8039394141 2005

WOMEN'S HEALTH STUDY 1 / ☐☐ - ☐☐☐☐☐☐ - ☐

Birth date: ☐☐ / ☐☐ / ☐☐ (MO / DY / YR) → **Last 6 digits of SSN:** X X X - ☐☐ - ☐☐☐☐ **(optional)**

2. <u>SINCE YOU LAST RETURNED A QUESTIONNAIRE</u> (approximately 1 year ago), have you been <u>NEWLY DIAGNOSED</u> with any of the following? If YES, please provide the MO/YR of the diagnosis or procedure.

a. Myocardial infarction	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
If YES, confirmed by: angiogram/cardiac cath? O No O Yes		stress test? O No O Yes
c. Acute coronary syndrome/unstable angina O No O Yes		
If YES, were you HOSPITALIZED as a result? O No O Yes →		Hospitalization date: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA)	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. Ventricular tachycardia	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
h. Atrial fibrillation	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
i. Intermittent claudication	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
If YES, did you have <u>related</u> angioplasty, stenting or bypass? O No O Yes		
j. Peripheral artery disease (not varicose veins) O No O Yes →		MO/YR of diagnosis: ☐☐ / ☐☐
If YES, did you have <u>related</u> angioplasty, stenting or bypass? O No O Yes		
k. Pulmonary embolism (PE)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. 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 →	MO/YR of procedure: ☐☐ / ☐☐
p. Melanoma	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Non-melanoma skin cancer	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
If YES, what type? O basal cell O squamous cell O unknown type		
r. Breast cancer	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
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)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
SITE: ☐		

Office use: O 1 O 2

(OVER)

v. Colon polyp	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
w. Fibrocystic or other benign breast disease If YES, confirmed by: breast biopsy?	O No O No	O Yes → O Yes	MO/YR of diagnosis: 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. Active or chronic liver disease	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
aa. Kidney disease (other than kid. stones)	O No	O Yes →	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	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ee. Depression (dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ff. Macular degeneration: **RIGHT** eye **LEFT** eye	O No O No	O Yes → O Yes →	MO/YR of diagnosis (R): MO/YR of diagnosis (L):	☐☐ / ☐☐ ☐☐ / ☐☐
gg. Cataract: **RIGHT** eye **LEFT** eye	O No O No	O Yes → O Yes →	MO/YR of diagnosis (R): MO/YR of diagnosis (L):	☐☐ / ☐☐ ☐☐ / ☐☐
hh. Cataract extraction: **RIGHT** eye **LEFT** eye	O No O No	O Yes → O Yes →	MO/YR of procedure (R): MO/YR of procedure (L):	☐☐ / ☐☐ ☐☐ / ☐☐
ii. Dry eye syndrome	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
jj. Rheumatoid arthritis	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
kk. Parkinson's disease	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ll. Elevated cholesterol (dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
mm. Hypertension (dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
nn. Periodontal disease Number of teeth lost : ☐☐	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
oo. Asthma	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
pp. Other chronic lung disease (e.g., emphysema, chronic bronchitis)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐

qq. Note any other MAJOR ILLNESS diagnosed within the past year and NOT included in the above list and provide the date of diagnosis.

	OTHER MAJOR ILLNESS:	MO/YR OF DIAGNOSIS:
a.		
b.		
c.		

Office use: O 1 O 2 O Y

PLEASE GO TO THE TOP OF THE NEXT PAGE

3. **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	→	MO/YR of diagnosis: ☐☐ / ☐☐
b. Fractures from osteoporosis	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
c. Osteoarthritis	O No	O Yes	→	MO/YR of diagnosis: ☐☐ / ☐☐
d. Joint replacement	O No	O Yes	→	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.**

	DAYS USED IN THE PAST MONTH				
	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O

5. **Do you CURRENTLY take a MULTIVITAMIN?** O No O Yes

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

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

a. Antihypertensive medications

O No O Yes → If YES, mark ALL of the specific drugs you are CURRENTLY 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. STATIN cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)

O No O Yes → If YES, mark ALL of the specific drugs you are CURRENTLY taking:

O Lipitor O Mevacor O Crestor O Zocor
O Pravachol O Lescol O Other

c. Other NON-STATIN lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)

O No O Yes

Have you EVER received a blood transfusion (exclude transfusions of your own blood)?

O No O Yes → 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+

Office use: O 1 O 2

(OVER)

8. What is your CURRENT blood pressure (mmHg)? → ☐☐☐ systolic / ☐☐☐ diastolic ○ Don't know my blood pressure

9. What is your CURRENT weight? ☐☐☐ pounds

10. Do you CURRENTLY smoke cigarettes? ○ No ○ Yes → If YES, on average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

11. What is your CURRENT TOTAL CHOLESTEROL (if checked within the past 5 years)?

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

12. What is your CURRENT HDL-CHOLESTEROL (if checked within the past 5 years)?

○ <30 mg/dl ○ 30-39 ○ 40-49 ○ 50-59 ○ 60-69 ○ 70-79
○ 80-89 ○ 90-99 ○ 100+ ○ unknown/not checked in 5 yrs

13. 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 (1 glass or bottle or can) Regular beer	○	○	○	○	○	○	○	○	○
a. Beer (1 glass or bottle or can) Light beer	○	○	○	○	○	○	○	○	○
b. Red wine/sherry/port (4 oz. glass)	○	○	○	○	○	○	○	○	○
c. White wine (4 oz. glass)	○	○	○	○	○	○	○	○	○
d. Liquor (1 drink or shot) (e.g., vodka, rum, gin, brandy, etc.)	○	○	○	○	○	○	○	○	○

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. ○ No ○ Yes

15. IN THE PAST YEAR, have you had:

	No	Yes, for symptoms	Yes, for screening
a. Physical exam	○	○	○
b. Fasting blood sugar	○	○	○
c. Blood pressure check	○	○	○
d. Cholesterol check	○	○	○
e. Eye exam	○	○	○
f. Stool occult blood test	○	○	○
g. Colonoscopy	○	○	○
h. Sigmoidoscopy	○	○	○
i. Pap smear	○	○	○
j. Mammogram	○	○	○

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

HOME PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

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: _____ ZIP: _____

PHONE NO: _____

PLEASE COMPLETE THE CONTACT INFORMATION IN THE RIGHT COLUMN. THANK YOU.

