	2009		
	8039394141 WOMEN'S HEAL	н study 1 /	-
<u>→</u> E	Birth date: / / /	$\rightarrow \text{Last 6 digits of SSN: } X X X - \Box - \Box$	
		<u>ONNAIRE</u> (approximately 1 year ago), have you been <u>NEWL</u> f YES, please provide the MO/YR of the diagnosis or proced	
	a. Myocardial infarction	O No O Yes → MO/YR of diagnosis:	
	b. Angina pectoris If YES, confirmed by: angiogram/card	O No O Yes → MO/YR of diagnosis: // iac cath? O No O Yes stress test? O No O Yes	
	c. Acute coronary syndrome/unstable a If YES, were you HOSPITALIZED as	ngina ONo OYes a result? ONo OYes → Hospitalization date: /	
	d. Coronary angioplasty (PTCA)	O No O Yes \rightarrow MO/YR of procedure:	
	e. Coronary bypass surgery (CABG)	O No O Yes -> MO/YR of procedure:	
	f. Congestive heart failure	O No O Yes \rightarrow MO/YR of diagnosis:	
	g. Ventricular tachycardia	O No O Yes → MO/YR of diagnosis:	
	h. Atrial fibrillation	O No O Yes → MO/YR of diagnosis:	
	i. Intermittent claudication If YES, did you have <u>related</u> angiopla	O No O Yes \rightarrow MO/YR of diagnosis: [] / ty, stenting or bypass? O No O Yes	
	j. Peripheral artery disease (not varicos If YES, did you have <u>related</u> angioplas	e veins) O No O Yes \rightarrow MO/YR of diagnosis: / y, stenting or bypass? O No O Yes	
	k. Pulmonary embolism (PE)	O No O Yes → MO/YR of diagnosis:	
	I. Deep vein thrombosis (DVT)	O No [™] O Yes → MO/YR of diagnosis:	
;	m. Stroke	O No O Yes → MO/YR of diagnosis: /	
	n. TIA (transient ischemic attack)	O No O Yes → MO/YR of diagnosis: /	
	o. Carotid artery surgery (endarterectomy)	O No O Yes \rightarrow MO/YR of procedure: \square /	
	p. Melanoma	O No O Yes \rightarrow MO/YR of diagnosis: \square /	
	q. Non-melanoma skin cancer If YES, what type? O basal cell	O No O Yes \rightarrow MO/YR of diagnosis: \square / O squamous cell O unknown type	
	r. Breast cancer	O No O Yes → MO/YR of diagnosis:	
Ľ	s. Lung cancer	O No O Yes → MO/YR of diagnosis:	
)	t. Colon cancer	O No O Yes → MO/YR of diagnosis: /	
	u. Other cancer (non-skin) SITE:	O No O Yes \rightarrow MO/YR of diagnosis: \square /	
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396394148 WOMEN	I'S HEALTH	STUD	Y 1	/ [-
v. Colon polyp		O No	O Yes	\rightarrow	MO/YR of	diagnosis:	
w. Fibrocystic or other beni	gn	O No	O Yes	\rightarrow	MO/YR of	diagnosis:	
breast disease If YES, confirmed by: b	oreast biopsy?	O No	O Yes	a	spiration?	O No O Ye	s
x. Diabetes mellitus		O No	O Yes	\rightarrow	MO/YR of	diagnosis:	
y. Peptic ulcer		O No	O Yes	\rightarrow	MO/YR of	diagnosis:	
z. Active or chronic liver dis	sease	O No	O Yes	\rightarrow	MO/YR o	f diagnosis:	
aa. Kidney disease (other th	han kid. stones) O No	O Yes	\rightarrow	MO/YR o	f diagnosis:	
bb. Chronic kidney failure		O No	O Yes	\rightarrow	MO/YR o	f diagnosis:	
cc. Migraine headaches		O No	O Yes	\rightarrow	MO/YR o	f diagnosis:	
dd. Other headaches		O No	O Yes	\rightarrow	MO/YR of	f diagnosis:	
ee. Depression (dx by a clir	nician)	O No	O Yes	\rightarrow	MO/YR o	f diagnosis:	
ff. Macular degeneration:	RIGHT eye	O No	O Yes	\rightarrow	MO/YR o	f diagnosis (R):	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR o	f diagnosis (L):	
gg. Cataract:	RIGHT eye	O No	O Yes	\rightarrow	MO/YR o	f diagnosis (R):	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR o	f diagnosis (L):	
hh. Cataract extraction:	RIGHT eye	O No	O Yes	\rightarrow		procedure (R):	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR of	procedure (L):	
ii. Dry eye syndrome		O Ño	O Yes	\rightarrow	MO/YR of	f diagnosis:	
jj. Rheumatoid arthritis		O No	O Yes	\rightarrow	MO/YR of	diagnosis:	
kk. Parkinson's disease		O No	O Yes	\rightarrow	MO/YR of	diagnosis:	
II. Elevated cholesterol (dx	by a clinician)	O No	O Yes	\rightarrow	MO/YR of	diagnosis:	
nm. Hypertension (dx by a c	clinician)	Ó No	O Yes	\rightarrow	MO/YR of	diagnosis:	
nn. Periodontal disease Number of teeth lost :		O No	O Yes	\rightarrow	MO/YR of	diagnosis:	
oo. Asthma		O No	O Yes	\rightarrow	MO/YR o	f diagnosis:	
pp. Other chronic lung dise (e.g., emphysema, chro		O No	O Yes	\rightarrow	MO/YR o	f diagnosis:	
qq. Note any other MAJOF	त्ववारा वहने सम्पन्धनां राजन	C	THER MAJ	ORILLI	NESS:	MO/YR C	OF DIAGNOSIS:
ILLNESS diagnosed w	ithin the ^{a.} –					• 	
past year and NOT inc the above list and prov		jel i		•			a - 19 19 - 19 - 19 - 19 - 19 - 19 - 19 - 19 -
date of diagnosis.	c					·	
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WOMEN'S HEALTH STUDY

DAYS USED IN THE PAST MONTH

Have you EVER had any of the following? If YES, please provide the MO/YR of the diagnosis or procedure.

a. Osteoporosis	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
b. Fractures from osteoporosis	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
c. Osteoarthritis	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
d. Joint replacement	O No	O Yes	\rightarrow	MO/YR of procedure:	

4. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.

any of the following? Please answer on each line.	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	0	0	0	0	0
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0
d. COX-2 inhibitors (e.g., Celebrex)	0	0	0	0	0
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0

O No O Yes 5. Do you <u>CURRENTLY</u> take a MULTIVITAMIN?

O 10 or more If YES, how many multivitamins do you take per week? O 2 or less O 3-5 O 6-9

6. Are you <u>CURRENTLY</u> taking any of the following medications REGULARLY? Please complete NO/YES for each.

a.	Antihype	tensive med	lications									
	O No O Yes \rightarrow If YES, mark ALL of the specific drugs you are <u>CURRENTLY</u> taking:											
			O Diuretic (e.g., hydrochlorothiazide)									
			O Calcium channel blocker (e.g., Norvasc, Calan, Procardia, Cardizem)									
	O Beta blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)											
			O ACE inhibitor (e.g., Capoten, Vasotec, Zestril)									
			O Angiotensin receptor blocker (e.g., Cozaar, Diovan, Avapro)									
	O Other antihypertensive (e.g., doxazosin)											
b.			wering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)									
	O No O Yes -> If YES, mark ALL of the specific drugs you are <u>CURRENTLY</u> taking:											
			O Lipitor O Mevacor O Crestor O Zocor									
			O Pravachol O Lescol O Other									
c. (Other NON O No	I- STATIN lipi O Yes	d-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)									
Have y	ou <u>EVER r</u>	<u>eceived</u> a blo	ood transfusion (exclude transfusions of your own blood)?									
	O No	$^{ m O Yes} \rightarrow$	 If YES, your age at transfusion(s)? Mark ALL that apply. 									
			O <30 O 30-39 O 40-49 O 50-59 O 60-69 O 70+									

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5455394140 WOMEN	'S HEALTH ST	UDY	1 /]-[- 🗌
8. What is your <u>CURRENT</u> blood 9. What is your <u>CURRENT</u> weigh		o? →	systol	ic [diastolic		Don't kr	וow my b	lood pres
0. Do you <u>CURRENTLY</u> smoke ci	garettes? O No	O Yes	$\rightarrow d^{\rm lf}$	YES, or o you sm	n average noke (1 p	, how n ack = 2	nany ciga 0 cigare	arettes/da ttes)?	
1. What is your <u>CURRENT</u> TOTAI	L CHOLESTEROL	(if check	ced with	nin the p	ast 5 yea	ars)?			cigs/d
O <140 mg/dl O 140-159 O 250-259 O 260-269 O 2	O 160-179 O 270-279 O 280-2	180-199 299 O		200-219 9 O 33	Ο220 30+ Οι		O 240-2 n/not ch		5 yrs
2. What is your <u>CURRENT</u> HDL-C O <30 mg/dl O 30-39 O 80-89 O 90-99 3. Please indicate your average u	O 40-49 C O 100+ O) 50-59 unknown	O (not che	60-69 ecked in	O 70- 5 yrs	79	<u>!:</u>		
O <30 mg/dl O 30-39 O 80-89 O 90-99	O 40-49 C O 100+ O) 50-59 unknown	O (not che	60-69 ecked in	O 70- 5 yrs	79	2-3 per day	4-5 per day	6+ per day
O <30 mg/dl O 30-39 O 80-89 O 90-99 3. Please indicate your average u BEVERAGE a. Beer Regular bee	O 40-49 C O 100+ O ise of the followin Never or less than 1/month) 50-59 unknown g bevera 1-3 per	O (n/not che nges <u>DU</u>	60-69 ecked in IRING TI 2-4 per	O 70- 5 yrs HE PAS	79 Г <u>YEAR</u> 1 per	2-3 per		•
O <30 mg/dl O 30-39 O 80-89 O 90-99 3. Please indicate your average u BEVERAGE	O 40-49 C O 100+ O Ise of the followin Never or less than 1/month	0 50-59 unknown g bevera 1-3 per month	O (n/not che nges <u>DU</u> 1 per week	60-69 ecked in IRING TI 2-4 per week	O 70- 5 yrs HE PAS	79 <u>TYEAR</u> 1 per day	2-3 per day	day	day
O <30 mg/dl O 30-39 O 80-89 O 90-99 B. Please indicate your average u BEVERAGE a. Beer (1 glass or Light boor	O 40-49 C O 100+ O ise of the followin Never or less than 1/month er O O	0 50-59 unknown g bevera 1-3 per month O	O (n/not che nges <u>DU</u> 1 per week	60-69 ecked in IRING TI 2-4 per week O	O 70- 5 yrs HE PAS 5-6 per week O	79 <u>TYEAR</u> 1 per day O	2-3 per day O	day O	day O
O <30 mg/dl O 30-39 O 80-89 O 90-99 B. Please indicate your average u BEVERAGE a. Beer Regular beer (1 glass or bottle or can) Light beer	O 40-49 C O 100+ O ise of the followin Never or less than 1/month er O O	0 50-59 unknown g bevera 1-3 per month O	O (Inot che Inges <u>DU</u> 1 per week O	60-69 ecked in IRING TI 2-4 per week O	O 70- 5 yrs HE PAS 5-6 per week O	79 <u>TYEAR</u> 1 per day O O	2-3 per day O	day O O	day O O

14. 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 a sample will not affect your participation in the follow-up study.

<u>IN THE PAST YEAR,</u> have you had:	No	Yes, for symptoms	Yes, for screening	THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.
a. Physical exam	0	0	0	
b. Fasting blood sugar	0	0	0	PHONE: - - - - WORK - - - -
c. Blood pressure check	0	0	0	PHONE: ()
d. Cholesterol check	0	0	0	Name, address and phone of <u>someone at a differen</u> address than you whom we may contact if we are
e. Eye exam	0	0	0	unable to reach you:
f. Stool occult blood test	0	0	0	NAME:
g. Colonoscopy	0	0	0	
h. Sigmoidoscopy	0	0	0	
i. Pap smear	0	0	0	STATE:ZIP:
j. Mammogram	0	O`	0	PHONE NO:

6469 WOMEN'S HEALTH ST	Y 2 /	
Birth date: MO INCE YOU LAST RETURNED A QUESTION IAGNOSED with any of the following? If YI	Last 6 digits of SSN: X X X - (optional) RE (approximately 1 year ago), hav	re you been NEWLY
	No O Yes MO/YR of diag	
a. Myocardial infarction		
b. Angina pectoris If YES, confirmed by: angiogram/cardiac	No O Yes → MO/YR of diag ? O No O Yes stress test? C	
c. Acute coronary syndrome/unstable angin If YES, were you HOSPITALIZED as a re	O No O Yes > O No O Yes → Hospitalizatio	on date:
d. Coronary angioplasty (PTCA) or stent	No O Yes -> MO/YR of pro	cedure: /
e. Coronary bypass surgery (CABG)	No O Yes -> MO/YR of proc	cedure: /
f. Congestive heart failure	No O Yes \rightarrow MO/YR of diag	gnosis:
g. Ventricular tachycardia	No O Yes -> MO/YR of diag	gnosis:
h. Atrial fibrillation	No O Yes -> MO/YR of diag	gnosis:
i. Intermittent claudication If YES, did you have RELATED angioplas	No O Yes -> MO/YR of diag stenting or bypass? O No O Yes	gnosis:
j. Peripheral artery disease (not varicose ve If YES, did you have RELATED angioplas		gnosis: /
k. Pulmonary embolism (PE)	No O Yes -> MO/YR of diag	gnosis:
I. Deep vein thrombosis (DVT)	No O Yes \rightarrow MO/YR of diag	gnosis:
m. Stroke	No OYes \rightarrow MO/YR of diag	gnosis:
n. TIA (transient ischemic attack)	No O Yes \rightarrow MO/YR of diag	gnosis:
o. Carotid artery surgery (endarterectomy)	No O Yes -> MO/YR of prov	cedure: /
p. Melanoma	No OYes 🔶 MO/YR of diag	gnosis:
q. Non-melanoma skin cancer If YES, what type? O basal cell O s	O No O Yes → MO/YR of diag mous cell O unknown type	gnosis: /
r. Breast cancer	O No O Yes → MO/YR of diag	gnosis:
s. Lung cancer	No OYes → MO/YR of diag	gnosis: /
t. Colon cancer	No O Yes \rightarrow MO/YR of diag	gnosis:

6469 WOMEN'S HEALTH S	TUDY	2 / 🗌	-
v. Colon polyp	O No	o Yes →	MO/YR of diagnosis:
w. Fibrocystic or other benign breast disease	O No	o Yes →	MO/YR of diagnosis:
If YES, confirmed by: breast biopsy?	O No	O Yes by	aspiration? O No O Yes
x. Diabetes mellitus	O No	o Yes →	MO/YR of diagnosis:
y. Peptic ulcer	O No	o Yes →	MO/YR of diagnosis:
z. Gastrointestinal bleeding	O No	O Yes 🗲	MO/YR of diagnosis:
aa. Kidney disease (other than kid. stones)	O No	$_{\text{OYes}}$ \rightarrow	MO/YR of diagnosis:
bb. Chronic kidney failure	O No	O Yes →	MO/YR of diagnosis:
cc. Migraine headaches	O No	o Yes →	MO/YR of diagnosis:
dd. Other headaches	O No	$_{\text{OYes}}$ \rightarrow	MO/YR of diagnosis:
ee. Macular degeneration: RIGHT eye	O No	$_{\text{OYes}}$ \rightarrow	MO/YR of diagnosis (R):
LEFT eye	O No	$o_{\text{Yes}} \rightarrow$	MO/YR of diagnosis (L):
ff. Cataract: RIGHT eye	O No	OYes →	MO/YR of diagnosis (R):
LEFT eye	O No	$O Yes \rightarrow$	MO/YR of diagnosis (L):
gg. Cataract extraction: RIGHT eye	O No	OYes →	MO/YR of procedure (R):
LEFT eye	O No	OYes →	MO/YR of procedure (L):
hh. Dry eye syndrome	O No	OYes →	MO/YR of diagnosis:
ii. Parkinson's disease	O No	$\text{OYes} \rightarrow$	MO/YR of diagnosis:
jj. Elevated cholesterol (dx by a clinician)	O No	$\circ_{\text{Yes}} \rightarrow$	MO/YR of diagnosis:
kk. Hypertension (dx by a clinician)	O No	$\text{O Yes} \rightarrow$	MO/YR of diagnosis:
II. Asthma	O No	OYes →	MO/YR of diagnosis:
mm. Other chronic lung disease (e.g., emphysema, chronic bronchitis)	O No	o Yes →	MO/YR of diagnosis:
nn. Osteoporosis	O No	o Yes 🗲	MO/YR of diagnosis:
oo. Fractures from osteoporosis (e.g., hip, wrist)	O No	$o_{Yes} \rightarrow$	MO/YR of diagnosis:
pp. Osteoarthritis	O No	o Yes →	MO/YR of diagnosis:
qq. Joint replacement	O No	o Yes →	MO/YR of procedure:
rr. Rheumatoid arthritis	O No	OYes →	MO/YR of diagnosis:
ss. Note any other MAJOR ILLNESS diagnosed in the past year and a. – NOT included in above. b	ОТ	HER MAJOR ILLNI	ESS: MO/YR OF DIAGNOSIS:

6469

3.	8. IN THE PAST MONTH, on approximately how many DAYS did you take		DAYS USED IN THE PAST MON						
	any of the following? Please answer on each line.	None	1-3	4-10	11-20	21+			
	a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0			
	b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	0	0	0	0	0			
	c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0			
	d. COX-2 inhibitors (e.g., Celebrex)	0	0	0	0	0			
	e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0			
	f. Multivitamins	0	0	0	0	0			
	g. SINGLE supplements of vitamin A	0	0	0	0	0			
	h. SINGLE supplements of vitamin C	0	0	0	0	0			
	i. SINGLE supplements of vitamin E	0	0	0	0	0			
	j. SINGLE supplements of folic acid (with or without B-vitamins)	0	0	0	0	0			

4. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel, angiotensin receptor or β -blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes
d. Raloxifene (Evista) for prevention/treatment of bone loss	O No	O Yes
e. Other prescription medication for prevention/treatment of bone loss (e.g., Fosamax)	O No	O Yes
f. Over-the-counter medication for prevention/treatment of bone loss (e.g., calcium supplements)	O No	O Yes

AVERAGE TIME PER WEEK										
zero	1-19 min.	20-59 min.	1 hour	1.5 hours	2-3 hours	4-6 hours	7+ hours			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
0	0	0	0	0	0	0	0			
	0 0 0 0 0 0 0 0	zero min. O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O	zero 1-19 min. 20-59 min. O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O	zero 1-19 min. 20-59 min. 1 hour O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O	zero 1-19 min. 20-59 min. 1 hour 1.5 hours O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O I O O O	zero 1-19 min. 20-59 min. 1 hour 1.5 hours 2-3 hours O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O	zero 1-19 min. 20-59 min. 1 hour 1.5 hours 2-3 hours 4-6 hours O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O <t< td=""></t<>			

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

O None O 1-2 flights O 3-

O 3-4 flights

O 10-14 flights

O 15 or more flights

6469 WC	MEN'S	HEALTH	STUDY	2 /	
 7. What is your usual w O Don't walk regularly O Brisk pace (3-3.9 m) 	ph)	O Easy, cas O Very brisk	ual (less tha /striding (4 n	nph or f	aster)
					If YES, on average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? cigs/day r than oral contraceptives)?
O No O Yes	currentl	y C ↓	Yes, discon	itinued	
a. In the PAST YEAF	R, for hov 3-4 mo.	v many month O 5-6 mo.	ns have you O 7-8 mc	used fei	estions below. IF NO, please skip to question #10. male hormones? 9-10 mo. O 11-12 mo.
Estrogen: OC OV	ral Prem aginal es	arin C strogen C	Oral Premp Patch estro	gen	O Oral Premphase O Oral Estrace/Ogen O Other estrogen, specify
c. If you used <u>conjug</u> O 0.3 mg or le O >1.25 mg	SS	ogens (e.g., F O 0.45 mg O Dose unkr	00	.625 mg	or Premphase) what <u>dose</u> did you usually take? g O 0.9 mg O 1.25 mg ake conjugated estrogen
O <2.5 mg	O 2.5	mg O 5-	9 mg O	10 mg	empro or Premphase) what <u>dose</u> did you usually take? O >10 mg O Unknown O Not used
					use? (days per month) 27+ days per month
f. If you used <u>progest</u> O Not used					ys per month) 27+ days per month
10. IN THE PAST YEAR, httests or procedures?	ave you	had any of t	he following	g	THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.
(Please answer on each line)	No	Yes, for symptoms	Yes, for screening		
a. Fasting blood sugar	0	0	0		
b. Colonoscopy	0	0	0		PHONE: ()
c. Sigmoidoscopy	0	0	0		Name, address and phone of <u>someone at a different</u> <u>address</u> than you whom we may contact if we are
d. Mammogram	0	0	0		unable to reach you:
11. What is your CURREN	T weigh	t?	pounds	S	NAME:
12. In general, would you					
O Excellent O Very g					STATE: ZIP:
	T COLU	MN. THANK			
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28653 WOMEN'S HEALTH ST	UDY 3 /	-	-
 Birth date: MO MO J J J YR YR SINCE YOU LAST RETURNED A QUESTION DIAGNOSED with any of the following? If YE 	► Last 6 digits of SS (optional) NAIRE (approximately 2 S, please provide the I	لـــلـــا I year ago), have you be	- Den NEWLY or procedure.
a. Myocardial infarction	ONO OYes >	MO/YR of diagnosis:	
b. Angina pectoris If YES, confirmed by: angiogram/cardiac c	ONo OYes → ath? ONo OYes	MO/YR of diagnosis: stress test? O No C	Yes
c. Acute coronary syndrome/unstable angina If YES, were you HOSPITALIZED as a res		Hospitalization date:	
d. Coronary angioplasty (PTCA) or stent	O No O Yes \rightarrow	MO/YR of procedure:	
e. Coronary bypass surgery (CABG)	O No O Yes 🔶	MO/YR of procedure:	
f. Congestive heart failure	O No O Yes 🔶	MO/YR of diagnosis:	
g. Ventricular tachycardia	O No O Yes 🔶	MO/YR of diagnosis:	
h. Atrial fibrillation	O No O Yes \rightarrow	MO/YR of diagnosis:	
i. Intermittent claudication If YES, did you have RELATED angioplasi	O No O Yes \rightarrow ty, stenting or bypass?	MO/YR of diagnosis: O No O Yes	
j. Peripheral artery disease (not varicose vei If YES, did you have RELATED angioplast		-	
k. Pulmonary embolism (PE)	O No O Yes \rightarrow	MO/YR of diagnosis:	
I. Deep vein thrombosis (DVT)	O No O Yes 🔶	MO/YR of diagnosis:	
m. Stroke	O No O Yes \rightarrow	MO/YR of diagnosis:	
n. TIA (transient ischemic attack)	O No O Yes \rightarrow	MO/YR of diagnosis:	
o. Carotid artery surgery (endarterectomy)	O No O Yes 🗲	MO/YR of procedure:	
p. Melanoma	O No O Yes 🔶	MO/YR of diagnosis:	
q. Non-melanoma skin cancer		MO/YR of diagnosis:	
If YES, what type? O basal cell O so	uamous cell O unkno		
r. Breast cancer		MO/YR of diagnosis:	
s. Lung cancer	O No O Yes ->	MO/YR of diagnosis:	
t. Colon cancer	ONO OYes >	MO/YR of diagnosis:	
u. Other cancer (non-skin) SITE:	O No O Yes 🗲	MO/YR of diagnosis:	
Office use: O1 O2	Page 1		(OVER)

