar	O	O	O	O	O	O	O	O	O
h. Blood pressure check	O	O	O	O	O	O	O	O	O
i. Blood cholesterol check	O	O	O	O	O	O	O	O	O
j. An eye examination	O	O	O	O	O	O	O	O	O

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7. Have your menstrual periods ceased PERMANENTLY?

- O Yes: No menstrual periods →
- O Yes: Had menopause, but periods now induced by hormones →
- O No: Premenopausal
- O Not sure

IF YES, please answer the questions below:

a. At what age did your periods cease? ☐☐ age

b. For what reason did your periods cease?
- O Surgery
- O Radiation or chemotherapy
- O Natural

c. IF SURGERY, were your ovaries and/or uterus removed? (Mark ALL that apply)
- O Uterus removed
- O One ovary removed
- O Both ovaries removed

d. IF NATURAL menopause (non-surgical), have you had subsequent surgery to remove ovaries/uterus? (Mark ALL that apply)
- O No, did not have surgery
- O Uterus removed
- O One ovary removed
- O Both ovaries removed

8. IN THE LAST YEAR have you used over-the-counter or herbal remedies for hormone replacement or menopausal symptoms?

O No O Yes

IF YES, please mark the frequency of all the types you have used more than once/week.

	MONTHS used in the last year			
a. Soy pill	O 1-3 mos.	O 4-6	O 7-9	O 10-12
b. Soy powder	O 1-3 mos.	O 4-6	O 7-9	O 10-12
c. Black cohosh	O 1-3 mos.	O 4-6	O 7-9	O 10-12
d. Red clover	O 1-3 mos.	O 4-6	O 7-9	O 10-12
e. Natural progesterone cream	O 1-3 mos.	O 4-6	O 7-9	O 10-12
f. Other_____	O 1-3 mos.	O 4-6	O 7-9	O 10-12

9. IN THE PAST YEAR, have you used female hormones (other than oral contraceptives)?

O No O Yes, currently O Yes, discontinued

IF YES (either currently or discontinued), please answer the questions below. IF NO, please skip to question #10.

a. In the PAST YEAR, for how many months have you used female hormones?

O 1-2 mo. O 3-4 mo. O 5-6 mo. O 7-8 mo. O 9-10 mo. O 11-12 mo.

b. Mark the one type you have used the longest:

Estrogen: O Oral Premarin O Oral Prempro O Oral Premphase O Oral Estrace/Ogen
O Vaginal estrogen O Patch estrogen O Other estrogen, specify _____

Progesterone: O Oral O Vaginal O Other, specify _____

c. If you used conjugated estrogens (e.g., Premarin, Prempro or Premphase) what dose did you usually take?

O 0.3 mg or less O 0.625 mg O 0.9 mg O 1.25 mg O >1.25 mg
O Dose unknown O Did not take conjugated estrogen

d. If you used medroxy progesterone (e.g., Provera, Cycrin, Prempro or Premphase) what dose did you usually take?

O <5 mg O 5-9 mg O 10 mg O >10 mg O Unknown O Not used

e. If you used oral or patch estrogen, what was your pattern of use? (days per month)

O Not used O <1 O 1-8 O 9-18 O 19-26 O 27+ days per month

f. If you used progesterone, what was your pattern of use? (days per month)

O Not used O <1 O 1-8 O 9-18 O 19-26 O 27+ days per month

10. Did any of these relatives ever have . . .

	RELATIVE					
	None	Don't know	Mother	Any sister	Father	Any brother
a. Diabetes?	O	O	O	O	O	O
b. Hypertension?	O	O	O	O	O	O
c. Colon or rectal cancer?	O	O	O	O	O	O
d. Ovarian cancer?	O	O	O	O		

11. Did any of these relatives ever have . . .

a. Myocardial infarction?	No	Don't know	Yes	If YES, please provide age when first diagnosed:
Mother	O	O	O	→ Age when first diagnosed: ☐☐ O Don't know age
Father	O	O	O	→ Age when first diagnosed: ☐☐ O Don't know age
b. Breast cancer?	**No**	**Don't know**	**Yes**	**If YES, please provide age when first diagnosed:**
Mother	O	O	O	→ Age when first diagnosed: ☐☐ O Don't know age
Any sister	O	O	O	→ Age when first diagnosed: ☐☐ O Don't know age
Maternal grandmother	O	O	O	→ Age when first diagnosed: ☐☐ O Don't know age
Paternal grandmother	O	O	O	→ Age when first diagnosed: ☐☐ O Don't know age