Office use: ○ 1 ○ 2 Review: ☐

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WOMEN'S HEALTH STUDY 2 / ☐☐ - ☐☐☐☐☐☐ - ☐

1. Birth date: ☐☐ (MO) / ☐☐ (DY) / ☐☐ (YR) → **Last 6 digits of SSN: (optional)** X X X - ☐☐ - ☐☐☐☐

2. SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago), have you been NEWLY DIAGNOSED with any of the following? If YES, please provide the MO/YR of the diagnosis or procedure.

a. Myocardial infarction	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
If YES, confirmed by: angiogram/cardiac cath? O No O Yes stress test? O No O Yes		
c. Acute coronary syndrome/unstable angina O No O Yes If YES, were you HOSPITALIZED as a result? O No O Yes →		Hospitalization date: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA) 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. 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 RELATED angioplasty, stenting or bypass? O No O Yes	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Peripheral artery disease (not varicose veins) O No O Yes → If YES, did you have RELATED angioplasty, stenting or bypass? O No O Yes		MO/YR of diagnosis: ☐☐ / ☐☐
k. Pulmonary embolism (PE)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. 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 →	MO/YR of procedure: ☐☐ / ☐☐
p. Melanoma	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Non-melanoma skin cancer If YES, what type? O basal cell O squamous cell O unknown type	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Breast cancer	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
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 →	MO/YR of diagnosis: ☐☐ / ☐☐

Office use: O 1 O 2

(OVER)

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	O Yes →	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	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ee. Macular degeneration: **RIGHT** eye	O No	O Yes →	MO/YR of diagnosis (R):	☐☐ / ☐☐
LEFT eye	O No	O Yes →	MO/YR of diagnosis (L):	☐☐ / ☐☐
ff. Cataract: **RIGHT** eye	O No	O Yes →	MO/YR of diagnosis (R):	☐☐ / ☐☐
LEFT eye	O No	O Yes →	MO/YR of diagnosis (L):	☐☐ / ☐☐
gg. Cataract extraction: **RIGHT** eye	O No	O Yes →	MO/YR of procedure (R):	☐☐ / ☐☐
LEFT eye	O No	O Yes →	MO/YR of procedure (L):	☐☐ / ☐☐
hh. Dry eye syndrome	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ii. Parkinson's disease	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
jj. Elevated cholesterol (dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
kk. Hypertension (dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ll. Asthma	O No	O Yes →	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 →	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	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐

ss. Note any other MAJOR ILLNESS diagnosed in the past year and NOT included in above.

	OTHER MAJOR ILLNESS:	MO/YR OF DIAGNOSIS:
a.	→	
b.	→	

Office use: O 1 O 2 O Y

PLEASE GO TO THE TOP OF THE NEXT PAGE

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				
	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
f. Multivitamins	O	O	O	O	O
g. SINGLE supplements of vitamin A	O	O	O	O	O
h. SINGLE supplements of vitamin C	O	O	O	O	O
i. SINGLE supplements of vitamin E	O	O	O	O	O
j. SINGLE supplements of folic acid (with or without B-vitamins)	O	O	O	O	O

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

5. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

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

6. 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

7. What is your usual walking pace outdoors?

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

8. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES, on average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

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

O No O Yes, currently O Yes, discontinued

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

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

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

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

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

Progesterone: O Oral O Vaginal O Other, specify _____

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

O 0.3 mg or less O 0.45 mg O 0.625 mg O 0.9 mg O 1.25 mg
O >1.25 mg O Dose unknown O Did not take conjugated estrogen

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

O <2.5 mg O 2.5 mg O 5-9 mg O 10 mg O >10 mg O Unknown O Not used

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

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

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

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

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

	No	Yes, for symptoms	Yes, for screening
a. Fasting blood sugar	O	O	O
b. Colonoscopy	O	O	O
c. Sigmoidoscopy	O	O	O
d. Mammogram	O	O	O

11. What is your CURRENT weight? ☐☐☐ pounds

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

O Excellent O Very good O Good O Fair O Poor

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

HOME PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

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: _____ ZIP: _____

PHONE NO: _____

PLEASE COMPLETE THE CONTACT INFORMATION IN THE RIGHT COLUMN. THANK YOU.

28653

WOMEN'S HEALTH STUDY 3 / ☐☐ - ☐☐☐☐☐☐ - ☐

1. Birth date: ☐☐ (MO) / ☐☐ (DY) / ☐☐ (YR) → **Last 6 digits of SSN: (optional)** X X X - ☐☐ - ☐☐☐☐

2. SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago), have you been NEWLY DIAGNOSED with any of the following? If YES, please provide the MO/YR of the diagnosis or procedure.

a. Myocardial infarction	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
If YES, confirmed by: angiogram/cardiac cath? O No O Yes stress test? O No O Yes		
c. Acute coronary syndrome/unstable angina O No O Yes If YES, were you HOSPITALIZED as a result? O No O Yes →		Hospitalization date: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA) 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. 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 RELATED angioplasty, stenting or bypass? O No O Yes	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Peripheral artery disease (not varicose veins) O No O Yes → If YES, did you have RELATED angioplasty, stenting or bypass? O No O Yes		MO/YR of diagnosis: ☐☐ / ☐☐
k. Pulmonary embolism (PE)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. 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 →	MO/YR of procedure: ☐☐ / ☐☐
p. Melanoma	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Non-melanoma skin cancer If YES, what type? O basal cell O squamous cell O unknown type	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Breast cancer	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
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 →	MO/YR of diagnosis: ☐☐ / ☐☐

Office use: O 1 O 2

(OVER)

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	O Yes →	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	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ee. Macular degeneration: **RIGHT** eye	O No	O Yes →	MO/YR of diagnosis (R):	☐☐ / ☐☐
LEFT eye	O No	O Yes →	MO/YR of diagnosis (L):	☐☐ / ☐☐
ff. Cataract: **RIGHT** eye	O No	O Yes →	MO/YR of diagnosis (R):	☐☐ / ☐☐
LEFT eye	O No	O Yes →	MO/YR of diagnosis (L):	☐☐ / ☐☐
gg. Cataract extraction: **RIGHT** eye	O No	O Yes →	MO/YR of procedure (R):	☐☐ / ☐☐
LEFT eye	O No	O Yes →	MO/YR of procedure (L):	☐☐ / ☐☐
hh. Dry eye syndrome	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ii. Parkinson's disease	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
jj. Elevated cholesterol (dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
kk. Hypertension (dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ll. Asthma	O No	O Yes →	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 →	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	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐

ss. Note any other MAJOR ILLNESS diagnosed in the past year and NOT included in above.

OTHER MAJOR ILLNESS: → MO/YR OF DIAGNOSIS:

a. _____ →

b. _____ →

3. **Have you EVER been diagnosed with interstitial cystitis?** O No O Yes → MO/YR of diagnosis: ☐☐ / ☐☐

4. **Have you EVER been diagnosed with fibromyalgia?** O No O Yes → MO/YR of diagnosis: ☐☐ / ☐☐

5. **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.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: 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)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
f. Multivitamins	O	O	O	O	O
g. SINGLE supplements of vitamin A	O	O	O	O	O
h. SINGLE supplements of vitamin C	O	O	O	O	O
i. SINGLE supplements of vitamin E	O	O	O	O	O
j. SINGLE supplements of folic acid (with or without B-vitamins)	O	O	O	O	O
k. SINGLE supplements of omega-3 fatty acids	O	O	O	O	O

6. **Do you take SINGLE supplements of calcium (include elemental calcium in Tums)?** O No O Yes

IF YES, what dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown

7. **Do you take SINGLE supplements of vitamin D (in calcium supplements or separately)?** O No O Yes

IF YES, what dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown

8. **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. Fosamax for prevention/treatment of bone loss	O No O Yes
If YES, for how many years have you been taking Fosamax regularly?	O < 1 yr O 1-2 yrs O 3-4 yrs O 5+ yrs

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 (1 glass or bottle or can) Regular beer	O	O	O	O	O	O	O	O	O
a. Beer (1 glass or bottle or can) Light beer	O	O	O	O	O	O	O	O	O
b. Red wine/sherry/port (4 oz. glass)	O	O	O	O	O	O	O	O	O
c. White wine (4 oz. glass)	O	O	O	O	O	O	O	O	O
d. Liquor (1 drink or shot) (e.g., vodka, rum, gin, brandy, etc.)	O	O	O	O	O	O	O	O	O