28653 WOMEN'S H	HEALTH ST	rudy	3 /		-	-
v. Colon polyp		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
w. Fibrocystic or other benigr breast disease	1	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
If YES, confirmed by: bre	east biopsy?	O No	O Yes	by	aspiration? O No O Y	ïes
x. Diabetes mellitus		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
y. Peptic ulcer		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
z. Gastrointestinal bleeding		O No	Ó Yes	\rightarrow	MO/YR of diagnosis:	
aa. Kidney disease (other tha	n kid. stones)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
bb. Chronic kidney failure		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
cc. Migraine headaches		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
dd. Other headaches		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
ee. Macular degeneration: R	IGHT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis (R):	
L	EFT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis (L):	
	GHT eye	O No	O Yes	-	MO/YR of diagnosis (R):	
L	EFT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis (L):	
gg. Cataract extraction: R	IGHT eye	O No	O Yes	\rightarrow	MO/YR of procedure (R):	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR of procedure (L):	
hh. Dry eye syndrome		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
ii. Parkinson's disease		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
jj. Elevated cholesterol (dx b	y a clinician)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
κκ. Hypertension (dx by a clini	cian)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
II. Asthma		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
nm. Other chronic lung diseas (e.g., emphysema, chronic		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
nn. Osteoporosis		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
oo. Fractures from osteoporos (e.g., hip, wrist)	sis	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
pp. Osteoarthritis		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
qq. Joint replacement		O No	O Yes	\rightarrow	MO/YR of procedure:	
rr. Rheumatoid arthritis		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
ss. Note any other MAJOR IL diagnosed in the past yea NOT included in above.		·	THER MAJO	r illni	ESS: → MO/YR →	OF DIAGNOSIS:
Office use: O 1 O 2	ΟΥ		Page 2			

	28653 WOMEN'S HEA	LTH STUD	Y 3	/ [-				-		
3.	Have you EVER been diagnosed with	interstitial o	ystitis?	O No	O Yes	→ мо	/YR of d	liagnosis	s:]/[]	
4.	Have you EVER been diagnosed with	n fibromyalgi	a?	O No	O Yes	→ мо	/YR of d	liagnosis	s:]/[]	
5.	IN THE PAST MONTH, on approxima any of the following? Please answer			did you	u take	DA None	YS USE 1-3	ED IN TH 4-1	HE PAST 0 11-2		
	a. Acetaminophen (e.g., Tylenol, Exce	drin P.M.)				0	0	0	0	0	
	b. Aspirin (e.g., Bayer, Bufferin, Anacir On days taking, TOTAL DOSE per d)0-499 r	mg O	O 500-999	O mg O	O 1000+	mg O	O unknown	
	c. Medications containing aspirin (e.g.,	Alka-Seltzer,	Doan's F	Pills, Fio	rinal)	0	0	0	0	0	
	d. COX-2 inhibitors (e.g., Celebrex)					0	0	0	0	0	
	e. Other non-steroidal, anti-inflammato	ry agents (e.c	g., Motrin	, Advil, A	Aleve)	0	0	0	0	0	
	f. Multivitamins					0	0	0	0	0	
	g. SINGLE supplements of vitamin A					0	0	0	0	0	
	h. SINGLE supplements of vitamin C					0	0	0	0	0	
	i. SINGLE supplements of vitamin E					0	0	0	0	0	
	j. SINGLE supplements of folic acid (v	vith or without	B-vitami	ns)		0	0	0	0	0	
	k. SINGLE supplements of omega-3 fa	atty acids				0	0	0	0	0	
	IF YES, what dose per day (elemental Do you take SINGLE supplements of IF YES, what dose per day? O <30 Are you CURRENTLY taking any of t	i vitamin D (i i 0 IU O 30	n <mark>calciun</mark> 0-500 IU	n suppl O (ements 600-900	or separ IU O	ately)? 1000 IL	O No J or more	O Yes e O	s unknowr	
	a. Antihypertensives (e.g., diuretic, ca	alcium channe	el, angiote	ensin re	ceptor or	β-block	ers, ACI	E inhibito	or) ON	0 O Y	es
	b. Statin cholesterol-lowering medica	tions (e.g., Lip	oitor, Zoc	or, Meva	acor, Pra	vachol, C	Crestor,	Lescol)	O N	0 O Y	es
	c. Other non-statin lipid-lowering med	lications (e.g.	, niacin, L	.opid, Q	uestran,	Colestid,	Zetia)		ΟN	0 O Y	es
	d. Raloxifene (Evista) for prevention/	reatment of b	one loss						ON	0 O Y	es
	e. Fosamax for prevention/treatment If YES, for how many years have y		g Fosam	ax regu	larly? C) < 1 yr	O 1-2	yrs O	O N 3-4 yrs	ο ΟΥ Ο 5+ y	1
9.	Please indicate your average use of	the following	j bevera	ges DUI	RING TH	E PAST	YEAR:				
	BEVERAGE	Never or less than 1/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 Regular beer	0	0	0	0	0	0	0	0	0]
	(1 glass or Light beer bottle or can)	0	0	0	0	0	0	0	0	0	
	b. Red wine/sherry/port (4 oz. glass)	0	0	0	0	0	0	0	0	0	_
	c. White wine (4 oz. glass)	0	0	0	0	0	0	0	0	0	
	d. Liquor (1 drink or shot) (e.g., vodka, rum, gin, brandy, etc.)	0	0	0	0	0	0	0	0	0	

28653 WOM	EN'S F	IEALTH S	STUD	Y 3	/				
10. What is your CURRENT O Don't know m		-	nmHg)'	?→[systolic				
11. Do you CURRENTLY s	noke ci	garettes?	O No	O Ye	$s \rightarrow \frac{If Y}{do}$	ES, on ave	liastolic erage, how e (1 pack = :	many cig	arettes/day
12. What is your CURRENT	TOTAL	CHOLEST	EROL	(if chec				Lo olguio	cigs/day
O <140 mg/dl O 1 O 250-259 O 260-2	40-159	-	-) 180-1	99 O 2 O 300-329		O 220-239	-	
13. What is your CURRENT								OWINIOU	checked in 2 yrs
	30-39 O 90-99	O 40-49		O 50-59	0	60-69 60ked in 2 y	O 70-79		
14. Did any of these relativ	es ever	have			If YES,	please pr	ovide AGE	when fi	rst diagnosed:
a. Ovarian cancer?	No	Don't know	Yes		<50	50-59	60-69	70+	Age Unknown
Mother	0	0	0	\rightarrow	0	0	0	0	0
Sister	0	0	0	\rightarrow	0	0	Ο	0	0
b. Colon or rectal cance	r? No	Don't know	Yes		<50	50-59	60-69	70+	Age Unknown
Parent	0	0	0	\rightarrow	0	0	0	0	0
Sibling	0	0	0	\rightarrow	0	0	0	0	0
Additional sibling	0	0	0	$ $ \rightarrow	0	0	0	0	0
IF YES, when? C Are you the primary car 16. IN THE PAST YEAR, ha tests or procedures?	etaker o	f the pet(s)	(i.e., yo	u take c	are of mos	st of its nee	eds)? ON	lo pets	O No O Yes
(Please answer on each line)	No	Yes, for	Ye	s, for			NG FOLLO		22121202 IN
	140	symptoms	scre	ening	HO			_	
a. Fasting blood sugar	0	0		0	WC				
b. Colonoscopy	0	0	 	0)	-	
c. Sigmoidoscopy	0	0		0					neone at a different contact if we are
d. Mammogram	0	0	 	0		able to read		we may c	ontact if we are
e. Eye exam	0	0		0	NA	ME:			
. What is your CURRENT weight?			ounds					· · · · · · · · · · · · · · · · · · ·	
18. In general, would you s									
O Excellent O Very goo) Poor					
PLEASE COMPLETE IN THE RIGHT	COLUM	N. THANK							1997
Office	e use: C	D 1 O 2		Pa	age 4	ΟΑ	ов ос	OD	Review: 🔲

8671 WOMEN'S HEALTH	ISTUE	γ 4/							-	
1. Birth date: / / /	\rightarrow	Last 6 dig	jits o otion		ххх	‹ - 🗌] - [
2. SINCE YOU LAST RETURNED A QUESTION the following? If YES, please provide the ap	NAIRE (a proxima	approximat	ely ′	l year ago	o), have ; or proce	you been edure.	NEWLY	DIAGNOS	ED with a	ny of
IF NEW DIAGNOSIS OR NEW PROCEDURE sin up, please mark below and note the date to the				<2006	2006	20 Jan-Jun	07 Jul-Dec]	08 Jul-Dec	2009
a. Myocardial infarction	O No	O Yes	>	0	0	0	0	0	0	0
b. Angina pectoris	O No	O Yes	→	0	0	0	0	0	0	0
If YES, confirmed by: angiogram/cardiac cath?	O No	O Yes	stre	ss test?	O No	O Yes		1	1	
c. Acute coronary syndrome/unstable angina	O No	O Yes	→	0	0	0	0	0	0	0
d. Coronary angioplasty (PTCA) or stent	O No	O Yes	>	0	0	0	0	0	0	0
e. Coronary bypass surgery (CABG)	O No	O Yes	→	0	0	0	0	0	0	0
f. Congestive heart failure	O No	O Yes	→	0	0	0	0	0	0	0
g. Ventricular tachycardia	O No	O Yes	→	0	0	0	0	0	0	0
h. Atrial fibrillation	O No	O Yes	→	0	0	0	0	0	0	0
i. Intermittent claudication	O No	O Yes	→	0	0	0	0	0	0	0
j. Peripheral artery disease (not varicose veins)	O No	O Yes	>	0	0	0	0	0	0	0
k. Pulmonary embolism (PE)	O No	O Yes	→	0	0	0	0	0	0	0
I. Deep vein thrombosis (DVT)	O No	O Yes	→	0	0	0	0	0	0	0
m. Stroke	O No	O Yes	→	0	0	0	0	0	0	0
n. TIA (transient ischemic attack)	O No	O Yes	→	0	0	0	0	0	0	0
o. Carotid artery surgery (endarterectomy)	O No	O Yes	→	0	0	0	0	0	0	0
p. Melanoma	O No	O Yes	→	0	0	0	0	0	0	0
q. Non-melanoma skin cancer What type? O basal cell O squamous cel		O Yes iknown type	`	0	0	0	0	0	0	0
r. Breast cancer	O No	O Yes	́ →	0	0	0	0	0	0	0
s. Lung cancer	O No	O Yes	→ →	0	0	0	0	0	0	0
t. Colon cancer	O No	O Yes	→	0	0	0	0	0	0	0
u. Other cancer (non-skin) SITE:	O No	O Yes	→	0	0	0	0	0	0	0
v. Colon polyp	O No	O Yes	→	0	0	0	0	0	0	0
w. Diabetes mellitus	O No	O Yes	→	0	0	0	0	0	0	0
x. Migraine headaches	O No	O Yes	→	0	0	0	0	0	0	0
y. Other headaches	O No	O Yes	\rightarrow	0	0	0	0	0	0	0
z. Kidney disease (other than kidney stones)	O No	O Yes	→	0	0	0	0	0	0	0
aa. Chronic kidney failure	O No	O Yes	>	0	0	0	0	0	0	0

(OVER)

	3671 WC	OMEN'S	HEALT	H STU	DY	4 /		-				-	
	DIAGNOSIS OR NI se mark below an						<2006	2006		07 Jul-Dec		008 Jul-Dec	2009
bb. Macu	lar degeneration	RIGHT ey LEFT eye		O No O No	O Ye O Ye		0 0	00	0	0 0	00	00	00
cc. Catar	act	RIGHT eye		O No O No	O Ye O Ye	s 🔶	00	00	00	0	00	0	000
dd. Catar	act extraction	RIGHT ey		O No O No	O Ye O Ye	s 🗲	00	00	00	0	00	00	000
ee. Dry e	ye syndrome			O No	O Ye		0	0	0	0	0	0	0
ff. Parki	nson's disease			O No	O Yes	\rightarrow	0	0	0	0	0	0	0
gg. Eleva	ted cholesterol (dx	by a clinicia	an)	O No	O Ye	s 🗲	0	0	0	0	0	0	0
hh. Hypei	rtension (dx by a cl	linician)		O No	O Ye	s 🗲	0	0	0	0	0	0	0
ii. Ostec	parthritis			O No	O Ye	s 🗲	0	0	0	0	0	0	0
jj. Joint i	replacement			O No	O Ye	s 🗲	0	0	0	0	0	0	0
kk. Rheur	matoid arthritis			O No	O Ye	s 🗲	0	0	0	0	0	0	0
II. Fibror	nyalgia			O No	O Ye	s 🗲	0	0	0	0	0	0	0
mm. Fibroo	cystic or other beni	gn breast di	sease	O No	O Ye	s 🗲	0	0	0	0	0	0	0
	you EVER been d parent or sibling	-	-		O No psorias	O Yes is? O	No O`	Yes O	Not sure				
4. Has a 5. As you 6. Did yo 7. Have y	parent or sibling u age, do you hav ou EVER work in o you EVER been di u have unpleasan	EVER been re more trop or were you	n diagnos uble heari I EVER ex vith glauc	ed with p ing in a c posed to oma? (psorias crowdee o a nois O No	is? O d room v y enviro O Yes	No O` vhere lots nment tha → M	s of peop at cause 10/YR of	le are spo d you to s diagnosis:	uffer hea	/yr		O Yes
 4. Has a 5. As you 6. Did you 7. Have y 8. Do you 8. Do you 10. Have y 11. Have y 12. Did an 	parent or sibling u age, do you hav ou EVER work in o you EVER been di u have unpleasan ve? O No O S: Do these sympt Are these sympt How often do th Are your sympto you EVER had a b you EVER been di you EVER suffered ny of these relativ	EVER been re more trop or were you iagnosed w it leg sensa) Yes coms occur otoms worse bese sympto coms so seve cone densit agnosed w d a fracture es ever hav	a diagnos uble heari EVER ex vith glauc ations (cra only at res only at res on	ed with p ing in a c posed to oma? (awling, p t and doe ening/nigh ? O Da bu would d uch as D porosis? r doctor f clots in th	psorias crowded o a nois o a nois O No haraesth es movin ht comp aily C conside DEXA? DEXA? DEXA? DEXA? DEXA?	is? O d room v y enviro O Yes nesias, o ng improv ared to t 0 3-6/wee r taking r O No O Yes u was du s (deep	No O^{1} where lots nment that \rightarrow N r pain) co ve them? he morning k $O 1^{-1}$ nedication O Yes \Rightarrow What is \rightarrow What is to oster vein thror	at caused IO/YR of IO/YR of IO/NO	le are spo d you to s diagnosis: with moto O Yes lo O Yes lo O Ye O 1-3/m o O Ye vere you F	uffer hea mo pr restless es onth O s O No TIRST diag O Yes	ring loss / yr sness an < 1/mon ot sure gnosed? [? O No d an urge th O No year	it sure
 4. Has a 5. As you 6. Did you 7. Have y 8. Do you 8. Do you 10. Have y 11. Have y 12. Did an 	parent or sibling u age, do you hav ou EVER work in o you EVER been di u have unpleasan ve? O No O S: Do these sympt Are these symp How often do th Are your sympto you EVER had a b you EVER been di you EVER suffered ny of these relativ lism)? IF YES, ple	EVER been re more trop or were you iagnosed w it leg sensa o Yes coms occur otoms worse booms so seve booms so seve boome densit agnosed w d a fracture ease indica	a diagnos uble heari EVER ex vith glauce tith glauce tith glauce only at res only at res o	ed with p ing in a c posed to oma? (awling, p t and doe ening/nigi ? O Da bu would o uch as D porosis? r doctor f clots in ti ge when	psorias crowded o a nois o a nois O No haraesth es movin ht comp aily C conside DEXA? DEXA? DEXA? DEXA? DEXA?	is? O d room v y enviro O Yes nesias, o ng improv ared to t 9 3-6/wee r taking r O No O Yes u was du s (deep ident firs	No O^{1} where lots nment that \rightarrow M r pain) co ve them? he morning k O 1-2 he morning k O 1-2 he morning k O 1-2 he to oster what is to oster ve in throrest occurre	at caused at caused IO/YR of mbined O No g? O N 2/week ? O N at YEAR v oporosis mbosis) d. AT WHA	le are spo d you to s diagnosis: with moto O Yes lo O Ye O 1-3/m o O Ye vere you F ? O No or blood o T AGE?	uffer hea mo pr restless es onth O s O No IRST diag O Yes clots in th	ring loss / yr sness an < 1/mon ot sure gnosed? [eir lungs	? O No d an urge th O No year	it sure
 4. Has a 5. As you 6. Did you 7. Have y 8. Do you 8. Do you 10. Have y 11. Have y 12. Did an 	parent or sibling u age, do you hav ou EVER work in o you EVER been di u have unpleasan ve? O No O S: Do these sympt Are these sympt How often do th Are your sympto you EVER had a b you EVER been di you EVER suffered ny of these relativ	EVER been re more trop or were you iagnosed w it leg sensa o Yes coms occur otoms worse booms so seve booms so seve boome densit agnosed w d a fracture ease indica	a diagnos uble heari EVER ex vith glauc ations (cra only at res only at res on	ed with p ing in a c posed to oma? (awling, p t and doe ening/nigi ? O Da ou would o uch as D porosis? r doctor f clots in ti ge when	psorias crowded o a nois o a nois O No haraesth es movin ht comp aily C conside DEXA? DEXA? DEXA? DEXA? DEXA?	is? O d room v y enviro O Yes nesias, o ng improv ared to t 0 3-6/wee r taking r O No O Yes u was du s (deep	No O^{1} where lots nment that \rightarrow N r pain) co ve them? the morning the the the the the the the the the the	at caused at caused IO/YR of mbined O No g? O N 2/week ? O N at YEAR v oporosis mbosis) d	le are spe d you to s diagnosis: with moto O Yes lo O Yes	uffer hea mo pr restless es onth O s O No IRST diag O Yes clots in th	ring loss / yr sness an < 1/mon ot sure gnosed? [? O No d an urge th O No year	it sure

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	WOMEN'S HEALTH STUDY 4/] - [-		
	DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following						WEEK		.	
	recreational activities?	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)	0	0	0	0	0	0	0	0	
	b. Jogging (slower than 10 minute miles)	0	0	0	0	0	0	0	0	
	c. Running (10 minute miles or faster)	0	0	0	0	0	0	0	0	
	d. Bicycling (include stationary bike)	0	0	0	0	0	0	0	0	
	e. Aerobic exercise / aerobic dance / exercise machines	0	0	0	0	0	0	0	0	
	f. Lower intensity exercise / yoga / stretching / toning	0	0	0	0	0	0	0	0	
	g. Tennis, squash, or raquetball	0	0	0	0	0	0	0	0	
	h. Lap swimming	0	0	0	0	0	0	0	0	
	i. Weight lifting / strength training	0	0	0	0	0	0	0	0	
	j. Other: Please specify activity:	0	0	0	0	0	0	0	0	
14. O	N AVERAGE, how many FLIGHTS of stairs (not individual steps) do									
	O None O 1-2 flights O 3-4 flights O 5-9 flights	C) 10-14 1	lights	C) 15 or	more flig	ghts		
15. N	Vhat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less than 2 mpt	n)	O No	ormal, av	verage ((2-2.9m	ph)			
	O Brisk pace (3-3.9 mph) O Very brisk/striding (4 mph or f	-	U No	innai, ai	loiugo	(= =:011	p, r	 1		
16. E	oo you CURRENTLY smoke cigarettes? O № O Yes → If Yi	ES, on a	verage, ke (1 pac	how map	ny ciga	rettes/d	L			
	N THE <u>PAST 2 YEARS</u> , have you used female hormones?		te (1 pat	51 - 20 1	Sigarcia	00):	Cig	ls/day		
C	No Skip to question #18 O Yes									
	a. IF YES, in the PAST 2 YEARS, for how many months have ye O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 mo		female h 17-20 m		s?) 21-24	1 mos.				
	b. Are you CURRENTLY using them (within the last month)?	-								
	c. Mark the type(s) of hormones you have used the longest in the									
	CombinedO Prempro (cream)O Prempro (gold)O PremphaseO Combipatch		rempro emHRT	(peach)			empro (•	
	Estrogen: O Oral Premarin O Patch estrogen		aginal e			O O				
	O Estrace O Estratest		Other est				0.0	bor pro		20
	<u>Progesterone/Progestin:</u> O Provera/Cycrin/MPA O Vagir d. Over the PAST 2 YEARS, for how many months have you use								yesteror	10
	O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 m		-				10.1			
	e. If you used oral conjugated estrogens (e.g., Premarin) what d	ose did y	ou usua	illy take	?					
	O .30 mg/day or less O .45 mg/day O .625 l			9 mg/da	у	O 1.2	:5 mg/da	ay or hig	her	
	O Unsure O Did not take oral conjugated f. If you used oral medroxy progesterone (e.g., Provera, Cycrin)	-		u usual	v take?	•				
	O 2.5 mg or less O 5-9 mg O 10 mg O more th									
	g. What was your pattern of hormone use (days per month)?			• • • •	•		•			
	Oral or patch estrogen: (days/month) O Not used C					9 -2 6			er month	
\checkmark	Progesterone: (days/month) O Not used C)<1 C) 1-8	O 9-18	01	9-26	O 27+	days pe	er month	1
18.	Which hand do you prefer for writing? O Right O Left O Both	า								

19. Are you naturally right-handed, left-handed or equally handed? O Right-handed O Left-handed O Both

(OVER)



WOMEN'S HEALTH STUDY

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20. IN THE PAST MONTH, on approximately how many DAYS did you take any	DAY	S USED I	N THE P	AST MON	тн
of the following? Please answer on each line.	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	0	0	0	0	0
On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-9	999 mg 🛛 🕻) 1000+ r	ng O	unknown	
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0
d. COX-2 inhibitors (e.g., Celebrex)	0	0	0	0	0
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0
f. Multivitamins	0	0	0	0	0
g. SINGLE supplements of omega-3 fatty acids (fish oil)	0	0	0	0	0
h. SINGLE supplements of vitamin E	0	0	0	0	0
What dose per day? O <100 IU O 100-250 IU O 300-500 IU O 600)+ IU () unknow	'n		
i. SINGLE supplements of calcium (include elemental calcium in Tums)	0	0	0	0	0
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 90	1-1300 mg	O 130	1+ mg	O unkno	wn
j. SINGLE supplements of vitamin D (in calcium supplements or separately)?	0	0	0	0	0
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O) 1000 IU (or more	O u	nknown	

4

21. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel, angiotensin receptor or b-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes
d. Fosamax for prevention/treatment of bone loss If YES, for how many years have you been taking Fosamax regularly? O < 1 yr O 1-2 yrs O 3-4 yrs		O Yes

22. Do you have a twin sister/brother? O No O Yes -> IF YES, fraternal or identical? O Fraternal O Identical

23. Have you ever had a twin pregnancy lasting more than 6 months, excluding medically assisted pregnancies?

O No O Yes	► IF YES, how many?	O 1	O more than 1	\rightarrow	Were any of these identical?	O No	O Yes
------------	---------------------	------------	---------------	---------------	------------------------------	------	-------

24. In the following questions, we are interested			
in your perceptions about the way others			THE INFORMATION BELOW ASSISTS US IN
have treated you:	NO	YES	MAINTAINING FOLLOW-UP.
a. Have you ever been <u>unfairly</u> fired from a job or been <u>unfairly</u> denied a promotion?	0	0	HOME ()
b.For <u>unfair</u> reasons, have you ever <u>not</u> been hired for a job?	0	0	OTHER PHONE: ()
c. Have you ever been <u>unfairly</u> stopped, searched, questioned, physically threatened or abused by the police?	0	0	Is this "other phone" a work or cell number? O Work O Cell Name, address and phone of <u>someone at a different address</u>
d. Have you ever been <u>unfairly</u> prevented from moving into a neighborhood because the landlord or realtor refused to sell or rent you a house or apartment?		0	than you whom we may contact if we are unable to reach you: NAME: STREET:
25. What is your CURRENT weight?	pound	ds	CITY:
26. In general, would you say your health is: O Excellent O Very good O Good O Fa PLEASE COMPLETE THE CONTACT INFO			STATE: ZIP: PHONE NO:
IN THE RIGHT COLUMN. THANK YO Office use: O 1 O 2	OU.	Pa	Je 4 OA OB OC OD



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1. Birth date:

Last 6 digits of SSN: X X X -(optional)

SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago), have you been NEWLY DIAGNOSED with any
of the following? Please answer NO or YES on each line. IF YES, please mark the bubble to the right that corresponds to the
approximate date of the diagnosis/procedure. Only complete a date bubble if you have answered YES to a diagnosis/procedure.