12. Please provide the following information about your biological parents:

	Year of birth	Is parent alive or dead?	If applicable, year of death
Father	☐☐☐☐ O Don't know	O Alive O Dead O Unknown	☐☐☐☐ O Don't know
Mother	☐☐☐☐ O Don't know	O Alive O Dead O Unknown	☐☐☐☐ O Don't know

13. Have you EVER smoked cigarettes? O No O Yes → IF YES, how many TOTAL YEARS have you smoked? ☐☐ yrs.

During the time that you smoked, what is the **average** number of cigarettes that you smoked per day? (1 pack = 20 cigarettes) ☐☐ cigs/day

Do you CURRENTLY smoke cigarettes? O No O Yes ↓

If you are a CURRENT smoker, please answer the questions below. If NOT A CURRENT SMOKER, go to the next page.

a. ON AVERAGE, how many cigarettes / day do you currently smoke? (1 pack = 20 cigarettes) ☐☐ cigarettes per day (on average)

b. How soon after you wake up do you smoke your first cigarette?
O Within 5 mins. O 6-30 mins. O 31-60 mins. O After 60 mins.

c Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in church, at the library, in cinema, etc.? O No O Yes

d. Which cigarette would you hate most to give up? O The first one in the morning O All others

e. Do you smoke more frequently during the first hours after waking than during the rest of the day? O No O Yes

f. Do you smoke if you are so ill that you are in bed most of the day? O No O Yes

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14. Have you used any of the following treatments, for any purpose DURING THE PAST TWO YEARS?

a. Acupuncture	O No	O Yes
b. Chiropractic	O No	O Yes
c. Homeopathy	O No	O Yes
d. Herbal therapies	O No	O Yes
e. High-dose vitamins (not a daily vitamin or MD-prescribed)	O No	O Yes
f. Soy pills (taken for any reason)	O No	O Yes
g. Your own prayer or spiritual practice	O No	O Yes
h. Spiritual healing by others	O No	O Yes
i. Special diet programs that you pay for (e.g., Weight Watchers)	O No	O Yes
j. Lifestyle diet (e.g., low-fat, vegetarian)	O No	O Yes
k. Relaxation techniques (e.g., meditation)	O No	O Yes
l. Imagery techniques	O No	O Yes
m. Massage	O No	O Yes
n. Energy healing (e.g., magnets, machines, laying on of hands)	O No	O Yes
o. Folk remedies	O No	O Yes
p. Self-help group	O No	O Yes
q. Biofeedback	O No	O Yes
r. Hypnosis	O No	O Yes
s. Naturopathy	O No	O Yes
t. Yoga	O No	O Yes
u. Osteopathy	O No	O Yes
v. Chelation therapy	O No	O Yes
w. Other: _____	O No	O Yes

15. IN THE PAST YEAR, how many colds have you had?

O None O 1-2 O 3-5 O 6-10 O >10 colds

For a typical cold in the past year:

a. For how many days were symptoms usually present?

O 1-3 days O 4-7 days O > 1 week

b. For how many days were you usually confined to home?

O None O 1-3 days O 4-7 days O > 1 week

16. What are your most recent cholesterol levels (both total cholesterol level and HDL cholesterol level)?

TOTAL cholesterol: ☐☐☐ mg/100 ml O Don't know

HDL cholesterol: ☐☐☐ mg/100 ml O Don't know

17. Are you CURRENTLY being treated with:

a. Cholesterol-lowering medications? O No O Yes

b. Oral medications for diabetes? O No O Yes

c. Insulin injections? O No O Yes

18. How often are your eyes dry (not wet enough)? Would you say:

O Constantly O Often O Sometimes O Never

19. How often are your eyes irritated? Would you say:

O Constantly O Often O Sometimes O Never

20. IN THE PAST 5 YEARS, have you been diagnosed (by a clinician) as having dry eye syndrome?

O No O Yes

IF YES, when were you diagnosed (mo/yr)?