28653 **WOMEN'S HEALTH STUDY** 3 / ☐☐ - ☐☐☐☐☐☐ - ☐

10. What is your CURRENT blood pressure (mmHg)? → ☐☐☐ / ☐☐☐
systolic / diastolic
O Don't know my blood pressure

11. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES, on average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

12. 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

13. 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

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

a. Ovarian cancer?	**No**	**Don't know**	**Yes**	**If YES, please provide AGE when first diagnosed:** **<50**	**50-59**	**60-69**	**70+**	**Age Unknown**
Mother	O	O	O	O	O	O	O	O
Sister	O	O	O	O	O	O	O	O
b. Colon or rectal cancer?	**No**	**Don't know**	**Yes**	**<50**	**50-59**	**60-69**	**70+**	**Age Unknown**
Parent	O	O	O	O	O	O	O	O
Sibling	O	O	O	O	O	O	O	O
Additional sibling	O	O	O	O	O	O	O	O

15. Do you CURRENTLY own any of the following pets? Check ALL that apply.
O NONE O Dog(s) O Cat(s) O Bird(s) O Fish O Other
Have you EVER had to give up a pet due to health? O Not applicable O No O Yes
IF YES, when? O Within past 2 years O Within past 5 years O More than 5 years ago
Are you the primary caretaker of the pet(s) (i.e., you take care of most of its needs)? O No pets O No O Yes

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

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening
a. Fasting blood sugar	O	O	O
b. Colonoscopy	O	O	O
c. Sigmoidoscopy	O	O	O
d. Mammogram	O	O	O
e. Eye exam	O	O	O

17. What is your CURRENT weight? ☐☐☐ pounds

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

PLEASE COMPLETE THE CONTACT INFORMATION IN THE RIGHT COLUMN. THANK YOU.

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

HOME PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

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: _____ ZIP: _____

PHONE NO: _____

Office use: O 1 O 2

O A O B O C O D Review: ☐

8671

WOMEN'S HEALTH STUDY 4 / ☐☐ - ☐☐☐☐☐☐ - ☐

1. **Birth date:** ☐☐ / ☐☐ / ☐☐ → **Last 6 digits of SSN: (optional)** X X X - ☐☐ - ☐☐☐☐

2. **SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago), have you been NEWLY DIAGNOSED with any of the following? If YES, please provide the approximate date of the diagnosis or procedure.**

IF NEW DIAGNOSIS OR NEW PROCEDURE since your last follow up, please mark below and note the date to the right of the item. →			**<2006**	**2006**	**2007**		**2008**		**2009**
					Jan-Jun	**Jul-Dec**	**Jan-Jun**	**Jul-Dec**	
a. Myocardial infarction	O No	O Yes →	O	O	O	O	O	O	O
b. Angina pectoris	O No	O Yes →	O	O	O	O	O	O	O
If YES, confirmed by: angiogram/cardiac cath?	O No	O Yes	stress test?	O No	O Yes				
c. Acute coronary syndrome/unstable angina	O No	O Yes →	O	O	O	O	O	O	O
d. Coronary angioplasty (PTCA) or stent	O No	O Yes →	O	O	O	O	O	O	O
e. Coronary bypass surgery (CABG)	O No	O Yes →	O	O	O	O	O	O	O
f. Congestive heart failure	O No	O Yes →	O	O	O	O	O	O	O
g. Ventricular tachycardia	O No	O Yes →	O	O	O	O	O	O	O
h. Atrial fibrillation	O No	O Yes →	O	O	O	O	O	O	O
i. Intermittent claudication	O No	O Yes →	O	O	O	O	O	O	O
j. Peripheral artery disease (not varicose veins)	O No	O Yes →	O	O	O	O	O	O	O
k. Pulmonary embolism (PE)	O No	O Yes →	O	O	O	O	O	O	O
l. Deep vein thrombosis (DVT)	O No	O Yes →	O	O	O	O	O	O	O
m. Stroke	O No	O Yes →	O	O	O	O	O	O	O
n. TIA (transient ischemic attack)	O No	O Yes →	O	O	O	O	O	O	O
o. Carotid artery surgery (endarterectomy)	O No	O Yes →	O	O	O	O	O	O	O
p. Melanoma	O No	O Yes →	O	O	O	O	O	O	O
q. Non-melanoma skin cancer	O No	O Yes →	O	O	O	O	O	O	O
What type? O basal cell O squamous cell O unknown type									
r. Breast cancer	O No	O Yes →	O	O	O	O	O	O	O
s. Lung cancer	O No	O Yes →	O	O	O	O	O	O	O
t. Colon cancer	O No	O Yes →	O	O	O	O	O	O	O
u. Other cancer (non-skin) SITE: _____	O No	O Yes →	O	O	O	O	O	O	O
v. Colon polyp	O No	O Yes →	O	O	O	O	O	O	O
w. Diabetes mellitus	O No	O Yes →	O	O	O	O	O	O	O
x. Migraine headaches	O No	O Yes →	O	O	O	O	O	O	O
y. Other headaches	O No	O Yes →	O	O	O	O	O	O	O
z. Kidney disease (other than kidney stones)	O No	O Yes →	O	O	O	O	O	O	O
aa. Chronic kidney failure	O No	O Yes →	O	O	O	O	O	O	O

IF NEW DIAGNOSIS OR NEW PROCEDURE since your last follow up, please mark below and note the date to the right of the item. →			<2006	2006	2007		2008		2009
					Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	
bb. Macular degeneration	RIGHT eye	O No O Yes →	O	O	O	O	O	O	O
	LEFT eye	O No O Yes →	O	O	O	O	O	O	O
cc. Cataract	RIGHT eye	O No O Yes →	O	O	O	O	O	O	O
	LEFT eye	O No O Yes →	O	O	O	O	O	O	O
dd. Cataract extraction	RIGHT eye	O No O Yes →	O	O	O	O	O	O	O
	LEFT eye	O No O Yes →	O	O	O	O	O	O	O
ee. Dry eye syndrome		O No O Yes →	O	O	O	O	O	O	O
ff. Parkinson's disease		O No O Yes →	O	O	O	O	O	O	O
gg. Elevated cholesterol (dx by a clinician)		O No O Yes →	O	O	O	O	O	O	O
hh. Hypertension (dx by a clinician)		O No O Yes →	O	O	O	O	O	O	O
ii. Osteoarthritis		O No O Yes →	O	O	O	O	O	O	O
jj. Joint replacement		O No O Yes →	O	O	O	O	O	O	O
kk. Rheumatoid arthritis		O No O Yes →	O	O	O	O	O	O	O
ll. Fibromyalgia		O No O Yes →	O	O	O	O	O	O	O
mm. Fibrocystic or other benign breast disease		O No O Yes →	O	O	O	O	O	O	O
If YES, confirmed by: breast biopsy? O No O Yes aspiration? O No O Yes									

3. Have you EVER been diagnosed with psoriasis? O No O Yes

4. Has a parent or sibling EVER been diagnosed with psoriasis? O No O Yes O Not sure

5. As you age, do you have more trouble hearing in a crowded room where lots of people are speaking? O No O Yes

6. Did you EVER work in or were you EVER exposed to a noisy environment that caused you to suffer hearing loss? O No O Yes

7. Have you EVER been diagnosed with glaucoma? O No O Yes → MO/YR of diagnosis: ☐☐ (mo) / ☐☐ (yr)

8. Do 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 Not sure
Are your symptoms so severe that you would consider taking medication? O No O Yes O Not sure

9. Have you EVER had a bone density exam, such as DEXA? O No O Yes

10. Have you EVER been diagnosed with osteoporosis? O No O Yes → What YEAR were you FIRST diagnosed? ☐☐☐☐ (year)

11. Have you EVER suffered a fracture that your doctor told you was due to osteoporosis? O No O Yes

12. Did any of these relatives ever have blood clots in their legs (deep vein thrombosis) or blood clots in their lungs (pulmonary embolism)? IF YES, please indicate their age when the incident first occurred.