The first line is provided as an EXAMPLE of someone reporting a "hip replacement" performed in February 2009.

 \rightarrow

	NO or YES		→		800	20	Office Use	
		• Yes	<u>`</u>	Jan-Jun O	Jul-Dec O	Jan-Jun	Jul-Dec O	Ose
EXAMPLE: Hip replacement	O No O No	O Yes		- Harden werden Harden				
a. Acute coronary syndrome/unstable angina			<u>→</u>	0	0	0	0	
 b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? 	O No O No	O Yes O Yes	→ stress tes	O t? O No	O O Yes	0	0	0
c. Myocardial infarction	O No	O Yes	→	0	0	0	0	0
d. Coronary angioplasty (PTCA) or stent	O No	O Yes	→	0	0	0	0	0
e. Coronary bypass surgery (CABG)	O No	O Yes	→	0	0	0	0	0
f. Congestive heart failure	O No	O Yes	→	0	0	0	0	0
g. Ventricular tachycardia	O No	O Yes	>	0	0	0	0	0
h. Atrial fibrillation	O No	O Yes	*	0	0	0	0	0
i. Intermittent claudication	O No	O Yes	→	0	0	0	0	0
j. Peripheral artery disease (not varicose veins)	O No	O Yes	→	0	0	0	0	0
k. Pulmonary embolism (PE)	O No	O Yes	→	0	0	0	0	0
I. Deep vein thrombosis (DVT)	O No	O Yes	→	0	0	0	0	0
m. Stroke	O No	O Yes	→	0	0	0	0	0
n. TIA (transient ischemic attack)	O No	O Yes	→	0	0	0	0	0
o. Carotid artery surgery (endarterectomy)	O No	O Yes	→	0	0	0	0	0
p. Melanoma	O No	O Yes	→	0	0	0	0	0
q. Non-melanoma skin cancer What type? O basal cell O squamous cel	O No I O ur	O Yes	→	0	0	0	0	0
r. Breast cancer	O No	O Yes	→	0	0	0	0	0
s. Lung cancer	O No	O Yes	\rightarrow	0	0	0	0	0
t. Colon cancer	O No	O Yes	→	0	0	0	0	0
u. Other cancer (non-skin) SITE:	O No	O Yes	>	0	0	0	0	0
v. Colon polyp	O No	O Yes	→	0	0	0	0	0
w. Diabetes mellitus	O No	O Yes	→	0	0	0	0	0
x. Migraine headaches	O No	O Yes	→	0	0	0	0	0

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2. (continued) NEWLY DIAGNOSED SINCE LAST QUESTIONNAIRE? DIAGNOSIS OR PROCEDURE NO or YES						08 Jul-Dec	20 Jan-Jun	09 Jul-Dec	Office Use
y. Other headaches		O No	O Yes	>	0	0	0	0	0
z. Kidney disease (other than	kidney stones)	O No	O Yes	→	0	0	0	0	0
aa. Chronic kidney failure		O No	O Yes	→	0	0	0	0	0
bb. Macular degeneration	RIGHT eye LEFT eye	O No O No	O Yes O Yes	${\rightarrow}$	0	0 0	00	0 0	0 0
cc. Cataract	RIGHT eye LEFT eye	O No O No	O Yes O Yes	\rightarrow	00	0	00	0	000
dd. Cataract extraction	RIGHT eye LEFT eye	O No O No	O Yes O Yes	*	0 0	00	000	000	0
ee. Glaucoma		O No	O Yes	→	0	0	0	0	0
ff. Dry eye syndrome		O No	O Yes	→	0	0	0	0	0
gg. Parkinson's disease		O No	O Yes	→	0	0	0	0	0
hh. Elevated cholesterol (dx by	a clinician)	O No	O Yes	>	0	0	0	0	0
ii. Hypertension (dx by a clinic	ian)	O No	O Yes	>	0	0	0	0	0
jj. Osteoarthritis		O No	O Yes	→	0	0	0	0	0
kk. Osteoporosis		O No	O Yes	>	0	0	0	0	0
II. Fracture due to osteoporos	sis	O No	O Yes	→	0	0	0	0	0
mm. Bone density exam (DEXA))	O No	O Yes	\rightarrow	0	0	0	0	0
nn. Joint replacement		O No	O Yes	→	0	0	0	0	0
oo. Rheumatoid arthritis		O No	O Yes	→	0	0	0	0	0
pp. Fibromyalgia		O No	O Yes	→	0	0	0	0	0
qq. Psoriasis		O No	O Yes	→	0	0	0	0	0
rr. Fibrocystic or other benign	breast disease	O No	O Yes	→	0	0	0	0	0
If YES, confirmed by: bre	ast biopsy? O	No O	Yes asp	piration?		es			
 3. Within the PAST 2 YEARS, have you been NEWLY DIAGNOSED with either of the following (Mark all that apply)? O Peptic Ulcer O Gastrointestinal bleed O NEITHER 4. What is your CURRENT blood pressure (mmHg)? → 									

-

systolic diastolic 5. What is your CURRENT TOTAL CHOLESTEROL (if checked within the past 2 years)? **O** <140 mg/dl **O** 140-159 **O** 160-179 **O** 180-199 **O** 200-219 O 220-239 O 240-249 O 250-259 O 260-269 O 270-279 O 280-299 **O** 300-329 O 330+ O unknown/not checked in 2 yrs 6. What is your CURRENT HDL-CHOLESTEROL (if checked within the past 2 years)? O <30 mg/dl O 30-39 O 40-49 O 50-59 O 60-69 O 70-79 O 80-89 O 90-99 O 100+ O unknown/not checked in 2 yrs 7. What is your CURRENT weight? pounds If YES: On average, how many cigarettes/day cigs/day 8. Do you CURRENTLY smoke cigarettes? O No O Yes -> do you smoke (1 pack = 20 cigarettes)?

O Don't know my blood pressure



9 . Please indicate your average use of the following beverages DURING THE PAST YEAR:

BEVERAGE		Never or less than 1/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	Regular beer	0	0	0	0	0	0	0	0	0
(1 glass or bottle or can)	Light beer	0	0	0	0	0	0	0	0	0
b. Red wine/sherry/port (4 oz. glass)		0	0	0	0	0	0	0	0	0
c. White wine (4 oz. glass)		0	0	0	0	0	0	0	0	0
d. Liquor (1 drink or shot) (e.g., vodka, rum, gin, brandy, etc.)		0	0	0	0	0	0	0	0	0

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

Don't Yes a. Breast cancer? No know \rightarrow Mother 0 0 0 \rightarrow Any Sister 0 0 0 \rightarrow 0 0 0 Maternal grandmother \rightarrow Paternal grandmother 0 0 0 Don't **b. Endometrial cancer?** No Yes know \rightarrow Mother 0 0 0 \rightarrow 0 Any Sister 0 0 0 \rightarrow 0 0 Maternal grandmother \rightarrow Paternal grandmother 0 0 0

If YES, please provide AGE when first diagnosed:

				T
<50	50-5 9	60-69	70+	Age Unknown
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
<50	50-59	60-69	70+	Age Unknown
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0

11. Have you EVER had infectious mononucleosis? O Not sure O No O Yes

Γ	IF YES: How old were you when diagnosed? O 0-5 O 6-10 O 11-15 O 16-19 O 20-24 O 25-29 O 30+
	Did it require you to miss school or work? O No O Yes O Not sure
	Was the diagnosis confirmed by "mono spot", "heterophile antibody" or any other lab test? O No O Yes O Not sure
1:	2. Have you EVER been diagnosed with a uterine fibroid? O Not sure O No O Yes → Year of diagnosis:
1:	3. Has your sister or mother EVER been diagnosed with a uterine fibroid? O Not sure O No O Yes
14	4. Have you EVER had an abnormal Pap smear test? O Not sure O No O Yes
	IF YES: Was the Pap smear test persistently abnormal, or followed up by a non-Pap-smear test (for example, a colposcopy and/or biopsy)? O Not sure O No O Yes
1	5. In the LAST 12 MONTHS did you have unpleasant leg sensations (crawling, paraesthesias, or pain) combined with motor restlessness and an urge to move? O No O Yes
Γ	IF YES: Do these symptoms occur only at rest and does moving improve them? O No O Yes
	Are these symptoms worse in the evening/night compared to the morning? O No O Yes
	How often do these symptoms occur? O Daily O 3-6/week O 1-2/week O 1-3/month O < 1/month O Rarely/never

Have you EVER been specifically diagnosed with "restless legs syndrome" by a physician? O No O Yes



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THE INFORMATION BELOW ASSISTS US IN

16. IN THE PAST MONTH, on approximately how many DAYS did you take any	DAYS USED IN THE PAST MONTH						
of the following? Please answer on each line.	None	1-3	4-10	11-20	21+		
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0		
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	0	0	0	0	0		
On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-9	99 mg 🛛 🕻	O 1000+ r	ng O	unknown			
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0		
d. COX-2 inhibitors (e.g., Celebrex)	0	0	0	0	0		
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0		
f. Multivitamins	0	0	0	0	0		
g. SINGLE supplements of omega-3 fatty acids (fish oil)	0	0	0	0	0		
h. SINGLE supplements of calcium (include elemental calcium in Tums)	0	0	0	0	0		
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 90	1-1300 mg	O 130)1+ mg	O unkno	wn		
i. SINGLE supplements of vitamin D (in calcium supplements or separately)?	0	0	0	0	0		
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O) 1000 IU	or more	Ou	nknown			

17. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel, angiotensin receptor or b-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes
d. Fosamax for prevention/treatment of bone loss If YES, for how many years have you been taking Fosamax regularly? O < 1 yr O 1-2 yrs O 3-4 yrs	O No O 5+ yrs	O Yes

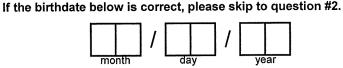
18. IN THE PAST YEAR, have you had any of the following tests or procedures?

					MAINTAINING FOLLOW-UP.
(Please answer on each line)	No	Yes, for symptoms	Yes, for screening		HOME ()
a. Fasting blood sugar	0	0	0		
b. Colonoscopy	0	0	0		
c. Sigmoidoscopy	0	0	0		WORK PHONE: ()
d. Mammogram	0	0	0		Name, address and phone of someone at a different address
e. Eye exam	0	0	0		than you whom we may contact if we are unable to reach you: NAME:
19. Have you had a hyster IF YES: At what age ?		O № O Y	′es		STREET:
20. In general, would you say your health is:					STATE: ZIP:
O Excellent O Very	good O	Good O Fa	air O Poor		PHONE NO:
PLEASE COMPLE IN THE RIGH		NTACT INFOI N. THANK YO	IS THIS CONTACT: O Relative O Friend O Neighbor O Other		

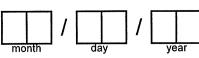


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Provide CORRECTED date of birth information below:



1. Below is the birthdate that we have on file for you. IF IT IS NOT CORRECT, please write your correct birthdate (month/day/year) in the space provided to the right.



2. Please read the list of illnesses and procedures below. If you have had a NEW diagnosis of the illness or the procedure <u>SINCE</u> <u>YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago)</u>, answer YES. If you have NOT had a new diagnosis of the illness or the procedure since returning your last questionnaire, answer NO. For each YES response, go to the columns to the right and mark the bubble which indicates the time period that you experienced the event. DO NOT COMPLETE A DATE BUBBLE UNLESS YOU ARE REPORTING AN EVENT.

Since last completing a questionnaire, did you have a NEW diagnosis or procedure?					20 an-Jun	09 Jul-Dec	2 Jan-Jun	Office Use	
EXAMPLE: Hip replacement	O No		1		O	O O	Jan-Jun	Jul-Dec O	_ 0
a. Myocardial infarction	O No	O Yes	4	When:	0	0	0	0	0
b. Coronary angioplasty (PTCA) or stent	O No	O Yes	4	When:	0	0	0	0	0
c. Coronary bypass surgery (CABG)	O No	O Yes	4	When:	0	0	0	0	0
d. Congestive heart failure	O No	O Yes	7	When:	0	0	0	0	0
e. Atrial fibrillation	O No	O Yes	+	When:	0	0	0	0	0
f. Intermittent claudication	O No	O Yes	+	When:	0	0	0	0	0
g. Peripheral artery disease (not varicose veins)	O No	O Yes	4	When:	0	0	0	0	0
h. Pulmonary embolism (PE)	O No	O Yes	+	When:	0	0	0	0	0
i. Deep vein thrombosis (DVT)	O No	O Yes	+	When:	0	0	0	0	0
j. Stroke	O No	O Yes	+	• When:	0	0	0	0	0
k. TIA (transient ischemic attack)	O No	O Yes	7	• When:	0	0	0	0	0
I. Carotid artery surgery (endarterectomy)	O No	O Yes	7	When:	0	0	0	0	0
m. Melanoma	O No	O Yes	7	When:	0	0	0	0	0
n. Non-melanoma skin cancer What type? O basal cell O squamous ce	O No II O ui	O Yes nknown type	, - }	When:	0	0	0	0	0
o. Breast cancer	O No	O Yes	4	• When:	0	0	0	0	0
p. Lung cancer	O No	O Yes	4	When:	0	0	0	0	0
q. Colon cancer	O No	O Yes	╡	• When:	0	0	0	0	0
r. Other cancer (non-skin) SITE:	O No	O Yes	4	When:	0	0	0	0	0
s. Diabetes mellitus	O No	O Yes	4	When:	0	0	0	0	0

Office use O1 O2 O3 O4



3. Below are the phone numbers that we have on file for you. IF THESE PHONE NUMBERS ARE NOT CORRECT OR HAVE CHANGED, please write the updated information in the space provided to the right. If the numbers below are correct, please skip to item #4.

Provide CORRECTED telephone numbers below:

HOME PHONE:	(
CELL PHONE:	(
WORK PHONE:	(

- 4. If you agree to allow us to contact you by e-mail, please provide your current e-mail address on the line below:
- 5. Please provide the name, address and phone of someone at a different address than you whom we may contact if we are unable to reach you:

NAME:				week of the second s	- 16/18-1990	
STREET:						
СІТҮ:				STATE:	ZIP:	
PHONE NO:						
IS THIS CONTACT:	O Relative	O Friend	O Neighbor	O Other		

Thank you. Please return the questionnaire in the pre-paid envelope provided.

	51586	WOMEN'S HEALTH STUDY		7 /						
۱.	· Birth date: / / / / Last 6 digits of SSN: X X X									
2.	WITHIN THE PAST 2 YEAR procedures? Please answ	S, have you been NEWLY DIAG er NO or YES on each line. IF Y	NOSEI ES, ind	D with an licate the	y of f date	he following illnesses or had any of the fo (month/year) of the diagnosis or the proc	ollowing edure.			
	The first line is provided a	s an EXAMPLE of someone rep	orting	a "hip rej	place	ment" performed in February 2010.				
	DIAGNOS	SIS OR PROCEDURE	NO d	or YES	\rightarrow	IF YES, PROVIDE DATE (MO/YR) IN BOX	ES BELOW			
	EXAMPLE: Hip replace	ement	O No	• Yes	→	MO/YR of procedure: 0 2 / 1	0			
	a. Acute coronary syndror	ne/unstable angina	O No	O Yes	\	MO/YR of diagnosis:				

a. Acute coronary syndrome/dristable angina	0110	0.00	7	mer ni er diagnooloi	
 b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No 	O No O Yes	O Yes stress	→ test?	MO/YR of diagnosis: O No O Yes	
c. Myocardial infarction (heart attack)	O No	O Yes	→	MO/YR of diagnosis:	
d. Coronary angioplasty (PTCA) or stent	O No	O Yes	→	MO/YR of procedure:	
e. Coronary bypass surgery (CABG)	O No	O Yes	\rightarrow	MO/YR of procedure:	
f. Congestive heart failure	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 disease (not varicose veins)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
j. Pulmonary embolism (PE)	O No	O Yes	→	MO/YR of diagnosis:	
k. Deep vein thrombosis (DVT)	O No	O Yes	→	MO/YR of diagnosis:	
I. Stroke	O No	O Yes	→	MO/YR of diagnosis:	
m. TIA (transient ischemic attack)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
n. Carotid artery surgery (endarterectomy)	O No	O Yes	→	MO/YR of surgery:	
o. Melanoma	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
p. Non-melanoma skin cancer What type? O basal cell O squamous cell O u	O No nknown ty	O Yes /pe	>	MO/YR of diagnosis:	
q. Breast cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
r. Lung cancer	O No	O Yes	→	MO/YR of diagnosis:	
s. Colon cancer	O No	O Yes	→	MO/YR of diagnosis:	
t. Other cancer (not including any of the above cancers) SITE:	O No	O Yes	>	MO/YR of diagnosis:	
u. Colon polyp	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
v. Diabetes mellitus (NEWLY diagnosed)	O No	O Yes	→	MO/YR of diagnosis:	
					· · · · · · · · · · · · · · · · · · ·

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WOMEN'S 7 / HEALTH STUDY

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2. (continued) NEWLY DIAGNOS	ED IN LAST 2 YEARS?		> IF YE	ES, PRO	VIDE DATE (MO/YR) IN	BOXES BELOW
w. Migraine headaches (NEWL)	(diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
x. Other headaches (NEWLY di	agnosed)	O No	O Yes	→	MO/YR of diagnosis:	
y. Kidney disease (other than ki	dney stones)	O No	O Yes	→	MO/YR of diagnosis:	
z. Chronic kidney failure		O No	O Yes	→	MO/YR of diagnosis:	
aa. Macular degeneration	RIGHT eye	O No	O Yes	→	MO/YR of diagnosis:	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
bb. Cataract (Newly diagnosed)	RIGHT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
cc. Cataract extraction	RIGHT eye	O No	O Yes	\rightarrow	MO/YR of procedure:	
	LEFT eye	O No	O Yes	→	MO/YR of procedure:	
dd. Glaucoma		O No	O Yes	>	MO/YR of diagnosis:	
ee. Dry eye syndrome		O No	O Yes	→	MO/YR of diagnosis:	
ff. Parkinson's disease		O No	O Yes	→	MO/YR of diagnosis:	
gg. Elevated cholesterol (NEW d	x by a clinician)	O No	O Yes	→	MO/YR of diagnosis:	
hh. Hypertension (NEW dx by a c	clinician)	O No	O Yes	→	MO/YR of diagnosis:	
ii. Osteoarthritis (NEWLY diagno	osed)	O No	O Yes	→	MO/YR of diagnosis:	
jj. Osteoporosis (NEWLY diagno	osed)	O No	O Yes	→	MO/YR of diagnosis:	
kk. Fracture due to osteoporosis		O No	O Yes	→	MO/YR of occurence:	
II. Joint replacement		O No	O Yes	>	MO/YR of surgery:	
mm. Psoriasis (NEWLY diagnosed)	O No	O Yes	→	MO/YR of diagnosis:	
nn. Fibrocystic or other benign br	east disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
If YES, confirmed by: breas	st biopsy? O No O	Yes as	spiration?	O No	O Yes	
3. What is your CURRENT blood pu O Don't know my blood		systolic (up	pper #)	dias	tolic (lower #)	
4. What is your CURRENT TOTAL (CHOLESTEROL (mg/dl)	if checke	ed within t	the past	2 years?	
O <140 mg/dl O 140-159 O 250-259 O 260-269	O 160-179 O 1 O 270-279 O 280-299	80-199 9 O 3	O 200 300-329	-219 O 330	O 220-239 O 240-2 + O unknown/not che	
5. What is your CURRENT HDL-CH	OLESTEROL (mg/dl) if a	checked	within the	e past 2 '	years?	
O <30 mg/dl O 30-39 O 80-89 O 90-9	O 40-49 O 5	50-59	O 60- ot checke	69	O 70-79	
6. What is your CURRENT weight?	pounds	5				
Office use: O 1 O	2 03 04	Page	2	PLEAS	SE GO TO TOP OF N	



WOM	EN'S
HEALTH	STUDY

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. Do you CURRENTLY sr	noke cigarettes?	O No O Ye	$res \rightarrow \int_{dc}^{lf}$	YES: On av o you smok	verage, l e (1 pac	now mar k = 20 c	ny cigai igarette	rettes/da es)?	ay		cigs/da
. DURING THE PAST YE						AVERA	AGE TI	ME PÉF	R WEEK	K	
AVERAGE TIME PER V recreational activities		ch of the follow	wing	zero	1-19 min.	20-59 min.	1 hour	1.5 hours	2-3 hours	4-6 hours	7+ hour
a. Walking or hiking (in	clude walking to w	ork)		0	0	0	0	0	0	0	0
b. Jogging (slower thar	10 minute miles)			0	0	0	0	0	0	0	0
c. Running (10 minute	miles or faster)			0	0	0	0	0	0	0	0
d. Bicycling (include st	ationary bike)			0	0	0	0	0	0	0	0
e. Aerobic exercise / a	erobic dance / exer	rcise machines		0	0	0	0	0	0	0	0
f. Lower intensity exerc	ise / yoga / stretch	ing / toning		0	0	0	0	0	0	0	0
g. Tennis, squash, or r	aquetball			0	0	0	0	0	0	0	0
h. Lap swimming				0	0	0	0	0	0	0	0
i. Weight lifting / streng	th training			0	0	0	0	0	0	0	0
j. Other: Please specify	v activity:			0	0	0	0	0	0	0	0
	3 YEARS, for how 5-8 mos. O 9-1	many months h 2 mos. O 13-	ave you u -16 mos.	sed female O 17-20	hormon mos.	es?			ete the b 4+ mos.		<u>~ </u>
b. Are you CURRENTL											
c. Mark the type(s) of h <u>Combined</u> O Pren O Pren	npro (cream)		ld)		o (peach		OP		(light bl	ue)	
<u>Estrogen:</u> O Oral O Estra		atch estrogen stratest		al estrogen gen gels, ci				O Oger		en	
Progesterone/Proge	stin: O Provera/C	ycrin/MPA O	Micronize	d (e.g., Pro	metrium) 0\	Vaginal	00	ther pro	ogester	one
d. If you used oral conju O .30 mg/day or O Unsure	less O .45 mg		.625 mg/c	lay O	ually take .9 mg/d		O 1.:	25 mg/d	lay or hi	gher	
e. What was your patte		-	-	-	O <1 () 1-8 (O 9-18	O 19	-26 O	27+ day	/s /mc
Are you CURRENTLY tak	ing any of the foll	lowing medicati	ions REG	ULARLY?	Please i	ndicate	NO/YE	ES for e	ach.		
a. Antihypertensives (e	.g., diuretic, calciur	n channel blocke	ers, angiot	ensin recep	otor or b-	blocker	s, ACE	inhibito	r) O N	lo O	Yes
b. Statin cholesterol-lov	vering medications	(e.g., Lipitor, Zo	cor, Meva	cor, Pravac	hol, Cre	stor, Le	scol)		ON	10 O	Yes
c. Other non-statin lipid	-lowering medication	ons (e.g., niacin,	Lopid, Qu	iestran, Co	lestid, Ze	etia)			ON	lo O	Yes