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21. In general, would you say your health is:

O Excellent O Very good O Good O Fair O Poor

22. For each of the study agents (white pill, amber capsule), please indicate below whether you believe you were assigned to the active agent or the placebo.

a. White pill:	O Active agent	O Placebo
b. Amber capsule:	O Active agent	O Placebo

Office use only: O RA review

1. Do you currently take a multi-vitamin? (Please report other individual vitamins in Question 2.)

○ Yes → **a) How many do you take per week?** ○ 2 or less ○ 3–5 ○ 6–9 ○ 10 or more

○ No **b) What specific brand (or equivalency) do you usually take?**

○ Centrum Silver ○ Centrum ○ Theragran M
○ One-A-Day Women's ○ One-A-Day Essential
○ Shaklee Vita-Lea ○ Nutrilite Double X ○ Other →

Ex: AARP Alphabet II Formula 643 Multivitamins and Minerals

2. Do you take the following separate preparations? (DO NOT report the contents of multi-vitamins reported above.)

			Dose per day					
a) Vitamin A	○ No	○ Yes, seasonal only ○ Yes, most months → If Yes,	○ Less than 8,000 IU	○ 8,000 to 12,000 IU	○ 13,000 to 22,000 IU	○ 23,000 IU or more	○ Don't know	
b) Vitamin C	○ No	○ Yes, seasonal only ○ Yes, most months → If Yes,	○ Less than 400 mg.	○ 400 to 700 mg.	○ 750 to 1250 mg.	○ 1300 mg. or more	○ Don't know	
c) Vitamin B_6	○ No	○ Yes → If Yes,	○ Less than 10 mg.	○ 10 to 39 mg.	○ 40 to 79 mg.	○ 80 mg. or more	○ Don't know	
d) Vitamin E	○ No	○ Yes → If Yes,	○ Less than 100 IU	○ 100 to 250 IU	○ 300 to 500 IU	○ 600 IU or more	○ Don't know	
e) Calcium (Include elemental Calcium in Tums, etc.)	○ No	○ Yes → If Yes,	Dose per day (elemental calcium): ○ Less than 400 mg.	○ 400 to 900 mg.	○ 901 to 1300 mg.	○ 1301 mg. or more	○ Don't know	
f) Vitamin D (In calcium supplement or separately)	○ No	○ Yes → If Yes,	○ Less than 300 IU	○ 300 to 500 IU	○ 600 to 900 IU	○ 1,000 IU or more	○ Don't know	
g) Selenium	○ No	○ Yes → If Yes,	○ Less than 80 mcg.	○ 80 to 130 mcg.	○ 140 to 250 mcg.	○ 260 mcg. or more	○ Don't know	
h) Niacin	○ No	○ Yes → If Yes,	○ Less than 50 mg.	○ 50 to 300 mg.	○ 400 to 800 mg.	○ 900 mg. or more	○ Don't know	
i) Zinc	○ No	○ Yes → If Yes,	○ Less than 25 mg.	○ 25 to 74 mg.	○ 75 to 100 mg.	○ 101 mg. or more	○ Don't know	

Are there other supplements that you take on a regular basis?

○ Metamucil/Citrucil ○ Lutein ○ Chromium ○ Folic Acid ○ DHEA ○ Other (Please specify)
○ Cod Liver Oil ○ Magnesium ○ Lecithin ○ B-Complex ○ Iron
○ Vitamin B_{12} ○ Melatonin ○ Beta-carotene ○ Ginkgo Biloba
○ Coenzyme Q10 ○ Fish Oil ○ Glucosamine ○ Garlic Supplements
○ Ginseng ○ St. John's Wort ○ Chondroitin ○ Lycopene

3. How many teaspoons of sugar do you add to your beverages or food each day? → _____ tsp.

4. What brand and type of cold breakfast cereal do you usually eat? → Specify cereal brand & type

○ Don't eat cold breakfast cereal.

5. What form of margarine do you usually use? → What specific brand & type of margarine (e.g., Blue Bonnet Lower Fat Spread)?

○ None
Form? ○ Stick ○ Tub ○ Spray ○ Squeeze *(liquid)*
Type? ○ Reg ○ Light ○ Extra Light ○ Nonfat

6. For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.

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DAIRY FOODS		AVERAGE USE LAST YEAR: Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Milk (8 oz. glass)	Skim milk	○	○	W	○	○	D	○	○	○
	1 or 2 % milk	○	○	W	○	○	D	○	○	○
	Whole milk	○	○	W	○	○	D	○	○	○
	Soy milk	○	○	W	○	○	D	○	○	○
Cream, e.g., coffee, whipped or sour cream (1 Tbs)		○	○	W	○	○	D	○	○	○
Non-dairy coffee whitener (1 Tbs)		○	○	W	○	○	D	○	○	○
Frozen yogurt, sherbet or non-fat ice cream (1 cup)		○	○	W	○	○	D	○	○	○
Regular ice cream (1 cup)		○	○	W	○	○	D	○	○	○
Yogurt	Artificially sweetened or plain (1 cup)	○	○	W	○	○	D	○	○	○
	Sweetened–with fruit or other flavoring (1 cup)	○	○	W	○	○	D	○	○	○
Margarine (pat), added to food or bread; exclude use in cooking		○	○	W	○	○	D	○	○	○
Butter (pat), added to food or bread; exclude use in cooking		○	○	W	○	○	D	○	○	○
Cottage or ricotta cheese (1/2 cup)		○	○	W	○	○	D	○	○	○
Cream cheese (1 oz.)		○	○	W	○	○	D	○	○	○
Other cheese, e.g., American, cheddar, etc., plain or as part of a dish (1 slice or 1 oz. serving)		○	○	W	○	○	D	○	○	○