RELATIVE	No	Not sure	Yes	→	AT WHAT AGE? <40	40-49	50-59	60+	Not sure
Parent	O	O	O	→	O	O	O	O	O
Sibling	O	O	O	→	O	O	O	O	O

13. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

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

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

15. What is your usual walking pace outdoors?

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

16. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES, on average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

17. IN THE PAST 2 YEARS, have you used female hormones?

O No Skip to question #18 O Yes

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.

b. Are you CURRENTLY using them (within the last month)? O No O Yes

c. Mark the type(s) of hormones you have used the longest in the PAST 2 YEARS:

Combined: O Prempro (cream) O Prempro (gold) O Prempro (peach) O Prempro (light blue) O Premphase O Combipatch O FemHRT

Estrogen: O Oral Premarin O Patch estrogen O Vaginal estrogen O Ogen O Estrace O Estratest O Other estrogen

Progesterone/Progestin: O Provera/Cycrin/MPA O Vaginal O Micronized (e.g., Prometrium) O Other progesterone

d. Over the PAST 2 YEARS, for how many months have you used the preparation(s) you marked in part c.?
O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 mos. O 17-20 mos. O 21-24 mos.

e. 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 oral conjugated estrogen

f. If you used oral medroxy progesterone (e.g., Provera, Cycrin) what dose did you usually take?
O 2.5 mg or less O 5-9 mg O 10 mg O more than 10 mg O Unsure O Not used

g. What was your pattern of hormone use (days per month)?
Oral or patch estrogen: (days/month) O Not used O <1 O 1-8 O 9-18 O 19-26 O 27+ days per month
Progesterone: (days/month) O Not used O <1 O 1-8 O 9-18 O 19-26 O 27+ days per month

18. Which hand do you prefer for writing? O Right O Left O Both

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

20. 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.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: 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)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
f. Multivitamins	O	O	O	O	O
g. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
h. SINGLE supplements of vitamin E	O	O	O	O	O
What dose per day? O <100 IU O 100-250 IU O 300-500 IU O 600+ IU O unknown					
i. SINGLE supplements of calcium (include elemental calcium in Tums)	O	O	O	O	O
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown					
j. SINGLE supplements of vitamin D (in calcium supplements or separately)?	O	O	O	O	O
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown					

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	O No	O Yes
If YES, for how many years have you been taking Fosamax regularly? O < 1 yr O 1-2 yrs O 3-4 yrs O 5+ yrs		

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 → Were any of these identical? O No O Yes

24. In the following questions, we are interested in your perceptions about the way others have treated you:

	NO	YES
a. Have you ever been unfairly fired from a job or been unfairly denied a promotion?	O	O
b. For unfair reasons, have you ever not been hired for a job?	O	O
c. Have you ever been unfairly stopped, searched, questioned, physically threatened or abused by the police?	O	O
d. Have you ever been unfairly prevented from moving into a neighborhood because the landlord or realtor refused to sell or rent you a house or apartment?	O	O

25. What is your CURRENT weight? ☐☐☐ pounds

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

PLEASE COMPLETE THE CONTACT INFORMATION IN THE RIGHT COLUMN. THANK YOU.

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

HOME PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

OTHER PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

Is this "other phone" a work or cell number? O Work O Cell

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: _____ ZIP: _____

PHONE NO: _____

Office use: O 1 O 2

O A O B O C O D

39033

WHS 5 / ☐☐ - ☐☐☐☐☐☐ - ☐

1. Birth date: ☐☐ / ☐☐ / ☐☐ → Last 6 digits of SSN: (optional) X X X - ☐☐ - ☐☐☐☐

2. 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.

DIAGNOSIS OR PROCEDURE	NO or YES		→	2008 Jan-Jun	2008 Jul-Dec	2009 Jan-Jun	2009 Jul-Dec	Office Use
EXAMPLE: Hip replacement	O No	● Yes	→	O	O	●	O	O
a. Acute coronary syndrome/unstable angina	O No	O Yes	→	O	O	O	O	O
b. Angina pectoris	O No	O Yes	→	O	O	O	O	O
If YES, confirmed by: angiogram/cardiac cath?	O No	O Yes	stress test?	O No	O Yes			
c. Myocardial infarction	O No	O Yes	→	O	O	O	O	O
d. Coronary angioplasty (PTCA) or stent	O No	O Yes	→	O	O	O	O	O
e. Coronary bypass surgery (CABG)	O No	O Yes	→	O	O	O	O	O
f. Congestive heart failure	O No	O Yes	→	O	O	O	O	O
g. Ventricular tachycardia	O No	O Yes	→	O	O	O	O	O
h. Atrial fibrillation	O No	O Yes	→	O	O	O	O	O
i. Intermittent claudication	O No	O Yes	→	O	O	O	O	O
j. Peripheral artery disease (not varicose veins)	O No	O Yes	→	O	O	O	O	O
k. Pulmonary embolism (PE)	O No	O Yes	→	O	O	O	O	O
l. Deep vein thrombosis (DVT)	O No	O Yes	→	O	O	O	O	O
m. Stroke	O No	O Yes	→	O	O	O	O	O
n. TIA (transient ischemic attack)	O No	O Yes	→	O	O	O	O	O
o. Carotid artery surgery (endarterectomy)	O No	O Yes	→	O	O	O	O	O
p. Melanoma	O No	O Yes	→	O	O	O	O	O
q. Non-melanoma skin cancer What type? O basal cell O squamous cell O unknown type	O No	O Yes	→	O	O	O	O	O
r. Breast cancer	O No	O Yes	→	O	O	O	O	O
s. Lung cancer	O No	O Yes	→	O	O	O	O	O
t. Colon cancer	O No	O Yes	→	O	O	O	O	O
u. Other cancer (non-skin) SITE: _____	O No	O Yes	→	O	O	O	O	O
v. Colon polyp	O No	O Yes	→	O	O	O	O	O
w. Diabetes mellitus	O No	O Yes	→	O	O	O	O	O
x. Migraine headaches	O No	O Yes	→	O	O	O	O	O

O 1 O 2
Office use

(OVER)