WOMEN'S **HEALTH STUDY** 7/

IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.	DAY	DAYS USED IN THE PAST MONTH						
	None	1-3	4-10	11-20	21+			
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0			
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	0	0	0	0	0			
On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-	999 mg 🛛) 1000+ ı	mg O	unknown	•			
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0			
d. COX-2 inhibitors (e.g., Celebrex)	0	0	0	0	0			
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0			
f. Multivitamins	0	0	0	0	0			
g. SINGLE supplements of omega-3 fatty acids (fish oil)	0	0	0	0	0			
h. SINGLE supplements of calcium (include elemental calcium in Tums)	0	0	0	0	0			
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 90)1-1300 mg	O 130)1+ mg	O unkno	wn			
i. SINGLE supplements of vitamin D (in calcium supplements or separately)	0	0	0	0	0			
What dose per day? O <300 IU O 300-500 IU O 600-900 IU	O 1000 IU	or more	Ou	nknown				

14. In the LAST 12 MONTHS did you have unpleasant leg sensations (crawling, paraesthesias, or pain) combined with motor restlessness and an urge to move? O No O Yes

IF YES: Do these symptoms occur only at rest and does moving improve them? O No O Yes	
Are these symptoms worse in the evening/night compared to the morning? O No O Yes	
How often do these symptoms occur? O Daily O 3-6/week O 1-2/week O 1-3/month O < 1/month	O Rarely/never
Have you EVER been specifically diagnosed with "restless legs syndrome" by a physician? O No O Yes	

15. IN THE PAST YEAR, h	ave you ha	id any of the f	ollowing?	THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.
(Please answer on each line)	No	Yes, for symptoms	Yes, for screening	HOME ()
a. Fasting blood sugar	0	0	0	
b. Colonoscopy	0	0	0	CELL () - -
c. Sigmoidoscopy	0	0	0	
d. Mammogram	0	0	0	WORK () - -
e. Eye exam	0	0	0	
f. Bone density exam (DEXA)	0	0	0	Name, address and phone of <u>someone at a different</u> <u>address than you</u> whom we may contact if we are unable to reach you:
16. Have you EVER had a k	preast biop	osy? O No	O Yes	NAME:
IF YES: How many?	01 0	more than 1		STREET:
Any with atypi	cal hyperpl	asia? O No	O Yes	СІТҮ:
i7. In general, would you s	ay your he	ealth is:		STATE: ZIP:
O Excellent O Very	good O	Good O Fa	air O Poor	PHONE NO:
PLEASE COMPLETE THE	CONTACT	INFORMATIO	N . THANKS.	IS THIS CONTACT: O Relative O Friend O Neighbor O Other
Office use: O	1 O 2	O3 O4	Pag	

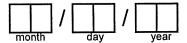


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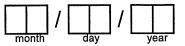
\rightarrow	•	<u>NOT</u> like thi	$s \rightarrow$	×	প

INSTRUCTIONS: Use a <u>ball-point pen</u> and DARKLY shade bubbles like this ightarrow

1. Below is the birthdate that we have on file for you. IF IT IS NOT CORRECT, please write your correct birthdate (month/day/year) in the space provided to the right. If the birthdate below is correct, please skip to question #2.



Provide CORRECTED date of birth information below:



 Please read the list of illnesses and procedures below. If you have had a NEW diagnosis or NEW procedure <u>SINCE YOU LAST</u> <u>RETURNED A QUESTIONNAIRE (approximately 1 year ago)</u>, mark YES and complete the MONTH / YEAR of the event. Answer NO for the other illnesses and procedures on the list that do not apply to you.

If, after reading down the list, your health situation has not changed and you have NOT HAD ANY OF THE DIAGNOSES OR PROCEDURES ON THE LIST SINCE YOU LAST COMPLETED A QUESTIONNAIRE (approximately 1 year ago), then simply mark the box to the right and turn to the back page: \rightarrow

a. Myocardial infarction	O No	O Yes	→ IF YES	6, When (month/year):	
b. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes	→ IF YES	6, When (month/year):	
c. Coronary bypass surgery (CABG)	O No	O Yes	→ IF YES	S, When (month/year):	
d. Congestive heart failure	O No	O Yes		S, When (month/year):	
e. Atrial fibrillation	O No	O Yes		s, When (month/year):	
f. Intermittent claudication	O No	O Yes	→ IF YES	S, When (month/year):	
g. Peripheral artery disease (not varicose veins)	O No	O Yes	→ IF YES	6, When (month/year):	
h. Pulmonary embolism (PE)	O No	O Yes		S, When (month/year):	
i. Deep vein thrombosis (DVT)	O No	O Yes		S, When (month/year):	
j. Stroke	O No	O Yes		S, When (month/year):	
k. TIA (transient ischemic attack)	O No	O Yes		6, When (month/year):	
I. Carotid artery surgery (endarterectomy)	O No	O Yes		S, When (month/year):	
m. Melanoma	O No	O Yes		6, When (month/year):	
n. Non-melanoma skin cancer What type? O basal cell O squamou	O No s cell C	O Yes) unknown		S, When (month/year):	
o. Breast cancer	O No	O Yes		S, When (month/year):	
p. Lung cancer	O No	O Yes		6, When (month/year):	
q. Colon cancer	O No	O Yes	→ IF YES	6, When (month/year):	
r. Other cancer (non-skin) SITE:	O No	O Yes		S, When (month/year):	
s. Diabetes mellitus	O No	O Yes	→ IF YES	S, When (month/year):	



3. Have you EVER had physician-diagnosed endometriosis? O No O Yes

IF YES, has your endometriosis diagnosis been confirmed by laparoscopy (a standard method for diagnosing endometriosis)?

4. Below are the phone numbers that we have on file for you. IF THESE PHONE NUMBERS ARE NOT CORRECT OR HAVE CHANGED, please write the updated information in the space provided to the right. If the numbers below are correct, please skip to item #5.

Provide CORRECTED telephone numbers below:

HOME PHONE:	(HOME ()
CELL PHONE:	(CELL PHONE: ()
WORK PHONE:	()	WORK ()
What is	s your preferred contact? O Home O Cell O Wor	k O No difference

5. The e-mail address we have on file for you is:

If this is NOT CORRECT, please provide your updated e-mail address on the line below:

6. Please provide the name, address and phone of <u>someone at a different address</u> than you whom we may contact if we are unable to reach you:

NAME:						
STREET:						
СІТҮ:				_ STATE:	ZIP:	
PHONE NO:						
IS THIS CONTACT:	O Relative	O Friend	O Neighbor	O Other		

Thank you. Please return the questionnaire in the pre-paid envelope provided.

	18916 2013-2014	(9 /							
	PLEASE USE A BALL-POINT PEN WHEN COMPLETING	THIS QU	ESTIONN	IAIRE.	IT IMPROVES THE QUAL	LITY OF OUR DATA.				
1.			ts of SSN onal)		P					
2.	WITHIN THE PAST 2 YEARS, have you been NEWLY DIA procedures? Please answer NO or YES on each line. IF	GNOSEE YES, ind) with an icate the	y of th date (e following illnesses or h month/year) of the diagn	nad any of the following osis or the procedure.				
	DIAGNOSIS OR PROCEDURE NO or YES -> IF YES, PROVIDE MO/YR IN BOXES BELOW									
	a. Acute coronary syndrome/unstable angina	O No	O Yes	→	MO/YR of diagnosis:					
	b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No	O No O Yes	O Yes stress	→ s test?	MO/YR of diagnosis: O No O Yes					
	c. Myocardial infarction (heart attack)	O No	O Yes	→	MO/YR of diagnosis:					
	d. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes	\rightarrow	MO/YR of procedure:					
	e. Coronary bypass surgery (CABG)	O No	O Yes	>	MO/YR of procedure:					
	f. Congestive heart failure	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	g. Atrial fibrillation	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	h. Intermittent claudication	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	i. Peripheral artery disease (not varicose veins)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	j. Pulmonary embolism (PE)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	k. Deep vein thrombosis (DVT)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	I. 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 surgery:					
	o. Melanoma	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	p. Non-melanoma skin cancer What type? O basal cell O squamous cell O u	O No nknown t	O Yes ype	>	MO/YR of diagnosis:					
	q. Breast cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	r. Lung cancer	O No	O Yes	>	MO/YR of diagnosis:					
	s. Colon cancer	O No	O Yes	>	MO/YR of diagnosis:					
	t. Other cancer (not including any of the above cancers) SITE:	O No	O Yes	→	MO/YR of diagnosis:					
	u. Colon polyp	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
	v. Diabetes mellitus (NEWLY diagnosed)	O No	O Yes	>	MO/YR of diagnosis:					

(OVER)



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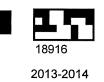
		ا		L		
2. (continued) NEWLY DIAGNOS	ED IN LAST 2 YEARS?	••••		ES, PRC	VIDE DATE (MO/YR) IN	BOXES BELOW
w. Migraine headaches (NEWL)	Y diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
x. Other headaches (NEWLY d	iagnosed)	O No	O Yes	→	MO/YR of diagnosis:	
y. Macular degeneration	RIGHT eye	O No	O Yes	→	MO/YR of diagnosis:	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
z. Cataract (Newly diagnosed)	RIGHT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	LEFT eye	O No	O Yes	>	MO/YR of diagnosis:	
aa. Cataract extraction	RIGHT eye	O No	O Yes	\rightarrow	MO/YR of procedure:	
	LEFT eye	O No	O Yes	→	MO/YR of procedure:	
bb. Glaucoma		O No	O Yes	>	MO/YR of diagnosis:	
cc. Dry eye syndrome		O No	O Yes	>	MO/YR of diagnosis:	
dd. Parkinson's disease		O No	O Yes	>	MO/YR of diagnosis:	
ee. Elevated cholesterol (NEW d	x by a clinician)	O No	O Yes	→	MO/YR of diagnosis:	
ff. Hypertension (NEW dx by a	clinician)	O No	O Yes	→	MO/YR of diagnosis:	
gg. Osteoarthritis (NEWLY diagr	iosed)	O No	O Yes	→	MO/YR of diagnosis:	
hh. Osteoporosis (NEWLY diagn	osed)	O No	O Yes	→	MO/YR of diagnosis:	
ii. Fracture due to osteoporosis		O No	O Yes	\rightarrow	MO/YR of occurence:	
jj. Joint replacement		O No	O Yes	→	MO/YR of surgery:	
kk. Fibrocystic or other benign br	east disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
If YES, confirmed by: brea	st biopsy? O No O	Yes a	spiration?	O No	O Yes	
3. In general, would you say your I	health is: O Excellent	O Ver	y good () Good	O Fair O Poor	
4. What is your CURRENT TOTAL	CHOLESTEROL (mg/dl)	if check	ed within	the pas	t 2 years?	
O <140 mg/dl O 140-159 O 250-259 O 260-269	O 160-179 O 1 O 270-279 O 280-299	80-199 9 O	O 200 300-329		O 220-239 O 240-2)+ O unknown/not che	
5. What is your CURRENT HDL-CH	IOLESTEROL (mg/dl) if	checked	within the	e past 2	years?	
O <30 mg/dl O 30-39 O 80-89 O 90-9		50-59 Inknown/I	O 60- not checke		O 70-79 s	
6. Do you CURRENTLY smoke cig	arettes? O No O Y				e, how many cigarettes/da back = 20 cigarettes)?	ay cigs/day
7. What is your CURRENT weight?	pounds					
8. What is your CURRENT blood p		stolic (upp	er #)	diasto	O Don't kno	w my blood pressure



interactional activities? zero min. min. min. hours hours hours a. Walking or hiking (include walking to work) 0	VERAGE TIME PER WEEK spent at each of the following	Г		1-19	20-59	1	1.5	2-3	4-6
b. Jogging (slower than 10 minute miles) 0 <th>creational activities?</th> <th></th> <th>zero</th> <th></th> <th></th> <th>hour</th> <th></th> <th></th> <th>hours</th>	creational activities?		zero			hour			hours
c. Running (10 minute miles or faster) 0	a. Walking or hiking (include walking to work)		0	0	0	0	0	0	0
d. Bicycling (include stationary bike) 0	b. Jogging (slower than 10 minute miles)		0	0	0	0	0	0	0
e. Aerobic exercise / aerobic dance / exercise machines 0	c. Running (10 minute miles or faster)		0	0	0	0	0	0	0
f. Lower intensity exercise / yoga / stretching / toning 0 <td>d. Bicycling (include stationary bike)</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td>	d. Bicycling (include stationary bike)		0	0	0	0	0	0	0
g. Tennis, squash, or raquetball 0	e. Aerobic exercise / aerobic dance / exercise machines		0	0	0	0	0	0	0
g. 10110; outputs, or request, or r	f. Lower intensity exercise / yoga / stretching / toning		0	0	0	0	0	0	0
i. Weight lifting / strength training 0 0 0 0 0 0 0 0 j. Other: Please specify activity:	g. Tennis, squash, or raquetball		0	0	0	0	0	0	0
j. Other: Please specify activity:	h. Lap swimming		0	0	0	0	0	0	0
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 hat 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) O Normal, average (2-2.9mph) RING THE PAST YEAR, on average, how many burs PER WEEK did you spend: 0 1 2-5 6-10 11-20 21-40 41-60 61-90 90+ a. Sitting at work or away from home or while driving O O O O O O O b. Sitting at home while watching TV/VCR/DVD O O O O O O O O	i. Weight lifting / strength training		0	0	0	0	0	0	0
I 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 hat 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) O Normal, average (2-2.9mph) VRING THE PAST YEAR, on average, how many burss PER WEEK did you spend: 0 1 2-5 6-10 11-20 21-40 41-60 61-90 90+ a. Sitting at work or away from home or while driving O O O O O O O b. Sitting at home while watching TV/VCR/DVD O O O O O O O O	i. Other: Please specify activity:		0	0	0	0	0	0	0
RING THE PAST YEAR, on average, how many URS PER WEEK did you spend:012-56-1011-2021-4041-6061-9090+hrs.hrs.hrs.hrs.hrs.hrs.hrs.hrs.hrs.hrs.hrs.a. Sitting at work or away from home or while drivingOOOOOOOOb. Sitting at home while watching TV/VCR/DVDOOOOOOOO	O None O 1-2 flights O 3-4 flights O 5-9 nat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less that	flights n 2 mph	())) 10-14	flights	_			ghts
nrs.nr	 O None O 1-2 flights O 3-4 flights O 5-9 At is your usual walking pace outdoors? O Don't walk regularly O Brisk pace (3-3.9 mph) O Very brisk/striding (4 model) 	flights n 2 mph	())	0 10-14 (O No	flights ormal, av	verage	(2-2.9m	ph)	ghts
b. Sitting at home while watching TV/VCR/DVD O <th> O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less that on the second seco</th> <th>flights n 2 mph nph or fa</th> <th>()) aster) 1 2-</th> <th>0 10-14 1 O No <u>AVER</u></th> <th>flights ormal, av AGE TI</th> <th>verage ME PE</th> <th>(2-2.9m R WEEI</th> <th>ph) {</th> <th></th>	 O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less that on the second seco	flights n 2 mph nph or fa	()) aster) 1 2-	0 10-14 1 O No <u>AVER</u>	flights ormal, av AGE TI	verage ME PE	(2-2.9m R WEEI	ph) {	
	O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less tha O Brisk pace (3-3.9 mph) O Very brisk/striding (4 m RING THE PAST YEAR, on average, how many DURS PER WEEK did you spend:	flights n 2 mph nph or fa 0 hrs.) aster) 1 2- hr. hi	O 10-14 O No AVER 5 6-10 rs. hrs.	flights ormal, av AGE TI 11-20 hrs.	/erage ME PE 21-40 hrs.	(2-2.9m R WEEI 41-60 hrs.	ph) <u><</u> 61-90 hrs.	90+ hrs.
	 O None O 1-2 flights O 3-4 flights O 5-8 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less that O Brisk pace (3-3.9 mph) O Very brisk/striding (4 methods) IRING THE PAST YEAR, on average, how many purs PER WEEK did you spend: a. Sitting at work or away from home or while driving 	flights n 2 mph nph or fa hrs. O	()) aster) 1 2- hr. h O C	O 10-14 O No AVER 5 6-10 rs. hrs. O O	flights ormal, av AGE TII 11-20 hrs. O	Verage ME PE 21-40 hrs. O	(2-2.9m R WEEI 41-60 hrs. O	ph) (61-90 hrs. O	90+ hrs. O
	 O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less that O Brisk pace (3-3.9 mph) O Very brisk/striding (4 methods) C RING THE PAST YEAR, on average, how many purs PER WEEK did you spend: a. Sitting at work or away from home or while driving b. Sitting at home while watching TV/VCR/DVD 	flights n 2 mph nph or fa hrs. O) aster) hr. h O C O C	O 10-14 O No AVER 5 6-10 5. hrs. O O O O	flights ormal, av AGE TII 11-20 hrs. O O	Verage ME PE 21-40 hrs. O O	(2-2.9m R WEEI 41-60 hrs. O O	ph) 61-90 hrs. O O	90+ hrs. O
	 O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less that O Brisk pace (3-3.9 mph) O Very brisk/striding (4 methods) RING THE PAST YEAR, on average, how many purs PER WEEK did you spend: a. Sitting at work or away from home or while driving b. Sitting at home while watching TV/VCR/DVD c. Other sitting at home (e.g., reading, meal times, at desk) 	flights n 2 mph nph or fa hrs. O O O	1 2- hr. h O C O C O C	O 10-14 O No AVER 5 6-10 5. hrs. O O O O O O	AGE TII 11-20 hrs. O O O	Verage 21-40 hrs. O O O	(2-2.9m R WEEI 41-60 hrs. O O O	ph) 61-90 hrs. O O O	90+ hrs. O O O
	 O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less tha O Brisk pace (3-3.9 mph) O Very brisk/striding (4 methods) RING THE PAST YEAR, on average, how many DURS PER WEEK did you spend: a. Sitting at work or away from home or while driving b. Sitting at home while watching TV/VCR/DVD c. Other sitting at home (e.g., reading, meal times, at desk) 	flights n 2 mph nph or fa hrs. O O No: Skip	1 2- hr. h O C O C O C	0 10-14 O No AVER 5 6-10 5 hrs. 0 O 0 O 0 O 0 O 0 O 0 O 0 O 0 O 0 O	AGE TII 11-20 hrs. O O O O	Verage 21-40 hrs. O O O	(2-2.9m R WEEI 41-60 hrs. O O O	ph) 61-90 hrs. O O O	90+ hrs. O O O
a. IF YES, in the PAST 2 YEARS, for how many months have you used female hormones?	 O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less that O Brisk pace (3-3.9 mph) O Very brisk/striding (4 methods) PRING THE PAST YEAR, on average, how many purs PER WEEK did you spend: a. Sitting at work or away from home or while driving b. Sitting at home while watching TV/VCR/DVD c. Other sitting at home (e.g., reading, meal times, at desk) THE PAST 2 YEARS, have you used female hormones? O a. IF YES, in the PAST 2 YEARS, for how many months have y 	flights n 2 mph nph or fa hrs. O No: Skip Du used	1 2- hr. hr O C O C O C o to the female	0 10-14 0 No AVER 5 6-10 nrs. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	AGE TII AGE TII 11-20 hrs. O O O estion (es?	Verage ME PEI 21-40 hrs. O O O O Yes:	(2-2.9m R WEEI 41-60 hrs. O O O Comple	ph) 61-90 hrs. O O O	90+ hrs. O O O O O O O O
a. IF YES, in the PAST 2 YEARS, for how many months have you used female hormones? O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 mos. O 17-20 mos. O 21-24 mos. O 24+ mos.	 O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less tha O Brisk pace (3-3.9 mph) O Very brisk/striding (4 m RING THE PAST YEAR, on average, how many DURS PER WEEK did you spend: a. Sitting at work or away from home or while driving b. Sitting at home while watching TV/VCR/DVD c. Other sitting at home (e.g., reading, meal times, at desk) THE PAST 2 YEARS, have you used female hormones? O a. IF YES, in the PAST 2 YEARS, for how many months have y O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 m 	flights n 2 mph nph or fa hrs. O No: Skip ou used os. C	() aster) 1 2- hr. hi O C O C O C O C O C O C O C O 17-20	0 10-14 O No AVER 5 6-10 5 6-10 5 0 0 0	AGE TII AGE TII 11-20 hrs. O O O estion (es?	Verage ME PEI 21-40 hrs. O O O O Yes:	(2-2.9m R WEEI 41-60 hrs. O O O Comple	ph) 61-90 hrs. O O O	90+ hrs. O O O O O O O O
 a. IF YES, in the PAST 2 YEARS, for how many months have you used female hormones? O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 mos. O 17-20 mos. O 21-24 mos. O 24+ mos. b. Are you CURRENTLY using them (within the last month)? O No O Yes 	 O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less tha O Brisk pace (3-3.9 mph) O Very brisk/striding (4 methods) RING THE PAST YEAR, on average, how many purs PER WEEK did you spend: a. Sitting at work or away from home or while driving b. Sitting at home while watching TV/VCR/DVD c. Other sitting at home (e.g., reading, meal times, at desk) THE PAST 2 YEARS, have you used female hormones? O a. IF YES, in the PAST 2 YEARS, for how many months have y O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 methods. 	flights n 2 mph nph or fa hrs. O No: Skip ou used os. C O No	1 2. hr. h O C O C O C O C o to the female 0 17-20 O Yes	0 10-14 O No AVER 5 6-10 5 6-10 5 6-10 0 O	AGE TII AGE TII 11-20 hrs. O O O estion (es?	Verage ME PEI 21-40 hrs. O O O O Yes:	(2-2.9m R WEEI 41-60 hrs. O O O Comple	ph) 61-90 hrs. O O O	90+ hrs. O O O O O O O O
a. IF YES, in the PAST 2 YEARS, for how many months have you used female hormones? O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 mos. O 17-20 mos. O 21-24 mos. O 24+ mos.	 O None O 1-2 flights O 3-4 flights O 5-9 hat is your usual walking pace outdoors? O Don't walk regularly O Easy, casual (less tha O Brisk pace (3-3.9 mph) O Very brisk/striding (4 methods) PRING THE PAST YEAR, on average, how many DURS PER WEEK did you spend: a. Sitting at work or away from home or while driving b. Sitting at home while watching TV/VCR/DVD c. Other sitting at home (e.g., reading, meal times, at desk) THE PAST 2 YEARS, have you used female hormones? O a. IF YES, in the PAST 2 YEARS, for how many months have y O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 m b. Are you CURRENTLY using them (within the last month)? O c. Mark the type(s) of hormones you have used the longest in the Combined O Prempro (cream) O Prempro (gold) 	flights n 2 mph nph or fa hrs. O No: Skip ou used os. C O No e PAST O F	()) aster) 1 2- hr. hi O C O C O C O C O C O C O C O C O C O C	0 10-14 O No 5 6-10 5 6-10 5 6-10 9 O 0 O <t< td=""><td>AGE TII 11-20 hrs. O O O estion (es? O 21-24</td><td>Verage ME PE 21-40 hrs. O O O O Yes: 4 mos.</td><td>(2-2.9m R WEEI 41-60 hrs. O O Comple</td><td>ph) 61-90 hrs. O O O te the t</td><td>90+ hrs. O O O O O O O</td></t<>	AGE TII 11-20 hrs. O O O estion (es? O 21-24	Verage ME PE 21-40 hrs. O O O O Yes: 4 mos.	(2-2.9m R WEEI 41-60 hrs. O O Comple	ph) 61-90 hrs. O O O te the t	90+ hrs. O O O O O O O

d. If you used oral conjugated estrogens (e.g., Premarin) what dose did you usually take?