→ **What type of cheese do you usually eat?** ○ Regular ○ Low fat or Lite ○ Nonfat ○ None

6. For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.

Please try to average your seasonal use of foods over the entire year. For example, if a food such as cantaloupe is eaten 4 times a week during the approximate 3 months that it is in season, then the average use would be once per week.

FRUITS	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Raisins (1 oz. or small pack)			W			D			
Grapes (1 cup)			W			D			
Prunes (7 prunes or 1/2 cup)			W			D			
Prune juice (glass)			W			D			
Bananas (1)			W			D			
Cantaloupe (1/4 melon)			W			D			
Applesauce (1/2 cup)			W			D			
Fresh apples or pears (1)			W			D			
Apple juice or cider (glass)			W			D			
Oranges (1)			W			D			
Orange juice (glass) — Calcium fortified			W			D			
Orange juice (glass) — Regular (not fortified)			W			D			
Grapefruit (1/2) or grapefruit juice (glass)			W			D			
Other fruit juices (glass)			W			D			
Strawberries, fresh, frozen or canned (1/2 cup)			W			D			
Blueberries, fresh, frozen or canned (1/2 cup)			W			D			
Peaches, apricots or plums (1 fresh, or 1/2 cup canned)			W			D			

VEGETABLES	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Tomatoes (3 slices or 1/2 small tomato)			W			D			
Tomato or V-8 juice (small glass)			W			D			
Tomato sauce (1/2 cup) e.g., spaghetti sauce			W			D			
Salsa, picante or taco sauce (1/4 cup)			W			D			
Tofu, soy burger or other soy protein			W			D			
String beans (1/2 cup)			W			D			
Beans or lentils, baked or dried (1/2 cup)			W			D			
Peas or lima beans (1/2 cup fresh, frozen, canned)			W			D			
Broccoli (1/2 cup)			W			D			
Cauliflower (1/2 cup)			W			D			
Cabbage or coleslaw (1/2 cup)			W			D			
Brussels sprouts (1/2 cup)			W			D			
Carrots, raw (1/2 carrot or 2–4 sticks)			W			D			
Carrots, cooked (1/2 cup) or carrot juice (2–3 oz.)			W			D			
Corn (1 ear or 1/2 cup frozen or canned)			W			D			
Mixed vegetables, stir-fry, vegetable soup (1/2 cup)			W			D			
Yams or sweet potatoes (1/2 cup)			W			D			
Dark orange (winter) squash (1/2 cup)			W			D			
Eggplant, zucchini or other summer squash (1/2 cup)			W			D			
Kale, mustard greens or chard (1/2 cup)			W			D			
Spinach, cooked (1/2 cup)			W			D			
Spinach, raw as in salad (serving)			W			D			
Iceberg or head lettuce (serving)			W			D			
Romaine or leaf lettuce (serving)			W			D			
Celery (4" stick)			W			D			
Green or red peppers (3 slices or 1/4 pepper)			W			D			
Onions as a garnish or in salad (1 slice)			W			D			
Onions as a vegetable, rings or soup (1 onion)			W			D			

EGGS, MEAT, ETC.	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Egg Beaters or egg whites only (1/4 cup or 1 egg)			W			D			
Eggs including yolk (1)			W			D			
Beef or pork hot dogs (1)			W			D			
Chicken or turkey hot dogs (1)			W			D			
Chicken/Turkey sandwich or frozen dinner			W			D			
Other chicken or turkey, with skin (3 oz.)			W			D			
Other chicken or turkey, without skin (3 oz.)			W			D			
Bacon (2 slices)			W			D			

6. For each food listed, fill in the circle indicating how often <u>on average</u> you have used the amount specified <u>during the past year</u>.