39033

WOMEN'S HEALTH STUDY 5 / ☐☐ - ☐☐☐☐☐☐ - ☐

2. (continued) NEWLY DIAGNOSED SINCE LAST QUESTIONNAIRE? DIAGNOSIS OR PROCEDURE		NO or YES	2008 Jan-Jun	2008 Jul-Dec	2009 Jan-Jun	2009 Jul-Dec	Office Use
y. Other headaches		O No O Yes →	O	O	O	O	O
z. Kidney disease (other than kidney stones)		O No O Yes →	O	O	O	O	O
aa. Chronic kidney failure		O No O Yes →	O	O	O	O	O
bb. Macular degeneration	RIGHT eye	O No O Yes →	O	O	O	O	O
	LEFT eye	O No O Yes →	O	O	O	O	O
cc. Cataract	RIGHT eye	O No O Yes →	O	O	O	O	O
	LEFT eye	O No O Yes →	O	O	O	O	O
dd. Cataract extraction	RIGHT eye	O No O Yes →	O	O	O	O	O
	LEFT eye	O No O Yes →	O	O	O	O	O
ee. Glaucoma		O No O Yes →	O	O	O	O	O
ff. Dry eye syndrome		O No O Yes →	O	O	O	O	O
gg. Parkinson's disease		O No O Yes →	O	O	O	O	O
hh. Elevated cholesterol (dx by a clinician)		O No O Yes →	O	O	O	O	O
ii. Hypertension (dx by a clinician)		O No O Yes →	O	O	O	O	O
jj. Osteoarthritis		O No O Yes →	O	O	O	O	O
kk. Osteoporosis		O No O Yes →	O	O	O	O	O
ll. Fracture due to osteoporosis		O No O Yes →	O	O	O	O	O
mm. Bone density exam (DEXA)		O No O Yes →	O	O	O	O	O
nn. Joint replacement		O No O Yes →	O	O	O	O	O
oo. Rheumatoid arthritis		O No O Yes →	O	O	O	O	O
pp. Fibromyalgia		O No O Yes →	O	O	O	O	O
qq. Psoriasis		O No O Yes →	O	O	O	O	O
rr. Fibrocystic or other benign breast disease		O No O Yes →	O	O	O	O	O

If YES, confirmed by: breast biopsy? O No O Yes aspiration? O No O Yes

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

O Don't know my blood pressure

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

8. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES: On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

Office use: O 1 O 2

PLEASE GO TO TOP OF NEXT PAGE

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 (1 glass or bottle or can) — Regular beer	O	O	O	O	O	O	O	O	O
a. Beer (1 glass or bottle or can) — Light beer	O	O	O	O	O	O	O	O	O
b. Red wine/sherry/port (4 oz. glass)	O	O	O	O	O	O	O	O	O
c. White wine (4 oz. glass)	O	O	O	O	O	O	O	O	O
d. Liquor (1 drink or shot) (e.g., vodka, rum, gin, brandy, etc.)	O	O	O	O	O	O	O	O	O

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

If YES, please provide AGE when first diagnosed:

	Don't know	No	Yes	<50	50-59	60-69	70+	Age Unknown
a. Breast cancer?								
Mother	O	O	O	O	O	O	O	O
Any Sister	O	O	O	O	O	O	O	O
Maternal grandmother	O	O	O	O	O	O	O	O
Paternal grandmother	O	O	O	O	O	O	O	O
b. Endometrial cancer?	**Don't know**	**No**	**Yes**	**<50**	**50-59**	**60-69**	**70+**	**Age Unknown**
Mother	O	O	O	O	O	O	O	O
Any Sister	O	O	O	O	O	O	O	O
Maternal grandmother	O	O	O	O	O	O	O	O
Paternal grandmother	O	O	O	O	O	O	O	O

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

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

12. Have you EVER been diagnosed with a uterine fibroid? O Not sure O No O Yes → Year of diagnosis: ☐☐☐☐

13. Has your sister or mother EVER been diagnosed with a uterine fibroid? O Not sure O No O Yes

14. 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

15. 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

16. 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.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: 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)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
f. Multivitamins	O	O	O	O	O
g. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
h. SINGLE supplements of calcium (include elemental calcium in Tums)	O	O	O	O	O
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown					
i. SINGLE supplements of vitamin D (in calcium supplements or separately)?	O	O	O	O	O
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown					

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	O No	O Yes
If YES, for how many years have you been taking Fosamax regularly? O < 1 yr O 1-2 yrs O 3-4 yrs O 5+ yrs		

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

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening
a. Fasting blood sugar	O	O	O
b. Colonoscopy	O	O	O
c. Sigmoidoscopy	O	O	O
d. Mammogram	O	O	O
e. Eye exam	O	O	O

19. Have you had a hysterectomy? O No O Yes

IF YES: At what age ? ☐☐

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

O Excellent O Very good O Good O Fair O Poor

PLEASE COMPLETE THE CONTACT INFORMATION IN THE RIGHT COLUMN. THANK YOU.

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

HOME PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

CELL PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

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: _____ ZIP: _____

PHONE NO: _____

IS THIS CONTACT:

O Relative O Friend O Neighbor O Other

39909

WHS #6 FORM

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.

month / day / year

Provide CORRECTED date of birth information below:

month / day / year

2. Please read the list of illnesses and procedures below. If you have had a NEW diagnosis of the illness or the procedure SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago), 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.

The first line is provided as an EXAMPLE of someone reporting a "hip replacement" performed in February 2010.

Since last completing a questionnaire, did you have a NEW diagnosis or procedure?	NO or YES	Complete a date bubble below only if you answer YES: When:	2009 Jan-Jun	2009 Jul-Dec	2010 Jan-Jun	2010 Jul-Dec	Office Use
EXAMPLE: Hip replacement	O No ● Yes	When:	O	O	●	O	O
a. Myocardial infarction	O No O Yes	When:	O	O	O	O	O
b. Coronary angioplasty (PTCA) or stent	O No O Yes	When:	O	O	O	O	O
c. Coronary bypass surgery (CABG)	O No O Yes	When:	O	O	O	O	O
d. Congestive heart failure	O No O Yes	When:	O	O	O	O	O
e. Atrial fibrillation	O No O Yes	When:	O	O	O	O	O
f. Intermittent claudication	O No O Yes	When:	O	O	O	O	O
g. Peripheral artery disease (not varicose veins)	O No O Yes	When:	O	O	O	O	O
h. Pulmonary embolism (PE)	O No O Yes	When:	O	O	O	O	O
i. Deep vein thrombosis (DVT)	O No O Yes	When:	O	O	O	O	O
j. Stroke	O No O Yes	When:	O	O	O	O	O
k. TIA (transient ischemic attack)	O No O Yes	When:	O	O	O	O	O
l. Carotid artery surgery (endarterectomy)	O No O Yes	When:	O	O	O	O	O
m. Melanoma	O No O Yes	When:	O	O	O	O	O
n. Non-melanoma skin cancer What type? O basal cell O squamous cell O unknown type	O No O Yes	When:	O	O	O	O	O
o. Breast cancer	O No O Yes	When:	O	O	O	O	O
p. Lung cancer	O No O Yes	When:	O	O	O	O	O
q. Colon cancer	O No O Yes	When:	O	O	O	O	O
r. Other cancer (non-skin) SITE: _____	O No O Yes	When:	O	O	O	O	O
s. Diabetes mellitus	O No O Yes	When:	O	O	O	O	O

Office use O 1 O 2 O 3 O 4

(OVER)

WHS #6 FORM

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.**

HOME PHONE: ( ) - -

CELL PHONE: ( ) - -

WORK PHONE: ( ) - -

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: _____

STREET: _____

CITY: _____ **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

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1. Birth date: ☐☐ / ☐☐ / ☐☐ → Last 6 digits of SSN: X X X - ☐☐ - ☐☐☐☐ (optional)

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 YES, indicate the date (month/year) of the diagnosis or the procedure.**

The first line is provided as an EXAMPLE of someone reporting a "hip replacement" performed in February 2010.