O .30 mg/day or less	O .45 mg/day	O .625 mg/day	O .9 mg/day	O 1.25 mg/day or higher
O Unsure	O Did not take ora	al conjugated estrogen		



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14. IN THE PAST MONTH, on approximately how many DAYS did you take any

of the following? 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.)	0	0	0	0	0
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	0	0	0	0	0
On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-9	99 mg 🛛 🕻) 1000+ r	ng O	unknown	
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0
d. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0
e. Multivitamins	0	0	0	0	0
f. SINGLE supplements of omega-3 fatty acids (fish oil)	0	0	0	0	0
g. SINGLE supplements of calcium (include elemental calcium in Tums)	0	0	0	0	0
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 90	1-1300 mg	O 130)1+ mg	O unkno	wn
h. SINGLE supplements of vitamin D (in calcium supplements or separately)	0	0	0	0	0
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O) 1000 IU	or more	Ou	nknown	

15. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or b-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes
d. Fosamax or other bisphosphonates for prevention/treatment of bone loss If YES, for how many years have you been regularly taking this bone loss med.? O < 1 yr O 1-2 yrs O		O Yes O 5+ yrs

16. IN THE PAST YEAR, have you had any of the following?

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening	•	(Please answer on each line)	No	Yes, for symptoms	Yes, for screening
a. Colonoscopy	0	0	0	A	d. Fasting blood sugar	0	0	0
b. Sigmoidoscopy	0	0	0		e. Eye exam	0	0	0
c. Mammogram	0	0	0		f. Bone density exam (DEXA)	0	0	0

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.						
YOUR HOME PHONE: ()	Name, address and phone of <u>someone at a different address than</u> <u>you</u> whom we may contact if we are unable to reach you:					
	NAME:					
YOUR CELL PHONE: ()	STREET:					
YOUR WORK PHONE: ()	PHONE NO: THIS CONTACT IS: O Relative O Friend O Neighbor O Other					

	WHS #10 FORM	
17772		
2014-2015		Request

INSTRUCTIONS: Use a <u>ball-point pen</u> and DARKLY shade bubbles like this \rightarrow • <u>NOT</u> like this \rightarrow ×

1. Have you had any of the following diagnoses or procedures <u>SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago)?</u> Please mark either YES or NO for each item. If YES, provide the MONTH/YEAR of the diagnosis or procedure.

However, if you HAVE NOT HAD ANY OF THE DIAGNOSES OR PROCEDURES ON THE LIST SINCE YOU LAST COMPLETED A QUESTIONNAIRE (approximately 1 year ago), then simply mark this box \rightarrow \square and then go to the next page.

a. Myocardial infarction	O No	O Yes	>	IF YES, When (month/year):
b. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes	\rightarrow	IF YES, When (month/year):
c. Coronary bypass surgery (CABG)	O No	O Yes	\rightarrow	IF YES, When (month/year):
d. Congestive heart failure	O No	O Yes	→	IF YES, When (month/year):
e. Atrial fibrillation	O No	O Yes	→	IF YES, When (month/year):
f. Intermittent claudication	O No	O Yes	→	IF YES, When (month/year):
g. Peripheral artery disease (not varicose veins)	O No	O Yes	→	IF YES, When (month/year):
h. Pulmonary embolism (PE)	O No	O Yes	→	IF YES, When (month/year):
i. Deep vein thrombosis (DVT)	O No	O Yes	→	IF YES, When (month/year):
j. Stroke	O No	O Yes	→	IF YES, When (month/year):
k. TIA (transient ischemic attack)	O No	O Yes	→	IF YES, When (month/year):
I. Carotid artery surgery (endarterectomy)	O No	O Yes	→	IF YES, When (month/year):
m. Melanoma	O No	O Yes	→	IF YES, When (month/year):
n. Non-melanoma skin cancer	O No	O Yes		IF YES, When (month/year):
What type? O basal cell O squamou	s cell C) unknown	type	Parameterization - Parameterizat
o. Breast cancer	O No	O Yes	\rightarrow	IF YES, When (month/year):
p. Lung cancer	O No	O Yes	\rightarrow	IF YES, When (month/year):
q. Colon cancer	O No	O Yes	→	IF YES, When (month/year):
r. Other cancer (non-skin) SITE:	O No	O Yes	→	IF YES, When (month/year):
s. Diabetes mellitus	O No	O Yes	\rightarrow	IF YES, When (month/year):
t. Migraine headaches (NEWLY diagnosed)	O No	O Yes	→	IF YES, When (month/year):
u. Other headaches (NEWLY diagnosed)	O No	O Yes	→	IF YES, When (month/year):
v. Parkinson's disease	O No	O Yes	>	IF YES, When (month/year):

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	WHS #10 FORM
17772	
2014-2015	

2. Below is the birth date that we have on file for you. IF IT IS NOT CORRECT, please write your correct birth date (month/day/year) in the space provided to the right. If the birth date below is correct, please skip to question #3.

3. Below are the phone numbers that we have on file for you. IF THESE PHONE NUMBERS ARE NOT CORRECT OR HAVE CHANGED, please write the updated information in the space provided to the right. If the numbers below are correct, please skip to item #4.

Provide <u>UPDATED</u> telephone nos. below: HOME HOME PHONE: _ PHONE: CELL CELL PHONE: PHONE: WORK WORK PHONE: PHONE: What is your preferred phone contact? O Home O Cell O Work O No difference

4. The e-mail address we have on file for you is:

If this is NOT CORRECT, please provide your updated e-mail address on the line below (PLEASE PRINT):

5. Please provide the name, address and phone of <u>someone at a different address than you</u> whom we may contact if we are unable to reach you:

NAME:	
STREET:	
СІТҮ:	STATE: ZIP:
PHONE NO:	
IS THIS CONTACT: O Relative O Friend O Neighbor	O Other

Thank you. Please return the questionnaire in the pre-paid envelope provided.



Provide CORRECTED date of birth

	,	

information below:

	Image: Non-Section 17788 WOMEN'S 17788 HEALTH STUDY	1	11/			
	PLEASE USE A BALL-POINT PEN WHEN COMPLETING	THIS QUI	ESTIONN	IAIRE.	IT IMPROVES THE QUA	LITY OF OUR DATA.
1.	Birth date: / / La	st 4 digil (optio	ts of SSN onal)	I: X	x x - x x-	
2.	WITHIN THE PAST 2 YEARS, have you been NEWLY DIA procedures? Please answer NO or YES on each line. IF `	GNOSED YES, indi) with an icate the	y of th date (e following illnesses or l month/year) of the diagn	nad any of the following osis or the procedure.
т	DIAGNOSIS OR PROCEDURE	NO o	r YES	>	IF YES, PROVIDE MO/	R IN BOXES BELOW
	a. Acute coronary syndrome/unstable angina	O No	O Yes	→	MO/YR of diagnosis:	
	b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No	O No O Yes	O Yes stress	-	MO/YR of diagnosis: O No O Yes	
	c. Myocardial infarction (heart attack)	O No	O Yes	→	MO/YR of diagnosis:	
	d. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes	→	MO/YR of procedure:	
	e. Coronary bypass surgery (CABG)	O No	O Yes	>	MO/YR of procedure:	
	f. Congestive heart failure	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 disease (not varicose veins)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	j. Pulmonary embolism (PE)	O No	O Yes	→	MO/YR of diagnosis:	
	k. Deep vein thrombosis (DVT)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	I. 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 surgery:	
	o. Melanoma	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	p. Non-melanoma skin cancer What type? O basal cell O squamous cell O ur	O No nknown ty	O Yes /pe	>	MO/YR of diagnosis:	
	q. Breast cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	r. Lung cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	s. Colon cancer	O No	O Yes	>	MO/YR of diagnosis:	
	t. Other cancer (not including any of the above cancers) SITE:	O No	O Yes	>	MO/YR of diagnosis:	
	u. Colon polyp	O No	O Yes	>	MO/YR of diagnosis:	
	v. Diabetes mellitus (NEWLY diagnosed)	O No	O Yes	→	MO/YR of diagnosis:	





2. (continued) NEWLY DIAGNOS	S?	> IF YE	ES, PRO	VIDE DATE (MO/YR) IN	BOXES BELOW	
w. Migraine headaches (NEWLY diagnosed)			O Yes	\rightarrow	MO/YR of diagnosis:	
x. Other headaches (NEWLY d	iagnosed)	O No	O Yes	→	MO/YR of diagnosis:	
y. Macular degeneration	RIGHT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
z. Cataract (Newly diagnosed)	RIGHT eye	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
	LEFT eye	O No	O Yes	→	MO/YR of diagnosis:	
aa. Cataract extraction	RIGHT eye	O No	O Yes	\rightarrow	MO/YR of procedure:	
	LEFT eye	O No	O Yes	\rightarrow	MO/YR of procedure:	
bb. Glaucoma		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
cc. Dry eye syndrome		O No	O Yes	>	MO/YR of diagnosis:	
dd. Parkinson's disease		O No	O Yes	\rightarrow	MO/YR of diagnosis:	
ee. Elevated cholesterol (NEW d	x by a clinician)	O No	O Yes	→	MO/YR of diagnosis:	
ff. Hypertension (NEW dx by a d	clinician)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
gg. Osteoarthritis (NEWLY diagn	osed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
hh. Osteoporosis (NEWLY diagn	osed)	O No	O Yes	→	MO/YR of diagnosis:	
ii. Fracture due to osteoporosis			O Yes	\rightarrow	MO/YR of occurence:	
jj. Joint replacement			O Yes	→	MO/YR of surgery:	
kk. Fibrocystic or other benign br	east disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
If YES, confirmed by: breast biopsy? O No O			spiration?	O No	O Yes	

3. What is your CURRENT TOTAL CHOLESTEROL (mg/dl) if checked within the past 2 years?

O <140 mg/d	I O 140-15	59 O 160-1	79 O 180)-199 O 20	0-219 () 220-239	O 240-249	
O 250 250	O 000 000	• 270 270	^ 200 200	^ 200 220	O 000 i		m/not chooles	

O 250-259	O 260-269	O 270-279	O 280-299	O 300-329	O 330+	O unknown/not checked in 2 yrs
------------------	------------------	------------------	------------------	------------------	---------------	--------------------------------

4. What is your CURRENT HDL-CHOLESTEROL (mg/dl) if checked within the past 2 years?

O <30	0 mg/dl 🛛 🕻) 30-39	O 40-49	O 50-59	O 60-	-69	O 70-79		
	O 80-89	O 90-99	O 100+	O unknown	/not checke	d in 2 yrs			
5. Do you C	URRENTLY s	moke cigaret	tes? O No	O Yes 🗲	lf YES: Or do you sm			y cigarettes/day garettes)?	cigs/day
6. What is y	our CURREN	T weight?	pounds						
7. What is y	our CURREN	T blood press	ure (mmHg)?	systolic (up	per #)	diastolic	(lower #)	O Don't know m	ny blood pressure
8. In genera	l, would you	say your heal	th is: O Exce	llent O Ve	ry good () Good	O Fair	O Poor	





9. The following items are about activities you might do during a typical d

day. Does YOUR HEALTH NOW LIMIT YOU in these activities?	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	0	0	0
 b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf 	0	0	0
c. Lifting or carrying groceries	0	0	0
d. Climbing several flights of stairs	0	0	0
e. Climbing one flight of stairs	0	0	0
f. Bending, kneeling, or stooping	0	0	0
g. Walking more than a mile	0	0	0
h. Walking several blocks	0	0	0
i. Walking one block	0	0	0
j. Bathing or dressing yourself	0	0	0

10. 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
 Cut down the amount of time you spent on work or other activities 	0	0
b. Accomplished less than you would like	0	0
c. Were limited in the kind of work or other activities	0	0
 Had difficulty performing the work or other activities (for example, it took extra effort) 	0	0

11. 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	0	0
b. Didn't do work or other activities as carefully as usual	0	0

- 12. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)? O Not at all O A little bit O Moderately O Quite a bit O Extremely
- 13. 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?	0	0	0	0	0	0
b. Did you have a lot of energy?	0	0	0	0	0	0
c. Have you felt downhearted and blue?	0	0	0	0	0	0

- 14. 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.)?
 - O All of the time O Most of the time O Some of the time O A little of the time O None of the time

Questions 8-14 are taken from the SF-12 Health Survey (Medical Outcomes Trust) QualityMetric Incorporated and the RAND 36-Item Health Survey 1.0.

(OVER)





15. IN THE PAST MONTH, on approximately how many DAYS did you take any

I THE PAST MONTH, on approximately how many DAYS did you take any f the following? Please answer on each line.		S USED	IN THE P	AST MON	тн
-	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	0	0	0	0	0
On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-5	999 mg	O 1000+	mg O	unknown	
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0
d. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0
e. Multivitamins	0	0	0	0	0
f. SINGLE supplements of omega-3 fatty acids (fish oil)	0	0	0	0	0
g. SINGLE supplements of calcium (include elemental calcium in Tums)	0	0	0	0	0
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 90)1-1300 mg	O 130	01+ mg	O unkno	wn
h. SINGLE supplements of vitamin D (in calcium supplements or separately)	0	0	0	0	0
What dose per day? O <300 IU O 300-500 IU O 600-900 IU (O 1000 IU	or more	O u	inknown	

16. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or b-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes
d. Fosamax or other bisphosphonates for prevention/treatment of bone loss If YES, for how many years have you been regularly taking this bone loss med.? O < 1 yr O 1-2 yrs O 3		O Yes O 5+ yrs

17. IN THE PAST YEAR, have you had any of the following?

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening	each line)		No	Yes, for symptoms	Yes, for screening
a. Colonoscopy	0	0	0	4	d. Fasting blood sugar	0	0	0
b. Sigmoidoscopy	0	0	0		e. Eye exam	0	0	0
c. Mammogram	0	0	0		f. Bone density exam (DEXA)	0	0	0

THE INFORMATION BELOW ASSIS	STS US IN MAINTAINING FOLLOW-UP.			
YOUR HOME PHONE: () - - - - YOUR CELL PHONE: () - - - - YOUR CELL PHONE: () - - - - - YOUR WORK PHONE: () - - - - -	Name, address and phone of someone at a different address than you whom we may contact if we are unable to reach you: NAME: STREET: CITY: STATE: PHONE NO:			
	THIS CONTACT IS: O Relative O Friend O Neighbor O Other			
YOUR E-MAIL ADDRESS: This is the e-mail address we have	on file:			
If it has changed, please provide your updated e-mail addre	ss below:			

Thank you for your participation in the continued follow-up of the Women's Health Study. Below is a brief questionnaire. Please complete the questions and return this sheet in the enclosed pre-paid envelope ONLY IF you have had any of the listed illnesses or procedures within the past year. Also, if you have a new mailing address, phone number, or e-mail address, please provide this updated information on the back of the form. Because we are streamlining our follow-up process, it is particularly helpful to us that we have your current e-mail address since this will be an important means of communication going forward.

As always, if you have any questions, please contact us at 1-800-633-6911 or at <u>whs@partners.org</u>. Again, you need not return this questionnaire if none of the items below apply to you or you are not reporting updated contact information on the back.

Yours sincerely,

Julie E. Buring, ScD Principal Investigator I-Min Lee, MD, ScD Principal Investigator

1. If you have had any of the following diagnoses or procedures SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago), please mark the YES bubble and provide the MONTH/YEAR of the diagnosis or procedure.

			(OVER)
i. Other cancer Specify: O Breast cancer O Lung c	-		
		IF YES, When (month/year):	
	s cell O unknown type	IF YES, When (month/year):	
h. Non-melanoma skin cancer			
g. Melanoma	O No O Yes>	IF YES, When (month/year):	
f. TIA (transient ischemic attack)	O No O Yes —>	IF YES, When (month/year):	
e. Stroke	O No O Yes 🔶	IF YES, When (month/year):	
d. Atrial fibrillation	O No O Yes →	IF YES, When (month/year):	
c. Coronary bypass surgery (CABG)	O No O Yes	IF YES, When (month/year):	
b. Coronary angioplasty (PTCA or PCI) or stent	O No O Yes	IF YES, When (month/year):	
a. Myocardial infarction	O No O Yes	IF YES, When (month/year):	

WHS #12 FORM

2016



2. Below are the phone numbers that we have on file for you. IF THESE PHONE NUMBERS ARE NOT CORRECT OR HAVE CHANGED, please write the updated information in the space provided to the right. If the numbers below are correct, please skip to item #3.

Provide <u>UPDATED</u> telephone nos. below:

HOME ()	HOME PHONE:
CELL PHONE: ()	CELL PHONE:
WORK ()	WORK PHONE:
What is your preferred phone contact? O Home O Cell	O Work O No difference

3. The e-mail address we have on file for you is:

If this is NOT CORRECT, please provide your updated e-mail address on the line below (PLEASE PRINT):

4. If you have a NEW ADDRESS, which is different than the one that appears on our letter, please provide updated address information below:

STREET:			
СІТҮ:	STATE:	ZIP:	

IF YOU ARE REPORTING NEW INFORMATION - EITHER A NEW DIAGNOSIS OR PROCEDURE OR NEW CONTACT INFORMATION -- PLEASE RETURN THIS FORM IN THE POSTAGE PRE-PAID ENVELOPE. THANK YOU!



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	PLEASE USE A BALL-POINT PEN WHEN COMPLETING	THIS QU	ESTIONN	AIRE.	IT IMPROVES THE QUAI	LITY OF OUR DATA.			
1.	1. Date of birth: / / We use DATE OF BIRTH to verify the identity of the person providing information. <u>Is the DOB above correct?</u> O Yes O No → IF NO, what is your correct date of birth?								
2.	2. WITHIN THE PAST 2 YEARS, have you been NEWLY DIAGNOSED with any of the following illnesses or had any of the following								
	procedures? Please answer NO or YES on each line. IF		icate the	date (month/year) of the diagn IF YES, PROVIDE MO/Y				
Γ	DIAGNOSIS OR PROCEDURE			-	· · · · · · · · · · · · · · · · · · ·				
_	a. Acute coronary syndrome/unstable angina	O No	O Yes		MO/YR of diagnosis:				
	b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No	O No O Yes	O Yes stress	•	MO/YR of diagnosis: O No O Yes				
	c. Myocardial infarction (heart attack)	O No	O Yes	→	MO/YR of diagnosis:				
	d. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes	→	MO/YR of procedure:				
-	e. Coronary bypass surgery (CABG)	O No	O Yes	→	MO/YR of procedure:				
-	f. Congestive heart failure	O No	O Yes	\rightarrow	MO/YR of diagnosis:				
t	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 disease (not varicose veins)	O No	O Yes	→	MO/YR of diagnosis:				
-	j. Pulmonary embolism (PE)	O No	O Yes	>	MO/YR of diagnosis:				
-	k. Deep vein thrombosis (DVT)	O No	O Yes	>	MO/YR of diagnosis:				
-	I. 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	\rightarrow	MO/YR of surgery:				
-	o. Melanoma	O No	O Yes	→	MO/YR of diagnosis:				
-	p. Non-melanoma skin cancer What type? O basal cell O squamous cell O u	O No nknown ty	O Yes ype	→	MO/YR of diagnosis:				
-	q. Breast cancer	O No	O Yes	→	MO/YR of diagnosis:				
-	r. Lung cancer	O No	O Yes	→	MO/YR of diagnosis:				
-	s. Colon cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:				
-	t. Other cancer (not including any of the above cancers) SITE:	O No	O Yes	→	MO/YR of diagnosis:				
	u. Colon polyp	O No	O Yes	→	MO/YR of diagnosis:				
-	v. Diabetes mellitus (NEWLY diagnosed)	O No	O Yes	→	MO/YR of diagnosis:				

(OVER)

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WOMEN'S HEALTH STUDY 13 /

	2017						
	2. (continued) NEWLY DIAGNOSED IN LAST 2 YEARS?		re (mo/yf	R) IN BO	XES BELC	w	
	w. Migraine headaches (NEWLY diagnosed) O No O Yes ->	MO/YR	of diagnos	is:			
	x. Other headaches (NEWLY diagnosed) O No O Yes ->	MO/YR	of diagnos	is:	\Box /[
	y. Parkinson's disease O No O Yes ->	MO/YR	of diagnos	is:	\Box /[
	z. Elevated cholesterol (NEW dx by a clinician) O No O Yes \rightarrow	MO/YR	of diagnos	is:			
	aa. Hypertension (NEW dx by a clinician) O No O Yes ->	MO/YR	of diagnos	is:]/[
	bb. Osteoarthritis (NEWLY diagnosed) O No O Yes ->	MO/YR	of diagnos	is:	\Box /[****
	cc. Osteoporosis (NEWLY diagnosed) O No O Yes ->	MO/YR	of diagnos	is:	\Box /[-
	dd. Fracture due to osteoporosis O No O Yes →	MO/YR	of occuren	ce:]/[
	ee. Joint replacement O No O Yes >	MO/YR	of surgery:]/[
	ff. Fibrocystic or other benign breast disease O No O Yes → If YES, confirmed by: breast biopsy? O No O Yes aspiration? O N		of diagnos	is:]/[
	Have you EVER been diagnosed with polycystic ovary syndrome (PCOS)? O What is your CURRENT TOTAL CHOLESTEROL (mg/dl) if checked within the p O <140 mg/dl O 140-159 O 160-179 O 180-199 O 200-219 O 250-259 O 260-269 O 270-279 O 280-299 O 300-329 O 300-329	ast 2 years? O 220-2	,	AR of Dx: 240-249 It checke	L_L_γ	 m	
5.	What is your CURRENT weight?						
6.	What is your CURRENT blood pressure (mmHg)?	tolic (lower #)	O Don	't know m	iy blood pi	essure	
7.	In general, would you say your health is: O Excellent O Very good O Go	od O Fair	O Poo	r			
8. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.			'S USED I				Ī
	a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	None	1-3 O	4-10 O	11-20 O	21+ O	ŀ
	b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	0	0	õ	0	0	ŀ
			O 1000+ r	-	unknown		ŀ
	c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0	
	d. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0	ĺ

9. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or b-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes

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WOMEN'S **HEALTH STUDY**

2017 10. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities? a. Walking or hiking (include walking to work) b

b. Jogging (slower than 10 minute miles)		U		1
c. Running (10 minute miles or faster)	0	0	0	
d. Bicycling (include stationary bike)	0	0	0	
e. Aerobic exercise / aerobic dance / exercise machines	0	0	0	
f. Lower intensity exercise / yoga / stretching / toning	0	0	0	
g. Tennis, squash, or raquetball	0	0	0	
h. Lap swimming	0	0	0	Γ
i. Weight lifting / strength training	0	0	0	
j. Other: Please specify activity:	0	0	0	

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

O 3-4 flights

O None

O 1-2 flights

O 5-9 flights O 10-14 flights

O 15 or more flights

AVERAGE TIME PER WEEK

1

hour

0

0

0

0

0

0

0

0

Ο

0

O Normal, average (2-2.9mph)

1.5

hours

0

0

0

0

0

0

0

0

0

0

2-3

hours

0

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0

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4-6

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0

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7+

hours

0

0

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0

0

0

0

0

1-19

min.