EGGS, MEAT, ETC.		Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Salami, bologna, or other processed meat sandwiches				W			D			
Other processed meats, e.g., sausage, kielbasa, etc. (2 oz. or 2 small links)				W			D			
Hamburger (1 patty)	Lean or extra lean			W			D			
	Regular			W			D			
Beef, pork, or lamb as a sandwich or mixed dish, e.g., stew, casserole, lasagna, frozen dinner, etc.				W			D			
Pork as a main dish, e.g., ham or chops (4–6 oz.)				W			D			
Beef or lamb as a main dish, e.g., steak, roast (4–6 oz.)				W			D			
Canned tuna fish (2–3 oz.)				W			D			
Breaded fish cakes, pieces, or fish sticks (1 serving, store bought)				W			D			
Shrimp, lobster, scallops as a main dish				W			D			
Dark meat fish, e.g., mackerel, salmon, sardines, bluefish, swordfish (3–5 oz.)				W			D			
Other fish, e.g., cod, haddock, halibut (3–5 oz.)				W			D			

BREADS, CEREALS, STARCHES		Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
Cold breakfast cereal (1 cup)				W			D			
Cooked oatmeal/cooked oat bran (1 cup)				W			D			
Other cooked breakfast cereal (1 cup)				W			D			
Bread (1 slice)	White bread, including pita			W			D			
	Rye/Pumpernickel			W			D			
	Whole wheat, oatmeal, other whole grain			W			D			
Bagels, English muffins, or rolls (1)				W			D			
Muffins or biscuits (1)				W			D			
Pancakes or waffles (2 small pieces)				W			D			
Brown rice (1 cup)				W			D			
White rice (1 cup)				W			D			
Pasta, e.g., spaghetti, noodles, etc. (1 cup)				W			D			
Tortillas (1)				W			D			
French Fries (4 oz. or 1 serving)				W			D			
Potatoes, baked, boiled (1) or mashed (1 cup)				W			D			
Potato chips or corn chips (small bag or 1 oz.)				W			D			
Crackers (6)	Fat free or light			W			D			
	Regular			W			D			
Pizza (2 slices)				W			D			

		BEVERAGES	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day
CARBONATED BEVERAGES Consider the serving size as 1 glass, bottle or can for these carbonated beverages.	Low-Calorie (sugar-free) types	Low-calorie beverage with caffeine, e.g., Diet Coke, Diet Mt. Dew			W			D			
		Other low-cal bev. without caffeine, e.g., Diet 7-Up			W			D			
	Regular types (not sugar-free)	Carbonated beverage with caffeine & sugar, e.g., Coke, Pepsi, Mt. Dew, Dr. Pepper			W			D			
		Other carbonated beverage with sugar, e.g., 7-Up, Root Beer, Ginger Ale			W			D			
OTHER BEVERAGES		Punch, lemonade, other non-carbonated fruit drinks, or sugared ice tea (1 glass, bottle, can)			W			D			
		Beer, regular (1 glass, bottle, can)			W			D			
		Light Beer, e.g., Bud Light (1 glass, bottle, can)			W			D			
		Red wine (5 oz. glass)			W			D			
		White wine (5 oz. glass)			W			D			
		Liquor, e.g., vodka, gin, etc. (1 drink or shot)			W			D			
		Plain water, bottled, sparkling, or tap (1 cup or glass)			W			D			
		Herbal tea or decaffeinated tea (8 oz. cup)			W			D			
		Tea with caffeine (8 oz. cup), including green tea			W			D			
		Decaffeinated coffee (8 oz. cup)			W			D			
		Coffee with caffeine (8 oz. cup)			W			D			

6. ***(continued)*** **For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.**