DIAGNOSIS OR PROCEDURE	NO or YES →	IF YES, PROVIDE DATE (MO/YR) IN BOXES BELOW
EXAMPLE: Hip replacement	○ No ● Yes →	MO/YR of procedure: 0 2 / 1 0
a. Acute coronary syndrome/unstable angina	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? ○ No ○ Yes stress test? ○ No ○ Yes	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
c. Myocardial infarction (heart attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA) or stent	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
e. Coronary bypass surgery (CABG)	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
f. Congestive heart failure	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
g. Atrial fibrillation	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
h. Intermittent claudication	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
i. Peripheral artery disease (not varicose veins)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Pulmonary embolism (PE)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
k. Deep vein thrombosis (DVT)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. Stroke	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	○ No ○ Yes →	MO/YR of surgery: ☐☐ / ☐☐
o. Melanoma	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
p. Non-melanoma skin cancer What type? ○ basal cell ○ squamous cell ○ unknown type	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Breast cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Lung cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
s. Colon cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
t. Other cancer (not including any of the above cancers) SITE: _____	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
u. Colon polyp	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
v. Diabetes mellitus (NEWLY diagnosed)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐

51586

WOMEN'S HEALTH STUDY

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2. (continued) NEWLY DIAGNOSED IN LAST 2 YEARS? → 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. Kidney disease (other than kidney 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 →	MO/YR of diagnosis:	/
bb. Cataract (Newly diagnosed)	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	/
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	/
cc. Cataract extraction	**RIGHT eye**	O No	O Yes →	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 dx by a clinician)		O No	O Yes →	MO/YR of diagnosis:	/
hh. Hypertension (NEW dx by a clinician)		O No	O Yes →	MO/YR of diagnosis:	/
ii. Osteoarthritis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	/
jj. Osteoporosis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	/
kk. Fracture due to osteoporosis		O No	O Yes →	MO/YR of occurence:	/
ll. 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 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					

3. What is your CURRENT blood pressure (mmHg)? →

O Don't know my blood pressure

systolic (upper #) / diastolic (lower #)

4. What is your CURRENT TOTAL CHOLESTEROL (mg/dl) 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

5. What is your CURRENT HDL-CHOLESTEROL (mg/dl) 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

6. What is your CURRENT weight? pounds

51586

WOMEN'S HEALTH STUDY

7 /

7. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES: On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

8. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

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

9. 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

10. What is your usual walking pace outdoors?

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

11. IN THE PAST 3 YEARS, have you used female hormones? O No: Skip to the next question O Yes: Complete the box below ↓

a. IF YES, in the PAST 3 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

c. Mark the type(s) of hormones you have used the longest in the PAST 3 YEARS:

Combined: O Prempro (cream) O Prempro (gold) O Prempro (peach) O Prempro (light blue) O Premphase O Combipatch O FemHRT

Estrogen: O Oral Premarin O Patch estrogen O Vaginal estrogen O Ogen O Estrace O Estratest O Estrogen gels, creams or skin spray O Other estrogen

Progesterone/Progestin: O Provera/Cycrin/MPA O Micronized (e.g., Prometrium) O Vaginal O Other progesterone

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 oral conjugated estrogen

e. What was your pattern of progesterone use (days per month)? O Not used O <1 O 1-8 O 9-18 O 19-26 O 27+ days /mo.

12. 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	O No	O Yes
If YES, for how many years have you been regularly taking this bone loss med.?	O < 1 yr O 1-2 yrs	O 3-4 yrs O 5+ yrs

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				
	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: 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)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
f. Multivitamins	O	O	O	O	O
g. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
h. SINGLE supplements of calcium (include elemental calcium in Tums)	O	O	O	O	O
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown					
i. SINGLE supplements of vitamin D (in calcium supplements or separately)	O	O	O	O	O
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown					

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, have you had any of the following?

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

16. Have you EVER had a breast biopsy? O No O Yes

IF YES: How many? O 1 O more than 1
Any with atypical hyperplasia? O No O Yes

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

O Excellent O Very good O Good O Fair O Poor

PLEASE COMPLETE THE CONTACT INFORMATION . THANKS.

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

HOME PHONE: ( ) - -

CELL PHONE: ( ) - -

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: _____ **ZIP:** _____

PHONE NO: _____

IS THIS CONTACT:
O Relative O Friend O Neighbor O Other

49464

WHS #8 FORM

INSTRUCTIONS: Use a ball-point pen and DARKLY shade bubbles like this → ● NOT like this →

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.**

   month / day / year

   Provide CORRECTED date of birth information below:

   month / day / year

2. **Please read the list of illnesses and procedures below. If you have had a NEW diagnosis or NEW procedure SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago), 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: → ☐

a. Myocardial infarction	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):	/
c. Coronary bypass surgery (CABG)	O No	O Yes	→ 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):	/
l. 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 What type? O basal cell O squamous cell O unknown type	O No	O Yes	→ IF YES, When (month/year):	/
o. Breast cancer	O No	O Yes	→ IF YES, When (month/year):	/
p. Lung cancer	O No	O Yes	→ 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	→ IF YES, When (month/year):	/

(OVER)

WHS #8 FORM

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)?
   O No O Yes O Unsure

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 PHONE: ( ) - -

CELL PHONE: ( ) - - CELL PHONE: ( ) - -

WORK PHONE: ( ) - - WORK PHONE: ( ) - -

What is your preferred contact? O Home O Cell O Work 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: _____

CITY: _____ **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

WOMEN'S HEALTH STUDY

9 /

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

1. Birth date: ☐☐ / ☐☐ / ☐☐ → Last 6 digits of SSN: (optional) X X X - ☐☐ - ☐☐☐☐

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 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 Yes stress test? O No O Yes	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
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: ☐☐ / ☐☐
l. Stroke	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	O No O Yes →	MO/YR of 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 unknown type	O No O Yes →	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: ☐☐ / ☐☐

Office use: O 1 O 2 O 3 O 4

(OVER)

18916

WOMEN'S HEALTH STUDY

9 /

2. (continued) NEWLY DIAGNOSED IN LAST 2 YEARS? → 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. Macular degeneration	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
z. Cataract (Newly diagnosed)	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
aa. Cataract extraction	**RIGHT eye**	O No	O Yes →	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 dx 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 diagnosed)		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
hh. Osteoporosis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ii. Fracture due to osteoporosis		O No	O Yes →	MO/YR of occurence:	☐☐ / ☐☐
jj. Joint replacement		O No	O Yes →	MO/YR of surgery:	☐☐ / ☐☐
kk. 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					

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

4. What is your CURRENT TOTAL CHOLESTEROL (mg/dl) 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

5. What is your CURRENT HDL-CHOLESTEROL (mg/dl) 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

6. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES: On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

7. What is your CURRENT weight? ☐☐☐ pounds

8. What is your CURRENT blood pressure (mmHg)? ☐☐☐ systolic (upper #) / ☐☐☐ diastolic (lower #) O Don't know my blood pressure