О

0

zero

0

0

20-59

Ο

0

min.

12. What is your usual walking pace outdoors?

- O Don't walk regularly
- O Brisk pace (3-3.9 mph)
- O Easy, casual (less than 2 mph) O Very brisk/striding (4 mph or faster)
- 13. The following items are about activities you might do during a Yes, limited Yes, limited No, not limited typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? a little at all a lot a. Moderate activities, such as moving a table, 0 0 0 pushing a vacuum cleaner, bowling, or playing golf 0 0 0 b. Climbing several flights of stairs
- 14. 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? No Vaa Т

	165	NO
a. Accomplished less than you would like	0	0
b. Were limited in the kind of work or other activities	0	0

15. 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	0	0
b. Didn't do work or other activities as carefully as usual	0	0

- 16. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)? O Not at all O A little bit O Moderately O Quite a bit O Extremely
- 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 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?	0	0	0	0	0	0
b. Did you have a lot of energy?	0	0	0	0	0	0
c. Have you felt downhearted and blue?	0	0	0	0	0	0

18. 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.)?

O All of the time O Most of the time O Some of the time O A little of the time O None of the time

Questions 13-18 are taken from the SF-12 Health Survey (Medical Outcomes Trust) QualityMetric Incorporated. (OVER)





WOMEN'S HEALTH STUDY

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THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.					
YOUR HOME PHONE: ()	Name, address and phone of <u>someone at a different address than</u> <u>you</u> whom we may contact if we are unable to reach you:				
	NAME:				
	STREET:				
	CITY:STATE:ZIP:				
WORK PHONE: (PHONE NO:				
	THIS CONTACT IS: O Relative O Friend O Neighbor O Other				
YOUR E-MAIL ADDRESS: This is the e-mail address we have	on file:				
If it has changed, please provide your updated e-mail address below:					
, , , , , , , , , , , , , , , , ,					

19. In this question, we are interested in your use of dietary supplements over the PAST 10 YEARS. Please read down the list of supplements, one by one. Stop at any that you have taken <u>AT LEAST ONCE PER WEEK FOR A</u> <u>YEAR OVER THE PAST 10 YEARS</u> and complete the information to the right. If you have not taken the supplement once per week for at least 1 year during the past 10 years, leave the information on the line BLANK for that supplement and continue down the list.

Supplement	YEARS taken in past 10 years	Average DAYS PER WEEK	Do you take it NOW?
Multivitamins	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
Vitamin B complex	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
Vitamin A (retinol)	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
	Dose per day: O <7,000 IU O 7,00	00-15,000 IU O 16,000-20,000 IU	O >20,000+ IU O unk
Beta-carotene	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
	Dose per day: O 10-20 mg O 21-{	50 mg O 51-150 mg O >150 mg	O unk
Vitamin B1 (thiamine)	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
(as single supplement)	Dose per day: O <11mg O 11-50	mg O 51-100 mg O >100 mg	O unk
Vitamin B2 (riboflavin)	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
(as single supplement)	Dose per day: O <26 mg O 26-50	0 mg O 51-100 mg O >100 mg	O unk
Vitamin B3 (niacin)	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
(as single supplement)	Dose per day: O <51 mg O 51-20	00 mg O 201-500 mg O >500 mg	O unk
Vitamin B6 (pyridoxine)	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
(as single supplement)	Dose per day: O <10 mcg O 10-3	9 mcg O 40-80 mcg O >80 mcg	O unk
Vitamin B7 (biotin)	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
(as single supplement)	Dose per day: O <101 mcg O 101	1-2500 mcg O 2501-5000 mcg O	>5000 mcg O unk
Vitamin B9 (folic acid)	O 1-3 O 4-6 O 7-9 O 10	O 1-2 O 3-4 O 5-6 O 7	O Yes O No
(as single supplement)	Dose per day: O <401 mcg O 401	1-800 mcg O 801-1000 mcg O >1	000 mcg O unk

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WOMEN'S HEALTH STUDY 13

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Supplement	YEARS	taken i	n past 10	years	Averag	je DAYS	PER WEI	ΞK	Do you t	ake it NOW?
Vitamin B12 (cobalamin) (as single supplement)			O 7-9 O <26 m		O 1-2 6-100 mcg		O 5-6 500 mcg	O 7 O >500	Mcg Oun	O No Ik
Vitamin C	O 1-3 Dose pe		O 7-9 O <101 n		O 1-2 01-500 mg		O 5-6 1000 mg		OYes 00 mg Our	
Vitamin D (in calcium supplement or sepa			O 7-9 O <601		O 1-2		O 5-6 -2000 IU		O Yes	O No k
Vitamin E	•	O 4-6	O 7-9	O 10	0 1-2	O 3-4	O 5-6		O Yes U O unk	O No
Calcium (incl. elemental calcium in Tum	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	OYes 00 mg Oui	O No nk
Chromium	O 1-3 Dose pe		O 7-9 O <201 n				O 5-6)1-1000 m		O Yes 1000 mcg	O No O unk
Iron	O 1-3 Dose pe				O 1-2 -50 mg C				O Yes) unk	O No
Magnesium	O 1-3 Dose pe		O 7-9 O <41 m		O 1-2 -250 mg		O 5-6 0 mg (O Yes O unk	O No
Selenium	O 1-3 Dose per		O 7-9 O <80 m		O 1-2 0-130 mcg		O 5-6 250 mcg		O Yes mcg O un	O No ik
Zinc					O 1-2				O Yes O unk	<u>O No</u>
Supplement	YEARS	taken i	n past 10	years	Averag	ge DAYS	PER WEI	EK	Do you ta	ke it NOW?
Potassium	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Omega-3 fatty acids (fish oil)	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Vitamin K	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Lutein and/or zeaxanthin	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Inositol	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Choline	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Amino acids	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Glucosamine	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Chondroitin	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Green tea (EGCG)	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Coenzyme Q10	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
										-



WOMEN'S HEALTH STUDY

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Supplement	YEAI	RS taken	in past 1	0 years	Avera	ige DAYS	PER WE	EK	Do you ta	ke it NOW?
SAMe (s-adenosyl-L-methionine)	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Cranberry	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Fiber	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Probiotics	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Evening primrose (GLA)	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Para-aminobenzoic acid (PABA)	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Alpha-linolenic acid (flaxseed)	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Ginko biloba	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Soy phytoestrogen	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Methylsulfonylmethane (MSM)	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Omega-9 fatty acids	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Grape seed	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Ginseng	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Ginger	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Garlic	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Bilberry	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Bromelain	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Quercetin	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No
Echinacea	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	07	O Yes	O No
Melatonin	O 1-3	O 4-6	O 7-9	O 10	O 1-2	O 3-4	O 5-6	O 7	O Yes	O No

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PLEASE RETURN ALL PAGES OF THIS FORM (PAGES 1-6) IN THE REPLY ENVELOPE. THANKS.

O 1-2 O 3-4

O 3-4

O 3-4

O 1-2

O 1-2

O 5-6

O 5-6

O 5-6

07

O7

O 7

O Yes

O Yes

O Yes

O No

O No

O No

O 1-3

O 1-3

O 1-3

St. John's wort

Copper

lodine

O 4-6

O 4-6

O 4-6

O 7-9

O 7-9

O 7-9

O 10

O 10

O 10

	43639 2018 PI FASE LISE & BALL-POINT PEN WHEN COMPLETING	Y	14 /								
	PLEASE USE A BALL-POINT PEN WHEN COMPLETING THIS QUESTIONNAIRE. IT IMPROVES THE QUALITY OF OUR DATA. 1. Date of birth: / / / / We use DATE OF BIRTH to verify the identity of the person providing information.										
••						_					
•	V										
۷.	2. WITHIN THE PAST YEAR, have you been NEWLY DIAGNOSED with any of the following illnesses or had any of the following procedures? Please answer NO or YES on each line. IF YES, indicate the date (month/year) of the diagnosis or the procedure.										
Т	DIAGNOSIS OR PROCEDURE	NO	or YES	→	IF YES, PROVIDE MO/	YR IN BOXES BELOW					
	a. Acute coronary syndrome/unstable angina	O No	O Yes	→	MO/YR of diagnosis:						
	b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No	O No O Yes	O Yes s stress	•	MO/YR of diagnosis: O No O Yes						
-	c. Myocardial infarction (heart attack)	O No	O Yes	→	MO/YR of diagnosis:						
	d. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes	>	MO/YR of procedure:						
-	e. Coronary bypass surgery (CABG)	O No	O Yes	\rightarrow	MO/YR of procedure:						
-	f. Congestive heart failure	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 disease (not varicose veins)	O No	O Yes	→	MO/YR of diagnosis:						
	j. Pulmonary embolism (PE)	O No	O Yes	→	MO/YR of diagnosis:						
	k. Deep vein thrombosis (DVT)	O No	O Yes	→	MO/YR of diagnosis:						
	I. 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 surgery:						
	o. Melanoma	O No	O Yes	→	MO/YR of diagnosis:						
	p. Non-melanoma skin cancer What type? O basal cell O squamous cell O u	O No nknown t	O Yes ype	>	MO/YR of diagnosis:						
	q. Breast cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:						
	r. Lung cancer	O No	O Yes	→	MO/YR of diagnosis:						
	s. Colon cancer	O No	O Yes	>	MO/YR of diagnosis:						
	t. Other cancer (not including any of the above cancers) SITE:	O No	O Yes	→	MO/YR of diagnosis:						
	u. Colon polyp	O No	O Yes	>	MO/YR of diagnosis:						
	v. Diabetes mellitus (NEWLY diagnosed)	O No	O Yes	→	MO/YR of diagnosis:						



2. (continued) NEWLY DIAGNOSED IN THE LAST YEAR? IF YES, PROVIDE DATE (MO/YR) IN BOXES BELOW O No O Yes \rightarrow MO/YR of diagnosis: w. Migraine headaches (NEWLY diagnosed) O No O Yes \rightarrow MO/YR of diagnosis: x. Other headaches (NEWLY diagnosed) \rightarrow O No O Yes MO/YR of diagnosis: y. Parkinson's disease O Yes \rightarrow O No MO/YR of diagnosis: z. Elevated cholesterol (NEW dx by a clinician) O No O Yes \rightarrow MO/YR of diagnosis: aa. Hypertension (NEW dx by a clinician) O No O Yes \rightarrow MO/YR of diagnosis: bb. Osteoarthritis (NEWLY diagnosed) \rightarrow O No O Yes MO/YR of diagnosis: cc. Osteoporosis (NEWLY diagnosed) O Yes \rightarrow O No dd. Fracture due to osteoporosis MO/YR of occurence: O No O Yes \rightarrow MO/YR of surgery: ee. Joint replacement O Yes \rightarrow O No MO/YR of diagnosis: ff. Fibrocystic or other benign breast disease O No O Yes aspiration? O No If YES, confirmed by: breast biopsy? O Yes 3. What is your CURRENT TOTAL CHOLESTEROL (mg/dl) if checked within the past year? O 160-179 O 180-199 O 200-219 O 220-239 O 240-249 O <140 mg/dl O 140-159 O 330+ O unknown/not checked in past year O 260-269 O 270-279 O 280-299 O 300-329 O 250-259 pounds 4. What is your CURRENT weight? 5. What is your CURRENT blood pressure (mmHg)? O Don't know my blood pressure systolic (upper #) diastolic (lower #) Questions 6-12 BELOW are taken from the SF-12 Health Survey (Medical Outcomes Trust) QualityMetric Incorporated and the RAND 36-Item Health Survey 1.0. 6. In general, would you say your health is: O Excellent O Very good O Good O Fair O Poor 7. The following items are about activities you might do during a No, not limited Yes, limited Yes, limited

typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? a lot a little at all a. Vigorous activities, such as running, lifting heavy 0 0 0 objects, participating in strenuous sports b. Moderate activities, such as moving a table, 0 0 0 pushing a vacuum cleaner, bowling, or playing golf 0 c. Lifting or carrying groceries 0 0 0 0 0 d. Climbing several flights of stairs 0 0 0 e. Climbing one flight of stairs f. Bending, kneeling, or stooping 0 0 0 g. Walking more than a mile 0 0 0 0 0 0 h. Walking several blocks 0 0 0 i. Walking one block j. Bathing or dressing yourself 0 0 0

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2018	

WOMEN'S **HEALTH STUDY**

14 /

8. 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?

AS A RESULT OF TOUR PHISICAL REALTH?	Yes	No
a. Cut down the amount of time you spent on work or other activities	0	0
b. Accomplished less than you would like	0	0
c. Were limited in the kind of work or other activities	0	0
 d. Had difficulty performing the work or other activities (for example, it took extra effort) 	0	0

9. 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	0	0
b. Didn't do work or other activities as carefully as usual	0	0

- 10. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)? O Not at all O A little bit O Moderately O Quite a bit O Extremely
- 11. 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?	0	0	0	0	0	0
b. Did you have a lot of energy?	0	0	0	0	0	0
c. Have you felt downhearted and blue?	0	0	0	0	0	0

12. 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.)?

O All of the time O Most of the time O Some of the time O A little of the time O None of the time

DURING THE PAST YEAR, what was your approximate		AVERAGE TIME PER WEEK								
AVERAGE TIME PER WEEK spent at each of the following recreational activities?	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)	0	0	0	0	0	0	0	0		
b. Jogging (slower than 10 minute miles)	0	0	0	0	0	0	0	0		
c. Running (10 minute miles or faster)	0	0	0	0	0	0	0	0		
d. Bicycling (include stationary bike)	0	0	0	0	0	0	0	0		
e. Aerobic exercise / aerobic dance / exercise machines	0	0	0	0	0	0	0	0		
f. Lower intensity exercise / yoga / stretching / toning	0	0	0	0	0	0	0	0		
g. Tennis, squash, or raquetball	0	0	0	0	0	0	0	0		
h. Lap swimming	0	0	0	0	0	0	0	0		
i. Weight lifting / strength training	0	0	0	0	0	0	0	0		
j. Other: Please specify activity:	0	0	0	0	0	0	0	0		

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

O None

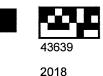
O 1-2 flights O 3-4 flights

o 5-9 flights

O 10-14 flights

O 15 or more flights

(OVER)





15. What is your usual walking pace outdoors?

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

O Normal, average (2-2.9mph)

90+

hours

0

0

0

0

0

0

AVERAGE HOURS PER WEEK 16. DURING THE PAST YEAR, what was your approximate AVERAGE TIME 41-60 61-90 1 2-5 6-10 11-20 21-40 IN HOURS PER WEEK spent at each of the following sedentary activities? zero hour hours hours hours hours hours hours a. Sitting at work or away from home or while driving (hrs/week) 0 0 0 Ο 0 0 0 b. Sitting at home while watching TV/VCR/DVD or using the computer (hrs/week) 0 0 0 0 0 0 0 c. Other sitting at home (e.g. reading, meal times, at desk) (hrs/week) 0 0 0 0 0 Ο 0

17. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blocker, angiotensin receptor or beta-blocker, ACE inhibitor)	O Yes	O No
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O Yes	O No
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O Yes	O No

18. Do you think you might have gum disease? O Yes O No O Don't know

19. Overall, how would you rate the health of your teeth and gums?

O Excellent O Very good O Good O Fair O Poor O Don't know

20. Have you EVER had treatment for gum disease such as scaling and root planing, sometimes called "deep cleaning?"

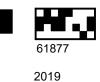
O Yes O No O Don't know

- O No O Don't know O Yes 21. Have you EVER been told by a dental professional that you lost bone around your teeth?
- 22. Aside from brushing your teeth with a toothbrush, in the LAST 7 DAYS, on how many DAYS did you use dental floss or any other device to clean between your teeth? 00 01 **O** 2 O3 O4 **O** 5 **O** 6 07
- 23. In the PAST 12 MONTHS, have you visited a dentist or dental hygienist? O Yes O No O Don't know
- 24. How often do you usually visit the dental office for routine check-ups or cleanings?
 - O More than once per year O Once per year O Less than once per year O Don't know

THE INFORMATION BELOW ASSIS	STS US IN MAINTAINING FOLLOW-UP.							
YOUR HOME PHONE: OUR -	Name, address and phone of <u>someone at a different address than</u> <u>you</u> whom we may contact if we are unable to reach you:							
	NAME:							
	CITY:STATE:ZIP:							
	PHONE NO: THIS CONTACT IS: O Relative O Friend O Neighbor O Other							
YOUR E-MAIL ADDRESS: This is the e-mail address we have								
<u>If it has changed</u> , please provide your updated e-mail address below:								

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	NT PEN WHEN COMPLETING	THIS QU		AIRE.	IT IMPROVES THE QUA				
1. Date of birth: /	/ We use DAT	e of Bi	RTH to ve	rify the	e identity of the person	providing information.			
Is the DOB above correct	<u>t?</u> O Yes O № → IF I	NO, what	is your c	orrect	date of birth?				
2. WITHIN THE PAST YEAR, have you been NEWLY DIAGNOSED with any of the following illnesses or had any of the following procedures? Please answer NO or YES on each line. IF YES, indicate the date (month/year) of the diagnosis or the procedure.									
DIAGNOS	SIS OR PROCEDURE	NO d	or YES	>	IF YES, PROVIDE MO/	YR IN BOXES BELOW			
a. Acute coronary syndror	ne/unstable angina	O No	O Yes	→	MO/YR of diagnosis:				
b. Angina pectoris	ngiogram/cardiac cath? O No	O No O Yes	O Yes	\rightarrow s test?	MO/YR of diagnosis: O No O Yes				
c. Myocardial infarction (h		O No	O Yes		MO/YR of diagnosis:				
d. Coronary angioplasty (F		O No	O Yes	-	MO/YR of procedure:				
e. Coronary bypass surge	ry (CABG)	O No	O Yes	→	MO/YR of procedure:				
f. Congestive heart failure		O No	O Yes	>	MO/YR of diagnosis:				
g. Atrial fibrillation		O No	O Yes	\rightarrow	MO/YR of diagnosis:				
h. Intermittent claudication	1	O No	O Yes	→	MO/YR of diagnosis:				
i. Peripheral artery diseas	e (not varicose veins)	O No	O Yes	→	MO/YR of diagnosis:				
j. Pulmonary embolism (P	E)	O No	O Yes	\rightarrow	MO/YR of diagnosis:				
k. Deep vein thrombosis (DVT)	O No	O Yes	→	MO/YR of diagnosis:				
I. Stroke		O No	O Yes	\rightarrow	MO/YR of diagnosis:				
m. TIA (transient ischemic	attack)	O No	O Yes	\rightarrow	MO/YR of diagnosis:				
n. Carotid artery surgery (endarterectomy)	O No	O Yes	\rightarrow	MO/YR of surgery:				
o. Melanoma		O No	O Yes	\rightarrow	MO/YR of diagnosis:				
p. Non-melanoma skin ca What type? O basal o		O No nknown t	O Yes ype	>	MO/YR of diagnosis:				
q. Breast cancer		O No	O Yes	→	MO/YR of diagnosis:				
r. Lung cancer		O No	O Yes	\rightarrow	MO/YR of diagnosis:				
s. Colon cancer		O No	O Yes	\rightarrow	MO/YR of diagnosis:				
t. Other cancer (not includ SITE:	ling any of the above cancers)	O No	O Yes	\rightarrow	MO/YR of diagnosis:				
u. Colon polyp		O No	O Yes	\rightarrow	MO/YR of diagnosis:				
v. Diabetes mellitus (NEW	/LY diagnosed)	O No	O Yes	→	MO/YR of diagnosis:				

Office use: O 1 O 2 O 3 O 4



2. (continued) NEWLY DIAGNOSED IN LAST 2 YEARS?	\longrightarrow	► IF YES, I	PROVID	E DATE (MO/YR) IN BO	XES BELOW
w. Migraine headaches (NEWLY diagnosed)	O No	O Yes	→	MO/YR of diagnosis:	
x. Other headaches (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
y. Parkinson's disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
z. Elevated cholesterol (NEW dx by a clinician)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
aa. Hypertension (NEW dx by a clinician)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
bb. Osteoarthritis (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
cc. Osteoporosis (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
dd. Fracture due to osteoporosis	O No	O Yes	\rightarrow	MO/YR of occurrence:	
ee. Joint replacement	O No	O Yes	\rightarrow	MO/YR of surgery:	
ff. Fibrocystic or other benign breast disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
If YES, confirmed by: breast biopsy? O No	O Yes	aspiration?	O No	O Yes	

3. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.		DAYS USED IN THE PAST MONTH				
		1-3	4-10	11-20	21+	
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0	
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) On days taking, TOTAL DOSE per day:	0	0	0	0	0	
O <100 mg O 100-499 mg O 500-999 mg O 1000+ mg O unknown						
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0	
d. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0	

4. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or b-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes

5. What is your CURRENT weight?

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Questions 6-18 are from the RAND SF-36 Short Form Survey

6. In general, would you say your health is: O Excellent O Very good O Good O Fair O Poor

7. COMPARED TO ONE YEAR AGO, how would you rate your health in general NOW?

O Much better now than one year ago O Somewhat better now than one year ago O About the same

O Somewhat worse now than one year ago O Much worse now than one year ago



8. 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?

activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, not limited at all
 a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports 	0	0	0
 b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf 	0	0	0
c. Lifting or carrying groceries	0	0	0
d. Climbing several flights of stairs	0	0	0
e. Climbing one flight of stairs	0	0	0
f. Bending, kneeling, or stooping	0	0	0
g. Walking more than a mile	0	0	0
h. Walking several blocks	0	0	0
i. Walking one block	0	0	0
j. Bathing or dressing yourself	0	0	0

9. 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?

	No	Yes
a. Cut down the amount of time you spent on work or other activities	0	0
b. Accomplished less than you would like	0	0
c. Were limited in the kind of work or other activities	0	0
d. Had difficulty performing the work or other activities (for example, it took extra effort)	0	0

10. 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)?