SWEETS, BAKED GOODS, MISCELLANEOUS	Never, or less than once per month	1–3 per month	1 per week	2–4 per week	5–6 per week	1 per day	2–3 per day	4–5 per day	6+ per day	P
Chocolate (bar or packet) e.g., Hershey's, M & M's	○	○	(W)	○	○	(D)	○	○	○	
Candy bars, e.g., Snickers, Milky Way, Reese's	○	○	(W)	○	○	(D)	○	○	○	
Candy without chocolate (1 oz.)	○	○	(W)	○	○	(D)	○	○	○	
Cookies (1) — Fat free or reduced fat	○	○	(W)	○	○	(D)	○	○	○	
Cookies (1) — Other ready made/frozen dough	○	○	(W)	○	○	(D)	○	○	○	
Cookies (1) — Home baked	○	○	(W)	○	○	(D)	○	○	○	
Brownies (1)	○	○	(W)	○	○	(D)	○	○	○	
Doughnuts (1)	○	○	(W)	○	○	(D)	○	○	○	
Cake, ready made (slice)	○	○	(W)	○	○	(D)	○	○	○	
Cake, home baked (slice)	○	○	(W)	○	○	(D)	○	○	○	
Pie, homemade or ready made (slice)	○	○	(W)	○	○	(D)	○	○	○	
Jams, jellies, preserves, syrup, or honey (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Peanut butter (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Popcorn (3 cups) — Fat free or light	○	○	(W)	○	○	(D)	○	○	○	
Popcorn (3 cups) — Regular	○	○	(W)	○	○	(D)	○	○	○	
Sweet roll, coffee cake or other pastry (serving) — Fat free or reduced fat	○	○	(W)	○	○	(D)	○	○	○	
Sweet roll, coffee cake or other pastry (serving) — Other ready made	○	○	(W)	○	○	(D)	○	○	○	
Sweet roll, coffee cake or other pastry (serving) — Home baked	○	○	(W)	○	○	(D)	○	○	○	
Pretzels (1 small bag or serving)	○	○	(W)	○	○	(D)	○	○	○	
Peanuts (small packet or 1 oz.)	○	○	(W)	○	○	(D)	○	○	○	
Walnuts (1 oz.)	○	○	(W)	○	○	(D)	○	○	○	
Other nuts (small packet or 1 oz.)	○	○	(W)	○	○	(D)	○	○	○	
Oat bran, added to food (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Other bran (e.g., wheat), added to food (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Wheat germ (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Chowder or cream soup (1 cup)	○	○	(W)	○	○	(D)	○	○	○	
Ketchup or red chili sauce (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Salt added at table (1 shake)	○	○	(W)	○	○	(D)	○	○	○	
Nutrasweet or Equal (1 packet) NOT Sweet 'N Low	○	○	(W)	○	○	(D)	○	○	○	
Garlic (1 clove or 4 shakes)	○	○	(W)	○	○	(D)	○	○	○	
Olive oil added to other food or bread (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Low-fat or fat-free mayonnaise (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Regular mayonnaise (1 Tbs)	○	○	(W)	○	○	(D)	○	○	○	
Salad dressing (2 Tbs)	○	○	(W)	○	○	(D)	○	○	○	

Type of salad dressing: ○ Nonfat ○ Low-fat ○ Olive oil ○ Other vegetable oil

7. Liver: beef, calf or pork (4 oz.) ○ Never ○ Less than 1/mo ○ 1/mo ○ 2-3/mo ○ 1/week or more

Liver: chicken or turkey (1 oz.) ○ Never ○ Less than 1/mo ○ 1/mo ○ 2-3/mo ○ 1/week or more

8. How much of the visible fat on your beef, pork or lamb do you remove before eating?
○ Remove all visible fat ○ Remove most ○ Remove small part of fat ○ Remove none ○ Don't eat meat

9. How often do you eat food fried, stir-fried or sautéed at home?
○ Never ○ Less than once a week ○ Once per week ○ 2–4 times/wk ○ 5–6 times/wk ○ Daily

10. What kind of fat is usually used for frying and sautéing at home? ○ Any "Pam"-type spray
○ Real butter ○ Margarine ○ Olive oil ○ Vegetable oil ○ Vegetable shortening ○ Lard

11. What kind of fat is usually used for baking at home?
○ Real butter ○ Margarine ○ Olive oil ○ Vegetable oil ○ Vegetable shortening ○ Lard

12. What type of cooking oil is usually used at home? (e.g., Mazola Corn Oil) Specify brand and type →

13. How often do you eat deep fried chicken, fish, shrimp or clams away from home?
○ Never ○ Less than once a week ○ 1–3 times per week ○ 4–6 times per week ○ Daily

14. What percent of your noon and evening meals are prepared at home? (exclude commercially prepared meals)
○ Almost none ○ 25% ○ 50% ○ 75% ○ Almost all

15. Are there any other important foods that you usually eat at least once per week?
Include for example: Avocado, mushrooms, bulgur, couscous, radish, horseradish, dried apricots, dates, figs, mango, mixed dried fruit, papaya, rhubarb, custard, venison, hot peppers, pickles, olives, SlimFast, Ensure (regular, plus or light), Power/Sports bars.
(Do not include dry spices.)

Other foods that you usually eat at least once per week	Servings per week
(a)	
(b)	
(c)	

Thank you! Please return form to: WHS, 900 Commonwealth Avenue, Boston, MA 02215.