PLEASE GO TO TOP OF NEXT PAGE

9. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

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

10. 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

11. What is your usual walking pace outdoors?

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

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

	AVERAGE TIME PER WEEK								
	0 hrs.	1 hr.	2-5 hrs.	6-10 hrs.	11-20 hrs.	21-40 hrs.	41-60 hrs.	61-90 hrs.	90+ hrs.
a. Sitting at work or away from home or while driving	O	O	O	O	O	O	O	O	O
b. Sitting at home while watching TV/VCR/DVD	O	O	O	O	O	O	O	O	O
c. Other sitting at home (e.g., reading, meal times, at desk)	O	O	O	O	O	O	O	O	O

13. IN THE PAST 2 YEARS, have you used female hormones? O No: Skip to the next question O Yes: Complete the box below ↓

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

c. Mark the type(s) of hormones you have used the longest in the PAST 2 YEARS:

Combined: O Prempro (cream) O Prempro (gold) O Prempro (peach) O Prempro (light blue) O Premphase O Combipatch O FemHRT

Estrogen: O Oral Premarin O Patch estrogen O Vaginal estrogen O Ogen O Estrace O Estratest O Estrogen gels, creams or skin spray O Other estrogen

Progesterone/Progestin: O Provera/Cycrin/MPA O Micronized (e.g., Prometrium) O Vaginal O Other progesterone

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 oral conjugated estrogen

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.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: 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)	O	O	O	O	O
d. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
e. Multivitamins	O	O	O	O	O
f. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
g. SINGLE supplements of calcium (include elemental calcium in Tums)	O	O	O	O	O
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown					
h. SINGLE supplements of vitamin D (in calcium supplements or separately)	O	O	O	O	O
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown					

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	O No	O Yes
If YES, for how many years have you been regularly taking this bone loss med.? O < 1 yr O 1-2 yrs O 3-4 yrs 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
a. Colonoscopy	O	O	O
b. Sigmoidoscopy	O	O	O
c. Mammogram	O	O	O
d. Fasting blood sugar	O	O	O
e. Eye exam	O	O	O
f. Bone density exam (DEXA)	O	O	O

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

YOUR HOME 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: _____ ZIP: _____

PHONE NO: _____

THIS CONTACT IS: O Relative O Friend O Neighbor O Other

17772

2014-2015

WHS #10 FORM

☐☐ - ☐☐☐☐☐☐ - ☐

Request

INSTRUCTIONS: Use a ball-point pen and DARKLY shade bubbles like this → ● NOT like this → ⊗ ✓

1. **Have you had any of the following diagnoses or procedures SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago)? 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 → ☐ 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	→ IF YES, When (month/year):	☐☐ / ☐☐
c. Coronary bypass surgery (CABG)	O No	O Yes	→ 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):	☐☐ / ☐☐
l. 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 What type? O basal cell O squamous cell O unknown type	O No	O Yes	→ IF YES, When (month/year):	☐☐ / ☐☐
o. Breast cancer	O No	O Yes	→ IF YES, When (month/year):	☐☐ / ☐☐
p. Lung cancer	O No	O Yes	→ 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	→ 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):	☐☐ / ☐☐

(OVER)

17772

2014-2015

WHS #10 FORM

__ - ____ - __

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.**

__ / __ / __
month day year

Provide CORRECTED date of birth information below:

__ / __ / __
month day year

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 PHONE: ( ) - -

HOME PHONE: _____

CELL PHONE: ( ) - -

CELL PHONE: _____

WORK PHONE: ( ) - -

WORK 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: _____

CITY: _____ **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.

17788

2015-2016

WOMEN'S HEALTH STUDY

11 /

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

1. Birth date: ☐☐ / ☐☐ / ☐☐ → Last 4 digits of SSN: (optional) X X X - X X - ☐☐☐☐

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 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 Yes stress test? O No O Yes	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
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: ☐☐ / ☐☐
l. Stroke	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	O No O Yes →	MO/YR of 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 unknown type	O No O Yes →	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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WOMEN'S HEALTH STUDY

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2. (continued) NEWLY DIAGNOSED IN LAST 2 YEARS? → 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. Macular degeneration	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	/
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	/
z. Cataract (Newly diagnosed)	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	/
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	/
aa. Cataract extraction	**RIGHT eye**	O No	O Yes →	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 dx 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 diagnosed)		O No	O Yes →	MO/YR of diagnosis:	/
hh. Osteoporosis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	/
ii. Fracture due to osteoporosis		O No	O Yes →	MO/YR of occurence:	/
jj. Joint replacement		O No	O Yes →	MO/YR of surgery:	/
kk. 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					

3. What is your CURRENT TOTAL CHOLESTEROL (mg/dl) 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

4. What is your CURRENT HDL-CHOLESTEROL (mg/dl) 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

5. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES: On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

6. What is your CURRENT weight? ☐☐☐ pounds

7. What is your CURRENT blood pressure (mmHg)? ☐☐☐ systolic (upper #) / ☐☐☐ diastolic (lower #) O Don't know my blood pressure

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

9. The following items are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities?

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

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

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	O	O
b. Didn't do work or other activities as **carefully** as usual	O	O

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

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.

15. 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.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: 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)	O	O	O	O	O
d. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
e. Multivitamins	O	O	O	O	O
f. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
g. SINGLE supplements of calcium (include elemental calcium in Tums)	O	O	O	O	O
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown					
h. SINGLE supplements of vitamin D (in calcium supplements or separately)	O	O	O	O	O
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown					

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	O No	O Yes
If YES, for how many years have you been regularly taking this bone loss med.? O < 1 yr O 1-2 yrs O 3-4 yrs 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
a. Colonoscopy	O	O	O
b. Sigmoidoscopy	O	O	O
c. Mammogram	O	O	O

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening
d. Fasting blood sugar	O	O	O
e. Eye exam	O	O	O
f. Bone density exam (DEXA)	O	O	O

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

YOUR HOME 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: _____ 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 on file:

If it has changed, please provide your updated e-mail address 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 whs@partners.org. 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.**

a. Myocardial infarction	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):	☐☐ / ☐☐
c. Coronary bypass surgery (CABG)	O No	O Yes →	IF YES, When (month/year):	☐☐ / ☐☐
d. Atrial fibrillation	O No	O Yes →	IF YES, When (month/year):	☐☐ / ☐☐
e. Stroke	O No	O Yes →	IF YES, When (month/year):	☐☐ / ☐☐
f. TIA (transient ischemic attack)	O No	O Yes →	IF YES, When (month/year):	☐☐ / ☐☐
g. Melanoma	O No	O Yes →	IF YES, When (month/year):	☐☐ / ☐☐
h. Non-melanoma skin cancer	O No	O Yes →	IF YES, When (month/year):	☐☐ / ☐☐
What type? O basal cell O squamous cell O unknown type				
i. Other cancer	O No	O Yes →	IF YES, When (month/year):	☐☐ / ☐☐
Specify: O Breast cancer O Lung cancer O Colon cancer O Other cancer site: _____				

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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 UPDATED telephone nos. below:

HOME PHONE: ( ) - -

HOME PHONE: _____

CELL PHONE: ( ) - -

CELL PHONE: _____

WORK PHONE: ( ) - -

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: _____

CITY: _____ **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 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.