	No	Yes
a. Cut down the amount of time you spent on work or other activities	0	0
b. Accomplished less than you would like	0	0
c. Didn't do work or other activities as carefully as usual	0	0

11. During the PAST 4 WEEKS, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

O Not at all O Slightly O Moderately O Quite a bit O Extremely

12. How much BODILY pain have you had during the PAST 4 WEEKS?

O None O Very mild O Mild O Moderate O Severe O Very severe

13. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)? O Not at all O A little bit O Moderately O Quite a bit O Extremely



14. 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. Did you feel full of pep?	0	0	0	0	0	0
b. Have you been a very nervous person?	0	0	0	0	0	0
c. Have you felt so down in the dumps that nothing could cheer you up?	0	0	Ο	0	0	0
d. Have you felt calm and peaceful?	0	0	0	0	0	0
e. Did you have a lot of energy?	0	0	0	0	0	0
f. Have you felt downhearted and blue?	0	0	0	0	0	0
g. Did you feel worn out?	0	0	0	0	0	0
h. Have you been a happy person?	0	0	0	0	0	0
i. Did you feel tired?	0	0	0	0	0	0

15. 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.)?

O All of the time O Most of the time O Some of the time O A little of the time O None of the time

16. How TRUE or FALSE is EACH of the following statements for you.

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	0	0	0	0	0
b. I am as healthy as anybody I know	0	0	0	0	0
c. I expect my health to get worse	0	0	0	0	0
d. My health is excellent	0	0	0	0	0

Please answer No or Yes for each of the following questions about your memory:	No	Yes
a. Have you recently experienced any change in your ability to remember things?	0	0
b. Do you have more trouble than usual remembering recent events?	0	0
c. Do you have more trouble than usual remembering a short list of items, such as a shopping list?	0	0
d. Do you have trouble remembering things from one second to the next?	0	0
e. Do you have difficulty in understanding or following spoken instructions?	0	0
f. Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?	0	0



18. Have you ever had migraine headaches?O No, please proceed to the contact information at the bottom of this pageO Yes, please proceed to the next question
19. At what age did your migraine headaches first begin?
O ≤10 years old O 11-20 years old O 21-30 years old O 31-50 years old O >50 years old
20. How often have you experienced aura before a migraine headache?O NeverO SometimesO Always
21. Do you ever experience aura which is NOT followed by a migraine headache?
 O No O Yes → Is this aura similar to the aura you experience prior to a migraine headache? O Yes, it is similar O No, it is not similar O Some auras are similar and some are not similar O I do not experience aura prior to my migraine headaches
22. In the past year, have you had migraine headaches?
O No, please go to questions 22a and 22b O Yes → What was the frequency of your migraine headaches in the past year? O Daily O Weekly O Monthly O Every other month
✓ O Less than 6 times per year
22a. At what age did your migraine headaches stop? O ≤50 O 51-55 O 56-60 O 61-65 O 66-70 O >70 years old

22b. Are there times when you think you may get a migraine, but the headache pain does not occur? O No O Yes

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.				
YOUR HOME PHONE: ()	Name, address and phone of <u>someone at a different address than</u> <u>you</u> whom we may contact if we are unable to reach you:			
YOUR CELL PHONE: ()	NAME:			
YOUR WORK PHONE: ()	CITY: STATE: ZIP: PHONE NO: THIS CONTACT IS: O Relative O Friend O Neighbor O Other			
YOUR E-MAIL ADDRESS: This is the e-mail address we have If it has changed, please provide your updated e-mail addres				

Thank you! Please return the questionnaire in the pre-paid envelope provided.



WOMEN'S	10
HEALTH STUDY	15

	-							
WOMEN'S 31461 HEALTH STUDY	16	1						
PLEASE USE A BALL-POINT PEN WHEN COMPLETING		STIONNAIRE.	IT IMPROVES THE QUALITY OF OUR DATA.					
1. Date of birth:	TE OF BIRT	H to verify the	e identity of the person providing information.					
<u>Is the DOB above correct?</u> O Yes O № → IF N	NO, what is	your correct	date of birth?					
2. WITHIN THE PAST YEAR, have you been NEWLY DIAGN	NOSED with	h any of the fo	bllowing illnesses or had any of the following					
procedures? Please answer NO or YES on each line. IF YES, indicate the date (month/year) of the diagnosis or the procedure.								
	NO or `	YES ->	IF YES, PROVIDE MO/YR IN BOXES BELOW					
a. Acute coronary syndrome/unstable angina	O No C	O Yes →	MO/YR of diagnosis:					
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No	O No (O Yes	O Yes →	MO/YR of diagnosis: / / /					
	-	stress test?						
c. Myocardial infarction (heart attack)	O No (^{OYes} →	MO/YR of diagnosis:					
d. Coronary angioplasty (PTCA or PCI) or stent	O No C	O Yes →	MO/YR of procedure:					
e. Coronary bypass surgery (CABG)	O No C	O Yes 🗲	MO/YR of procedure:					
f. Congestive heart failure	O No (O Yes 🗲	MO/YR of diagnosis:					
g. Atrial fibrillation	O No C	O Yes 🗲	MO/YR of diagnosis:					
h. Intermittent claudication	O No C	O Yes 🗲	MO/YR of diagnosis:					
i. Peripheral artery disease (not varicose veins)	O No C	O Yes 🗲	MO/YR of diagnosis:					
j. Pulmonary embolism (PE)	O No C	O Yes 🔶	MO/YR of diagnosis:					
k. Deep vein thrombosis (DVT)	O No C	O Yes 🗲	MO/YR of diagnosis:					
I. Stroke	O No C	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 C	O Yes 🔸	MO/YR of surgery:					
o. Melanoma	O No C	O Yes 🔶	MO/YR of diagnosis:					
p. Non-melanoma skin cancer What type? O basal cell O squamous cell O u	O No C	O Yes → e	MO/YR of diagnosis:					
q. Breast cancer	O No C	O Yes 🔸	MO/YR of diagnosis:					
r. Lung cancer	O No C	O Yes 🔶	MO/YR of diagnosis:					
s. Colon cancer	O No C	O Yes 🔸	MO/YR of diagnosis:					
t. Other cancer (not including any of the above cancers) SITE:	O No C	O Yes 🗲	MO/YR of diagnosis:					
u. Colon polyp	O No C	O Yes 🔸	MO/YR of diagnosis:					
v. Diabetes mellitus (NEWLY diagnosed)	O No C	O Yes 🔶	MO/YR of diagnosis:					



2. (continued) NEWLY DIAGNOSED WITHIN THE PAST	YEAR? —	-> IF YE	S, PRO	VIDE DATE (MO/YR) IN	BOXES BELOW
w. Migraine headaches (NEWLY diagnosed)	O No	O Yes	→	MO/YR of diagnosis:	
x. Other headaches (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
y. Parkinson's disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
z. Elevated cholesterol (NEW dx by a clinician)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
aa. Hypertension (NEW dx by a clinician)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
bb. Osteoarthritis (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
cc. Osteoporosis (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
dd. Fracture due to osteoporosis	O No	O Yes	\rightarrow	MO/YR of occurrence:	
ee. Joint replacement	O No	O Yes	\rightarrow	MO/YR of surgery:	
ff. Fibrocystic or other benign breast disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
If YES, confirmed by: breast biopsy? O No	O Yes	aspiration?	O No	O Yes	

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3. Has a doctor or another healthcare professional diagnosed you as having had or probably having had the coronavirus (COVID-19)?

O No O Yes O Not sure

IF YES:

a. Please provide date (MO/YR) of diagnosis:

WOMEN'S

HEALTH STUDY

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b. Was this confirmed by a COVID-19 test? O No O Yes

c. What kind of test(s) did you have? MARK ALL THAT APPLY.

- O Nasal swab (testing for presence of the virus)
- O Saliva test (testing for presence of the virus or for antibodies/immune response)
- O Throat swab (testing for presence of the virus)
- O Blood test (testing for antibodies/immune response)

d. Which test(s) came back positive? MARK ALL THAT APPLY.

- O None of the tests
- O Nasal swab
- O Saliva test
- O Throat swab
- O Blood test

e. Were you hospitalized? O No O Yes

f. Did you require treatment in an Intensive Care Unit (ICU)? O No O Yes







4. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.		DAYS USED IN THE PAST MONTH					
		1-3	4-10	11-20	21+		
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0		
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) On days taking, TOTAL DOSE per day:	0	0	0	0	0		
O <100 mg O 100-499 mg O 500-999 mg O 1000+ mg O unknown							
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0		
d. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0		

5. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or b-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes

Questions 6-7 are from the RAND SF-36 Short Form Survey

6. In general, would you say your CURRENT health is: O Excellent O Very good O Good O Fair O Poor

7. Please answer NO or YES for each of the following questions about your memory:	No	Yes
a. Have you recently experienced any change in your ability to remember things?	0	0
b. Do you have more trouble than usual remembering recent events?	0	0
c. Do you have more trouble than usual remembering a short list of items, such as a shopping list?	0	0
d. Do you have trouble remembering things from one second to the next?	0	0
e. Do you have difficulty in understanding or following spoken instructions?	0	0
f. Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?	0	0

8. DURING THE PAST YEAR, what was your approximate	AVERAGE TIME PER WEEK							
AVERAGE TIME PER WEEK spent at each of the following recreational activities?	0 min.	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)	0	0	0	0	0	0	0	0
b. Jogging (slower than 10 minute miles)	0	0	0	0	0	0	0	0
c. Running (10 minute miles or faster)	0	0	0	0	0	0	0	0
d. Bicycling (include stationary bike)	0	0	0	0	0	0	0	0
e. Aerobic exercise / aerobic dance / exercise machines	0	0	0	0	0	0	0	0
f. Lower intensity exercise / yoga / stretching / toning	0	0	0	0	0	0	0	0
g. Tennis, squash, or raquetball	0	0	0	0	0	0	0	0
h. Lap swimming	0	0	0	0	0	0	0	0
i. Weight lifting / strength training	0	0	0	0	0	0	0	0
j. Other: Please specify activity:	0	0	0	0	0	0	0	0

Page 4		Page	4
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10. What is your usual walking pace of	utdoors?									
O Don't walk regularly O Brisk pace (3-3.9 mph)	O Easy, casual (less than 2 mp O Very brisk/striding (4 mph or			O Norn	nal, ave	rage (2-	-2.9 mp	h)		
				AVE	RAGE	HOURS	PER V	VEEK		
11. DURING THE PAST YEAR, on avera HOURS PER WEEK did you spend		0 min.	1 hour	2-5 hours	6-10 hours	11-20 hours	21-40 hours	41-60 hours	61-90 hours	90+ hours
a. Sitting at work or away from home	or while driving	0	0	0	0	0	0	0	0	0
b. Sitting at home while watching TV/	VCR/DVD or using the computer	0	0	0	0	0	0	0	0	0
c. Other sitting at home (e.g., reading	ı, meal times, at desk)	0	0	0	0	0	0	0	0	0
 14. What is your CURRENT blood press 15. What is your CURRENT total choice O <140 mg/dl O 140-159 	systolic (upper #)	O 200-	year?	C (lower ; 0 22/)+ 0] #) 0 -2 39	Don't k O 24 wn/not c	0-249			e
	– <u>you</u> wh	address nom we	s and p may co	ohone o ontact i	f <u>some</u> f we are	one at e unabl	e to rea	ach you	:	<u>ıan</u>
YOUR () -								-		
		ONTAC	TIS: C	Relativ	ve Ol	Friend	O Nei	ghbor	O Oth	er
YOUR E-MAIL ADDRESS: This is the e	e-mail address we have on file: be willing to share your e-mail ad	<u>ddress</u> ,	please	e provic	le your	update	d e-ma	il addro	ess bel	ow:

WOMEN'S
HEALTH STUDY

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

O 3-4 flights

16 /

O 10-14 flights

O 5-9 flights

O 15 or more flights

Thank you! Please return the questionnaire in the pre-paid envelope provided.

O None

O 1-2 flights

31508 WOMEN'S HEALTH STUDY] 17	, [
PLEASE USE A BALL-POINT PEN WHEN COMPLETING	THIS QU	ESTION	NAIRE. I	T IMPROVES THE QUAL	ITY OF OUR DATA.				
			-	identity of the person p late of birth?	providing information.				
V		-							
2. WITHIN THE PAST YEAR, have you been NEWLY DIAGNOSED with any of the following illnesses or had any of the following procedures? Please answer NO or YES on each line. IF YES, indicate the date (month/year) of the diagnosis or the procedure.									
DIAGNOSIS OR PROCEDURE	NO o	or YES	\rightarrow	IF YES, PROVIDE MO/Y	R IN BOXES BELOW				
a. Acute coronary syndrome/unstable angina	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No	O No O Yes	O Yes stree	→ ss test?	MO/YR of diagnosis: O No O Yes					
c. Myocardial infarction (heart attack)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
d. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes	→	MO/YR of procedure:					
e. Coronary bypass surgery (CABG)	O No	O Yes	\rightarrow	MO/YR of procedure:					
f. Congestive heart failure	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
g. Atrial fibrillation	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
h. Intermittent claudication	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
i. Peripheral artery disease (not varicose veins)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
j. Pulmonary embolism (PE)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
k. Deep vein thrombosis (DVT)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
I. Stroke	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
m. TIA (transient ischemic attack)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
n. Carotid artery surgery (endarterectomy)	O No	O Yes	\rightarrow	MO/YR of surgery:					
o. Melanoma	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
p. Non-melanoma skin cancer What type? O basal cell O squamous cell O u	O No nknown ty	O Yes /pe	→	MO/YR of diagnosis:					
q. Breast cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
r. Lung cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
s. Colon cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
t. Other cancer (not including any of the above cancers) SITE:	O No	O Yes	>	MO/YR of diagnosis:					
u. Colon polyp	O No	O Yes	\rightarrow	MO/YR of diagnosis:					
v. Diabetes mellitus (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:					



HEALTH STUDY 17 /

WOMEN'S

2. (continued) NEWLY DIAGNOSED WITHIN THE PAST	YEAR? -	-> IF YE	S, PRO	VIDE DATE (MO/YR) IN	BOXES BELOW
w. Migraine headaches (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
x. Other headaches (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
y. Parkinson's disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
z. Elevated cholesterol (NEW dx by a clinician)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
aa. Hypertension (NEW dx by a clinician)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
bb. Osteoarthritis (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
cc. Osteoporosis (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
dd. Fracture due to osteoporosis	O No	O Yes	\rightarrow	MO/YR of occurrence:	
ee. Joint replacement	O No	O Yes	\rightarrow	MO/YR of surgery:	
ff. Fibrocystic or other benign breast disease	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
If YES, confirmed by: breast biopsy? O No	O Yes	aspiration?	O No	O Yes	

3. IN THE PAS	3. IN THE PAST YEAR, have you had any of the following? (Please answer on each line)			Yes, for screening
	a. Colonoscopy	0	0	0
	b. Sigmoidoscopy	0	0	0
	c. Mammogram	0	0	0
	d. Fasting blood sugar	0	0	0
	e. Eye exam	0	0	0
	f. Bone density exam (DEXA)	0	0	0

4. Have you EVER been diag	nosed by	y a doctor	or healthcare professional as having had or probably having had the
coronavirus (COVID-19)?	O No	O Yes	O Not sure

IF YES: Please provide date (MO/YR) of diagnosis:

/	

5. Have you EVER been tested for the coronavirus (COVID-19, SARS-CoV-2) and/or its antibodies? O No O Yes O Not sure

IF YES: Have you had at least one test with a POSITIVE result? O No O Yes O Not sure

IF YES: Please provide the date (MO/YR) of your FIRST POSITIVE test:

6. Have you EVER been hospitalized due to COVID-19? O No O Yes O Not sure

IF YES: a. When were you hospitalized? (MO/YR)

b. Did you require treatment in an Intensive Care Unit (ICU)? O No O Yes O Not sure

7. Have you received at least one dose of a COVID-19 vaccine	? O No	O Yes	O Not sure
--	--------	-------	------------

IF YES: a. When die	d you FIRST get the va	accine? (MO/YR)
b. Which va	accine did you receive	?

O Moderna O Pfizer-BioNTech O Johnson & Johnson / Janssen O Other O Not sure

8. Did you receive the influenza (flu) vaccine after August 2020? O No O Yes O Not sure



9. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or beta-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes

10. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.

DAYS USED IN THE PAST MONTH

-	None	1-3	4-10	11-20	21+
a. Multivitamins	0	0	0	0	0
b. SINGLE supplements of omega-3 fatty acids (fish oil)	0	0	0	0	0
c. SINGLE supplements of calcium (include elemental calcium in Tums) What dose per day (elemental calcium)?	0	0	0	0	0
O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown					
d. SINGLE supplements of vitamin D (in calcium supplements or separately) What dose per day?	0	0	0	0	0
O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown					

11. Are you CURRENTLY taking any of the following drugs for prevention or treatment of bone loss? (Mark ALL that apply)

O Fosamax	(alendronate)	O Evista (raloxifene) O A	ctonel (risedronate)	O Reclast (zo	ledronic acid)
O Boniva	O Forteo (teripa	aratide injection)	O Miaca	alcin or Fortical (calc	itonin-salmon)	O Tymlos (abaloparatide) injection
O Evenity (r	omosozumab)	O Prolia (denosum	nab)	O Other osteoporos	sis medication, no	ot listed above
O I do NOT	take any medica	tions for bone loss tre	eatment/	prevention		

12. What is your CURRENT w	eight?	oounds			
13. What is your CURRENT he		nches			
14. What is your CURRENT bl	ood pressure (mmHg) [;]	systolic (upper #)	diastolic (lo		know my blood pressure
15. Do you CURRENTLY smol	ke cigarettes? O No		ES: On average, ho you smoke (1 pack		es/day cigs/day
16. What is your CURRENT to	tal cholesterol (mg/dl)	if checked within t	he past year?		
O <140 mg/dl O 140	-159 O 160-179	O 180-199	O 200-219 O	220-239 O 24	0-249
O 250-259 O 260-269	O 270-279 O 2	80-299 O 300-	-329 O 330+	O unknown/not o	checked in past year
17. What is your CURRENT H	DL-CHOLESTEROL (m	g/dl) if checked wi	thin the past 2 ye	ars?	
O <30 mg/dl O 30-3	39 O 40-49	O 50-59	O 60-69 O	70-79	
O 80-89 O	90-99 O 100+	O unknown/not cl	necked in 2 yrs		
Questions 18-24 are from th	e RAND SF-36 Short F	orm Survey			
18. In general, would you say y	our CURRENT health i	s: O Excellent	O Very good O	Good O Fair	O Poor





9. Please answer NO or YES for each of the following questions about your memory:	No	Yes
a. Have you recently experienced any change in your ability to remember things?	0	0
b. Do you have more trouble than usual remembering recent events?	0	0
c. Do you have more trouble than usual remembering a short list of items, such as a shopping list?	0	0
d. Do you have trouble remembering things from one second to the next?	0	0
e. Do you have difficulty in understanding or following spoken instructions?	0	0
f. Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?	0	0

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 YOUR PHYSICAL HEALTH? No Voc

	NO	163
a. Cut down the amount of time you spent on work or other activities	0	0
b. Accomplished less than you would like	0	0
c. Were limited in the kind of work or other activities	0	0
d. Had difficulty performing the work or other activities (for example, it took extra effort)	0	0

21. 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)? Na Vac

	NO	tes
a. Accomplished less than you would like	0	0
b. Didn't do work or other activities as carefully as usual	0	0

- 22. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)? O Not at all O A little bit O Moderately O Quite a bit O Extremely
- 23. 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?	0	0	0	0	0	0
b. Did you have a lot of energy?	0	0	0	0	0	0
c. Have you felt downhearted and blue?	0	0	0	0	0	0

24. During the PAST 4 WEEKS (apart from COVID-related restrictions), how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

> O All of the time O Most of the time O Some of the time

O A little of the time

O None of the time

YOUR E-MAIL ADDRESS: This is the e-mail address we have on file	:
If it has changed, or you would now be willing to share your e-mail	address , please provide your updated e-mail address below:

61945 WOMEN'S HEALTH STUDY] 18	8 / [
PLEASE USE A BALL-POINT PEN WHEN COMPLETING	THIS QU	ESTION	NAIRE.	IT IMPROVES THE QUAL	ITY OF OUR DATA.
1. Date of birth: / / We use DAT	TE OF BII	RTH to v	erify the	e identity of the person p	providing information.
Is the DOB above correct? O Yes O No → IF I	NO, what	is your	correct	date of birth? /	
2. WITHIN THE PAST YEAR, have you been NEWLY DIAG					
procedures? Please answer NO or YES on each line. IF DIAGNOSIS OR PROCEDURE		or YES	e date (i	IF YES, PROVIDE MO/Y	-
a. Acute coronary syndrome/unstable angina	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		ss test?	O No O Yes	
c. Myocardial infarction (heart attack)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
d. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes	\rightarrow	MO/YR of procedure:	
e. Coronary bypass surgery (CABG)	O No	O Yes	\rightarrow	MO/YR of procedure:	
f. Congestive heart failure	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
g. Atrial fibrillation	O No	O Yes	>	MO/YR of diagnosis:	
h. Intermittent claudication	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
i. Peripheral artery disease (not varicose veins)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
j. Pulmonary embolism (PE)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
k. Deep vein thrombosis (DVT)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
I. Stroke	O No	O Yes	\rightarrow	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	\rightarrow	MO/YR of surgery:	
o. Melanoma	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
p. Non-melanoma skin cancer What type? O basal cell O squamous cell O u	O No nknown t	O Yes ype	\rightarrow	MO/YR of diagnosis:	
q. Breast cancer	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
r. Lung cancer	O No	O Yes	>	MO/YR of diagnosis:	
s. Colon cancer	O No	O Yes	>	MO/YR of diagnosis:	
t. Other cancer (not including any of the above cancers) SITE:	O No	O Yes	→	MO/YR of diagnosis:	
u. Colon polyp	O No	O Yes	\rightarrow	MO/YR of diagnosis:	
v. Diabetes mellitus (NEWLY diagnosed)	O No	O Yes	\rightarrow	MO/YR of diagnosis:	

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2. (continued) NEWLY DIAGNOSED WITHIN THE PAS	TYEAR? \longrightarrow IF YES, PROVIDE DATE (MO/YR) IN BOXES BELOW
w. Migraine headaches (NEWLY diagnosed)	O No O Yes → MO/YR of diagnosis:
x. Other headaches (NEWLY diagnosed)	O No O Yes → MO/YR of diagnosis:
y. Parkinson's disease	O No O Yes → MO/YR of diagnosis:
z. Elevated cholesterol (NEW dx by a clinician)	O No O Yes → MO/YR of diagnosis:
aa. Hypertension (NEW dx by a clinician)	O No O Yes → MO/YR of diagnosis:
bb. Osteoarthritis (NEWLY diagnosed)	O No O Yes → MO/YR of diagnosis:
cc. Osteoporosis (NEWLY diagnosed)	O No O Yes → MO/YR of diagnosis:
dd. Fracture due to osteoporosis	O No O Yes -> MO/YR of occurrence:
ee. Joint replacement	O No O Yes → MO/YR of surgery:
ff. 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
. In general, would you say your CURRENT health is:	
	pounds 5. What is your CURRENT height?
. What is your CURRENT blood pressure (mmHg)?	systolic (upper #) diastolic (lower #) O Don't know my blood pressur
. Do you CURRENTLY smoke cigarettes? O No	O Yes
. Did you receive the <u>influenza (flu)</u> vaccine after Aug	gust 2021? O No O Yes
. Have you EVER been diagnosed by a doctor or heal coronavirus (COVID-19)? O No O Yes	Ithcare professional as having had or probably having had the
IF YES: a. Please provide date (MO/YR) of diagnosis:	
b. Have you EVER been hospitalized due to C	COVID-19? O No O Yes
IF YES: i. When were you hospitalized? (MC	
ii. Did you require treatment in an In	ntensive Care Unit (ICU)? O No O Yes
0. Have you EVER been tested for the coronavirus (C	COVID-19, SARS-CoV-2) and/or its antibodies? O No O Yes
IF YES: a. Have you had at least one test with a POS	SITIVE result? O No O Yes
b. Please provide the date (MO/YR) of your F	
1. Have you received at least one dose of a COVID-19	9 vaccine? O No O Yes
IF YES: a. When did you FIRST get the vaccine? (Mo	O/YR) $/$ \rightarrow Date of SECOND dose, if applicable: $/$
b. Which vaccine did you receive? O Moder	rna O Pfizer-BioNTech O Johnson & Johnson
c. Have you received a booster shot? O No	o O Yes
IF YES: Which booster did you receive? O	Moderna O Pfizer-BioNTech O Johnson & Johnson
	Page 2 PLEASE CONTINUE ON THE NEXT PAGE





18 /

12. Since January 2020 (PAST 2 YEARS), have you experienced any of these symptoms that may occur with conditions such as allergies, colds and flu, COVID-19 or when taking certain medications?

			Duration of symptom					
	Did not have this symptom	Less than 2 weeks	2 weeks to less than 8 weeks	8 weeks to less than 6 months	6 months or more	CURRENTLY present?		
a. Fever	0	0	0	0	0	O Yes		
b. Persistent cough	0	0	0	0	0	O Yes		
c. Chills or sweats	0	0	0	0	0	O Yes		
d. Headache	0	0	0	0	0	O Yes		
e. Sore throat	0	0	0	0	0	O Yes		
f. Hoarseness	0	0	0	0	0	O Yes		
g. Loss of smell or taste	0	0	0	0	0	O Yes		
h. Shortness of breath/difficulty breathing	0	0	0	0	0	O Yes		
i. Chest pain/tightness	0	0	0	0	0	O Yes		
j. Muscle aches	0	0	0	0	0	O Yes		
k. Abdominal pain	0	0	0	0	0	O Yes		
I. Diarrhea	0	0	0	0	0	O Yes		
m. Confusion or "brain fog"	0	0	0	0	0	O Yes		
n. Malaise- a general feeling of illness, discomfort, uneasiness	0	0	0	0	0	O Yes		
o. Sleep disturbance	0	0	0	0	0	O Yes		
p. Unusual fatigue	0	0	0	0	0	O Yes		

13. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.

DAYS USED IN THE PAST MONTH

ny of the following? Please answer on each line.									
		1-3	4-10	11-20	21+				
a. Multivitamins	0	0	0	0	0				
b. SINGLE supplements of omega-3 fatty acids (fish oil)	0	0	0	0	0				
c. SINGLE supplements of calcium (include elemental calcium in Tums) What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown	0	0	0	0	0				
 d. SINGLE supplements of vitamin D (in calcium supplements or separately) What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown 	0	0	0	0	0				
e. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0				
f. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-999 mg O 1000+ mg O unknown	0	0	0	0	0				
g. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0				
h. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0				

14. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or beta-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes

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1	8	/
-	-	

15. Are you CURRENTLY taking any of the following drugs for prevention or treatment of bone loss? (Mark ALL that apply)

O Fosamax (alendronate) O Evista (raloxifene) O Actonel (risedronate) O Reclast (zoledronic acid)

O Boniva O Forteo (teriparatide injection) O Miacalcin or Fortical (calcitonin-salmon) O Tymlos (abaloparatide) injection O Evenity (romosozumab) O Prolia (denosumab) O Other osteoporosis medication, not listed above

O I do NOT take any medications for bone loss treatment/prevention

16. In the PAST YEAR, has your memory changed? O No O Yes

IF YES: Which best describes the change?

O My memory is BETTER O My memory is WORSE but this does not worry me

O My memory is WORSE and this worries me

RING THE PAST YEAR, what was your approximate		AVERAGE TIME PER WEEK									
ERAGE TIME PER WEEK spent at each of the following reational activities?	0 min.	1-19 min.	20-59 min.	1 hour	1.5 hours	2-3 hours	4-6 hours	7+ hour			
a. Walking or hiking (include walking to work)	0	0	0	0	0	0	0	0			
b. Jogging (slower than 10 minute miles)	0	0	0	0	0	0	0	0			
c. Running (10 minute miles or faster)	0	0	0	0	0	0	0	0			
d. Bicycling (include stationary bike)	0	0	0	0	0	0	0	0			
e. Aerobic exercise / aerobic dance / exercise machines	0	0	0	0	0	0	0	0			
f. Lower intensity exercise / yoga / stretching / toning	0	0	0	0	0	0	0	0			
g. Tennis, squash, or racquetball	0	0	0	0	0	0	0	0			
h. Lap swimming	0	0	0	0	0	0	0	0			
i. Weight lifting / strength training	0	0	0	0	0	0	0	0			
j. Other: Please specify activity:	0	0	0	0	0	0	0	0			

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

O 3-4 flights

O 5-9 flights O 10-14 flights

0

O 15 or more flights

19. What is your usual walking pace outdoors?

O 1-2 flights

O None

O Don't walk regularly

O Brisk pace (3-3.9 mph)

O Easy, casual (less than 2 mph) O Very brisk/striding (4 mph or faster)

AVERAGE HOURS PER WEEK

11-20

21-40

41-60

61-90

90 +

O Normal, average (2-2.9 mph)

6-10

2-5

1

20. DURING THE PAST YEAR, on average, how many HOURS PER WEEK did you spend?

min. hour hours hours hours hours hours hours hours 0 0 0 a. Sitting at work or away from home or while driving Ο Ο 0 Ο Ο Ο b. Sitting at home while watching TV/VCR/DVD or using the computer 0 0 0 0 0 0 Ο Ο Ο 0 0 0 0 0 0 0 0 0 c. Other sitting at home (e.g., reading, meal times, at desk)

21. PLEASE COMPLETE YOUR CONTACT INFORMATION BELOW. IT WILL NOT BE SHARED. IT IS USED ONLY BY OUR STUDY.

YOUR HOME PHONE: ()	YOUR CELL PHONE: ()
YOUR E-MAIL ADDRESS: This is the e-mail address we have on file:	
If it has changed, or you would now be willing to share your e-mail a	<u>ddress</u> , please provide your updated e-mail address below:

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O Yes

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PLEASE USE A BALL-POINT PEN WHEN COMPLETING THIS QUESTIONNAIRE. IT IMPROVES THE QUALITY OF OUR DATA.

1. Date of birth:

Is the DOB above correct?

We use DATE OF BIRTH to verify the identity of the person providing information.

 $O No \rightarrow$ IF NO, what is your correct date of birth?

2. WITHIN THE PAST YEAR, have you been NEWLY DIAGNOSED with any of the following illnesses or had any of the following procedures? Please answer NO or YES on each line. IF YES, indicate the date (month/year) of the diagnosis or the procedure.

DIAGNOSIS OR PROCEDURE	NO	or YES —	>	IF YES, PROVIDE MO/	YR IN BOXES BELOW
a. Acute coronary syndrome/unstable angina	O No	O Yes 🗦	>	MO/YR of diagnosis:	
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No	O No O Yes	O Yes		MO/YR of diagnosis: O No O Yes	
c. Myocardial infarction (heart attack)	O No	O Yes	>	MO/YR of diagnosis:	
d. Coronary angioplasty (PTCA or PCI) or stent	O No	O Yes 🗦	>	MO/YR of procedure:	
e. Coronary bypass surgery (CABG)	O No	O Yes 🚽	>	MO/YR of procedure:	
f. Congestive heart failure	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 disease (not varicose veins)	O No	O Yes 🗦	>	MO/YR of diagnosis:	
j. Pulmonary embolism (PE)	O No	O Yes 🗦	≽	MO/YR of diagnosis:	
k. Deep vein thrombosis (DVT)	O No	O Yes 🗦	≻	MO/YR of diagnosis:	
I. 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 surgery:	
o. Melanoma	O No	O Yes 🗦	≻	MO/YR of diagnosis:	
p. Non-melanoma skin cancer What type? O basal cell O squamous cell O u	O No Inknown t	O Yes 🔶 ype	>	MO/YR of diagnosis:	
q. Breast cancer	O No	O Yes 🗦	≻	MO/YR of diagnosis:	
r. Lung cancer	O No	O Yes 🗦	>	MO/YR of diagnosis:	
s. Colon cancer	O No	O Yes 🗦	≻	MO/YR of diagnosis:	
t. Other cancer (not including any of the above cancers) SITE:	O No	O Yes 🗦	>	MO/YR of diagnosis:	
u. Colon polyp	O No	O Yes 🗦	≽	MO/YR of diagnosis:	
v. Diabetes mellitus (NEWLY diagnosed)	O No	O Yes 🚽	>	MO/YR of diagnosis:	







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3. In the past year, have you experienced any of these symptoms that may occur with conditions such as allergies, colds and flu, COVID-19 or when taking certain medications?

COVID-19 or when taking certain medications?			Is this symptom			
	Did not have this symptom	Less than 2 weeks	2 weeks to less than 8 weeks	8 weeks to less than 6 months	6 months or more	CURRENTLY present?
a. Fever	0	0	0	0	0	O Yes
b. Persistent cough	0	0	0	0	0	O Yes
c. Chills or sweats	0	0	0	0	0	O Yes
d. Headache	0	0	0	0	0	O Yes
e. Sore throat	0	0	0	0	0	O Yes
f. Hoarseness	0	0	0	0	0	O Yes
g. Loss of smell or taste	0	0	0	0	0	O Yes
h. Shortness of breath/difficulty breathing	0	0	0	0	0	O Yes
i. Chest pain/tightness	0	0	0	0	0	O Yes
j. Muscle aches	0	0	0	0	0	O Yes
k. Abdominal pain	0	0	0	0	0	O Yes
I. Diarrhea	0	0	0	0	0	O Yes
m. Confusion or "brain fog"	0	0	0	0	0	O Yes
n. Malaise - a general feeling of illness, discomfort, uneasiness	0	0	0	0	0	O Yes
o. Sleep disturbance	0	0	0	0	0	O Yes
p. Unusual fatigue	0	0	0	0	0	O Yes





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4. Have you received at least one dose of a COVID-19 vaccine? O No O Yes

IF YES, please indicate the date you received the shot and which vaccines you received:

	Date: MO/YR	Vaccine Received
a. FIRST vaccine		O Moderna O Pfizer-BioNTech O Johnson & Johnson
b. SECOND vaccine		O Moderna O Pfizer-BioNTech O Johnson & Johnson
c. FIRST booster shot		O Moderna O Pfizer-BioNTech
d. SECOND booster shot		O Moderna O Pfizer-BioNTech
e. THIRD booster shot		O Moderna O Pfizer-BioNTech
5. In general, would you say your CUR	RENT health is: O Exc	cellent O Very good O Good O Fair O Poor
6. What is your CURRENT weight?	pounds	7. What is your CURRENT height?
8. What is your CURRENT blood pres		lic (upper #) diastolic (lower #) O Don't know my blood pressure
9. What is your CURRENT total choles O <140 mg/dl O 140-159 O 250-259 O 260-269 O 2	terol (mg/dl) if checked O 160-179 O 180 70-279 O 280-299	
10. What is your CURRENT HDL-CHO	ESTEROL (mg/dl) if ch	hecked within the past 2 years?
O <30 mg/dl O 30-39 O 80-89 O 90-99	O 40-49 O 50-5 O 100+ O unkn	59 O 60-69 O 70-79 nown/not checked in 2 yrs
11. Do you CURRENTLY smoke cigar	ettes? O No O Yes	→ IF YES: On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)?
12. Have you EVER been diagnosed w IF YES, confirmed by: liver biopsy?		PONo OYes → IFYES, MO/YR of diagnosis: / / / / / / / / / / / / / / / / / / /
13. Have you EVER been diagnosed w	ith liver cirrhosis? O	No O Yes IF YES, MO/YR of diagnosis:
14. Have you EVER been diagnosed wi	th chronic viral hepatiti	is? O No O Yes IF YES, MO/YR of diagnosis:

15. IN THE PAST YEAR, have you had any of the following? (Please answer on each line)

	No	Yes, for symptoms	Yes, for screening		No	Yes, for symptoms	Yes, for screening
a. Colonoscopy	0	0	0	d. Fasting blood sugar	0	0	0
b. Sigmoidoscopy	0	0	0	e. Eye exam	0	0	0
c. Mammogram	0	0	0	f. Bone density exam (DEXA)	0	0	0

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16. Did you receive the influenza (flu) vaccine after August 2022? O No O Yes

17. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or beta-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes

18. Are you CURRENTLY taking any of the following drugs for prevention or treatment of bone loss? (Mark ALL that apply)

O Fosamax (alendronate) O Evista (raloxifene) O Actonel (risedronate) O Reclast (zoledronic acid)

O Boniva O Forteo (teriparatide injection) O Miacalcin or Fortical (calcitonin-salmon) O Tymlos (abaloparatide) injection

O Evenity (romosozumab) O Prolia (denosumab)

O Other osteoporosis medication, not listed above

O I do NOT take any medications for bone loss treatment/prevention

19. IN THE PAST MONTH, on approximately how many DAYS did you take

any of the following? Please answer on each line.	None	1-3	4-10	11-20	21+
a. Multivitamins	0	0	0	0	0
b. SINGLE supplements of omega-3 fatty acids (fish oil)	0	0	0	0	0
 c. SINGLE supplements of calcium (include elemental calcium in Tums) What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown 		0	0	0	0
 d. SINGLE supplements of vitamin D (in calcium supplements or separately) What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown 		0	0	0	0
e. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	0	0	0	0	0
f. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-999 mg O 1000+ mg O unknown		0	0	0	0
g. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	0	0	0	0	0
h. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	0	0	0	0	0

20. 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?	0	0	0	0	0	0
b. Did you have a lot of energy?	0	0	0	0	0	0
c. Have you felt downhearted and blue?	0	0	0	0	0	0

21. 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.)?

O All of the time O Most of the time O Some of the time O A little of the time

A little of the time O None of the time

DAYS USED IN THE PAST MONTH





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	No	Yes
a. Cut down the amount of time you spent on work or other activities	0	0
b. Accomplished less than you would like	0	0
c. Were limited in the kind of work or other activities	0	0
d. Had difficulty performing the work or other activities (for example, it took extra effort)	0	0

23. 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)?

	No	Yes
a. Accomplished less than you would like	0	0
b. Didn't do work or other activities as carefully as usual	0	0

24. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)? O Not at all O A little bit O Moderately O Quite a bit O Extremely

. Please answer NO or YES for each of the following questions about your memory:	No	Yes
a. Have you recently experienced any change in your ability to remember things?	0	0
b. Do you have more trouble than usual remembering recent events?	0	0
c. Do you have more trouble than usual remembering a short list of items, such as a shopping list?	0	0
d. Do you have trouble remembering things from one second to the next?	0	0
e. Do you have difficulty in understanding or following spoken instructions?		0
f. Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?	0	0

26. PLEASE COMPLETE YOUR CONTACT INFORMATION BELOW. IT WILL NOT BE SHARED. IT IS USED ONLY BY OUR STUDY.

YOUR HOME PHONE: ()	YOUR CELL PHONE: ()
YOUR E-MAIL ADDRESS: This is the e-mail address we have on	file:
If it has changed, or you would now be willing to share your e-r	nail address , please provide your updated e-mail address below:

Thank you! Please return the questionnaire in the pre-paid envelope provided.



OBS 20

Please complete the survey below.

This annual WHS survey is being sent to you earlier than usual (traditionally sent in May), so that we may focus on collecting the fullest information on any new illnesses or procedures that occurred in the past year.

We thank you for fully completing this survey!

Section I. Identification Information

We use the following information to authenticate the identity of the person completing this form.

Please write your FIRST and LAST initial only.

	(Example: John Doe = JD)	
Participant's birth month	 January February March April May June July August September October November December 	
Participant's birth day		
	(Day of the month (1-31))	
Participant's birth year		
Please indicate who is completing this form:	 Participant Spouse or family member on behalf of study participant 	
Section II. Health History		
2.IN THE PAST YEAR, have you been NEWLY DIAGNOSED with any of the following illnesses or had any of the following procedures?		
If YES, you will be asked to provide the year of diagnosis or the procedure, and, in some cases, for more information.		
In this section, you "must provide a value." In other words, you need to answer either YES or NO for each item. Please do not leave any questions incomplete in this section.		

a. Acute coronary syndrome/unstable angina

⊖ Yes ○ No



a. Month of diagnosis	 January February March April May June July August September October November December
a. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
b. Angina pectoris	○ Yes ○ No
b. Month of diagnosis	 January February March April May June July August September October November December
b. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
b. Was the angina confirmed by angiogram/cardiac cath?	○ Yes ○ No
b. Was the angina confirmed by stress test?	○ Yes ○ No
c. Myocardial infarction (heart attack)	○ Yes ○ No



c. Month of diagnosis	 January February March April May June July August September October November December
c. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
d. Coronary angioplasty (PTCA or PCI) or stent	○ Yes ○ No
d. Month of procedure	 January February March April May June July August September October November December
d. Year of procedure	 2024 2023 2022 2021 Before 2021 Unknown
e. Coronary bypass surgery (CABG)	○ Yes ○ No
e. Month of procedure	 January February March April May June July August September

- October
 November
 December



e. Year of procedure	 2024 2023 2022 2021 Before 2021
	O Unknown
f. Congestive heart failure	⊖ Yes ⊖ No
f. Month of diagnosis	 January February March April May June July August September October November December
f. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
g. Atrial fibrillation	○ Yes ○ No
g. Month of diagnosis	 January February March April May June July August September October November December
g. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
h. Intermittent claudication	○ Yes ○ No



Pa	ige 5
 January February March April May June July August September October November December 	
 2024 2023 2022 2021 Before 2021 Unknown 	
○ Yes ○ No	
 January February March April May June July August September October November December 	
	 January February March April May June July August September October November December 2024 2023 2022 2021 Before 2021 Unknown Yes No January February March April May June July August September October

	 September October November December
i. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
j. Pulmonary embolism (PE)	⊖ Yes ⊖ No
j. Month of diagnosis	 January February March April May June July August September October November

 $\bigcirc \begin{array}{c} \mathsf{November} \\ \bigcirc \end{array} \\ \mathsf{December} \end{array}$

j. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
k. Deep vein thrombosis (DVT)	○ Yes ○ No
k. Month of diagnosis	 January February March April May June July August September October November December
k. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
l. Stroke	○ Yes ○ No
l. Month of diagnosis	 January February March April May June July August September October November December
l. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
m. TIA (transient ischemic attack)	○ Yes ○ No



m. Month of diagnosis	 January February March April May June July August September October November December
m. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
n. Carotid artery surgery (endarterectomy)	○ Yes ○ No
n. Month of surgery	 January February March April May June July August September October November December
n. Year of surgery	 2024 2023 2022 2021 Before 2021 Unknown
o. Melanoma	○ Yes ○ No
o. Month of diagnosis	 January February March April May June July August September October November December



o. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
p. Non-melanoma skin cancer (i.e. basal or squamous cell)	○ Yes ○ No
p. What type?	 □ basal cell □ squamous cell □ unknown type
p. Month of diagnosis	 January February March April May June July August September October November December
p. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
q. Breast cancer	○ Yes ○ No
q. Month of diagnosis	 January February March April May June July August September October November December
q. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
r. Lung cancer	○ Yes ○ No

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r. Month of diagnosis	 January February March April May June July August September October November December 	
r. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown 	
s. Colon cancer	○ Yes ○ No	
s. Month of diagnosis	 January February March April May June July August September October November December 	
s. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown 	
t. Other cancer (not including any of the above cancers)	⊖ Yes ○ No	



t. Month of diagnosis	 January February March April May June July August September October November December
t. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
u. Colon polyp	○ Yes ○ No
u. Month of diagnosis	 January February March April May June July August September October November December
u. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
v. Diabetes mellitus (NEWLY diagnosed)	○ Yes ○ No
v. Month of diagnosis	 January February March April May June July August September October November December



v. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
w. Migraine headaches (NEWLY diagnosed)	○ Yes ○ No
w. Month of diagnosis	 January February March April May June July August September October November December
w. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
x. Other headaches (NEWLY diagnosed)	○ Yes ○ No
x. Month of diagnosis	 January February March April May June July August September October November December
x. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
y. Parkinson's disease	○ Yes ○ No

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y. Month of diagnosis	 January February March April May June July August September October November December
y. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
z. Elevated cholesterol (NEW diagnosis by a clinician)	○ Yes ○ No
z. Month of diagnosis	 January February March April May June July August September October November December
z. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
aa. Hypertension (NEW diagnosis by a clinician)	○ Yes ○ No
aa. Month of diagnosis	 January February March April May June July August September October November December



aa. Year of diagnosis	○ 2024 ○ 2023
	○ 2022 ○ 2022 ○ 2021
	🔿 Before 2021
	○ Unknown
bb. Osteoarthritis (NEWLY diagnosed)	○ Yes ○ No
bb. Month of diagnosis	 January February March April May June July August September October
	 November December
bb. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
cc. Osteoporosis (NEWLY diagnosed)	○ Yes ○ No
cc. Month of diagnosis	 January February March April May June July August September October November December
cc. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
dd. Fracture due to osteoporosis	○ Yes ○ No



dd. Month of occurrence	 January February March April May June July August September October November December
dd. Year of occurrence	 2024 2023 2022 2021 Before 2021 Unknown
ee. Joint replacement	○ Yes ○ No
ee. Month of surgery	 January February March April May June July August September October November December
ee. Year of surgery	 2024 2023 2022 2021 Before 2021 Unknown
ff. Fibrocystic or other benign breast disease	○ Yes ○ No
ff. Month of diagnosis	 January February March April May June July August September October November December



ff. Year of diagnosis	 2024 2023 2022 2021 Before 2021 Unknown
ff. Was this confirmed by breast biopsy?	○ Yes ○ No
ff. Was this confirmed by aspiration?	○ Yes ○ No
gg. Coronavirus (COVID-19)	○ Yes ○ No
Month of diagnosis	 January February March April May June July August September October November December
Year of diagnosis	 ○ 2024 ○ 2023 ○ 2022 ○ 2021 ○ 2020
Was this confirmed by a positive COVID-19 test?	○ Yes ○ No
Have you EVER been hospitalized due to COVID-19?	○ Yes ○ No
Month of HOSPITALIZATION	 January February March April May June July August September October November December
Year of HOSPITALIZATION	 ○ 2024 ○ 2023 ○ 2022 ○ 2021 ○ 2020



Did you require treatment in an Intensive Care Unit (ICU)?	○ Yes ○ No
Imported	○ Yes ○ No