Is the DOB above correct? O Yes O No → IF NO, what is your correct date of birth? _____

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 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 Yes stress test? O No O Yes	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
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: ☐☐ / ☐☐
l. Stroke	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	O No O Yes →	MO/YR of 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 unknown type	O No O Yes →	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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2. (continued) NEWLY DIAGNOSED IN LAST 2 YEARS? → 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 occurence:	☐☐ / ☐☐
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			

3. Have you EVER been diagnosed with polycystic ovary syndrome (PCOS)? O No O Yes → YEAR of Dx: ☐☐☐☐ YYYY

4. What is your CURRENT TOTAL CHOLESTEROL (mg/dl) 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

5. What is your CURRENT weight? ☐☐☐ pounds

6. What is your CURRENT blood pressure (mmHg)? ☐☐☐ systolic (upper #) / ☐☐☐ diastolic (lower #) O Don't know my blood pressure

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

8. 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.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: 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)	O	O	O	O	O
d. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O

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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10. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

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

11. 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

12. What is your usual walking pace outdoors?

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

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

13. The following items are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities?

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

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?

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

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	O	O
b. Didn't do work or other activities as **carefully** as usual	O	O

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

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.

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THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

YOUR HOME 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: _____ 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 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 AT LEAST ONCE PER WEEK FOR A YEAR OVER THE PAST 10 YEARS 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 7,000-15,000 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) (as single supplement)	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 <11mg O 11-50 mg O 51-100 mg O >100 mg O unk		
Vitamin B2 (riboflavin) (as single supplement)	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 <26 mg O 26-50 mg O 51-100 mg O >100 mg O unk		
Vitamin B3 (niacin) (as single supplement)	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 <51 mg O 51-200 mg O 201-500 mg O >500 mg O unk		
Vitamin B6 (pyridoxine) (as single supplement)	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 mcg O 10-39 mcg O 40-80 mcg O >80 mcg O unk		
Vitamin B7 (biotin) (as single supplement)	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 <101 mcg O 101-2500 mcg O 2501-5000 mcg O >5000 mcg O unk		
Vitamin B9 (folic acid) (as single supplement)	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 <401 mcg O 401-800 mcg O 801-1000 mcg O >1000 mcg O unk		

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2017

WOMEN'S HEALTH STUDY

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Supplement	YEARS taken in past 10 years	Average DAYS PER WEEK	Do you take it NOW?
Vitamin B12 (cobalamin) (as single supplement)	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 <26 mcg O 26-100 mcg O 101-500 mcg O >500 mcg O unk		
Vitamin C	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 <101 mg O 101-500 mg O 501-1000 mg O >1000 mg O unk		
Vitamin D (in calcium supplement or separately)	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 <601 IU O 601-1000 IU O 1001-2000 IU O >2000 IU O unk		
Vitamin E	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 <101 IU O 101-400 IU O 401-1000 IU O >1000 IU O unk		
Calcium (incl. elemental calcium in Tums)	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 <400 mg O 400-900 mg O 901-1300 mg O >1300 mg O unk		
Chromium	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 <201 mcg O 201-500 mcg O 501-1000 mcg O >1000 mcg O unk		
Iron	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 <25 mg O 25-50 mg O 51-70 mg O >70 mg O unk		
Magnesium	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 <41 mg O 41-250 mg O 251-350 mg O >350 mg O unk		
Selenium	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 <80 mcg O 80-130 mcg O 131-250 mcg O >250 mcg O unk		
Zinc	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 <25 mg O 25-74 mg O 75-100 mg O >100 mg O unk		

Supplement	YEARS taken in past 10 years	Average DAYS PER WEEK	Do you take it NOW?
Potassium	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-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 O 7	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 O 7	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 O 7	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 O 7	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 O 7	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 O 7	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 O 7	O Yes O No

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2017

WOMEN'S HEALTH STUDY

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Supplement	YEARS taken in past 10 years	Average DAYS PER WEEK	Do you take 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 O 7	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 O 7	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 O 7	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 O 7	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 O 7	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 O 7	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 O 7	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
St. John's wort	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
Copper	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
Iodine	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

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

Office use: O 1 O 2 O 3 O 4

43639

2018

WOMEN'S HEALTH STUDY

14 /

O K

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.

Is the DOB above correct? O Yes O No → 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 Yes stress test? O No O Yes	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
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: ☐☐ / ☐☐
l. Stroke	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	O No O Yes →	MO/YR of 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 unknown type	O No O Yes →	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: ☐☐ / ☐☐

Office use: O 1 O 2 O 3 O 4

(OVER)

2. (continued) NEWLY DIAGNOSED IN THE LAST YEAR? → 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 occurence:	☐☐ / ☐☐
ee. Joint replacement	O No	O Yes →	MO/YR of surgery:	☐☐ / ☐☐
ff. Fibrocystic or other benign breast disease If YES, confirmed by: breast biopsy? O No O Yes aspiration? O No O Yes	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐

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

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 past year

4. What is your CURRENT weight? ☐☐☐ pounds

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

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?

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

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	O	O
b. Didn't do work or other activities as **carefully** as usual	O	O

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

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

13. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

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

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

15. What is your usual walking pace outdoors?

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

16. DURING THE PAST YEAR, what was your approximate AVERAGE TIME IN HOURS PER WEEK spent at each of the following sedentary activities?

	AVERAGE HOURS PER WEEK								
	zero	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 (hrs/week)	O	O	O	O	O	O	O	O	O
b. Sitting at home while watching TV/VCR/DVD or using the computer (hrs/week)	O	O	O	O	O	O	O	O	O
c. Other sitting at home (e.g. reading, meal times, at desk) (hrs/week)	O	O	O	O	O	O	O	O	O

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

21. Have you EVER been told by a dental professional that you lost bone around your teeth? O Yes O No O Don't know

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? O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7

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 ASSISTS US IN MAINTAINING FOLLOW-UP.

YOUR HOME 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: _____ 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 on file:**

If it has changed, please provide your updated e-mail address below:

_____

61877

2019

WOMEN'S HEALTH STUDY

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O K

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.**

Is the DOB above correct? O Yes O No → **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 Yes stress test? O No O Yes	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
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: ☐☐ / ☐☐
l. Stroke	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	O No O Yes →	MO/YR of 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 unknown type	O No O Yes →	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: ☐☐ / ☐☐

Office use: O 1 O 2 O 3 O 4

(OVER)

2. (continued) NEWLY DIAGNOSED IN LAST 2 YEARS? → 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

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				
	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-999 mg O 1000+ mg O unknown	O	O	O	O	O
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
d. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O

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? ☐☐☐

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?

	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	○	○	○
b. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
c. Lifting or carrying groceries	○	○	○
d. Climbing **several** flights of stairs	○	○	○
e. Climbing **one** flight of stairs	○	○	○
f. Bending, kneeling, or stooping	○	○	○
g. Walking **more than a mile**	○	○	○
h. Walking **several blocks**	○	○	○
i. Walking **one block**	○	○	○
j. Bathing or dressing yourself	○	○	○

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	○	○
b. **Accomplished less** than you would like	○	○
c. Were limited in the **kind** of work or other activities	○	○
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	○	○

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	○	○
b. **Accomplished less** than you would like	○	○
c. Didn't do work or other activities as **carefully** as usual	○	○

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?

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

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

○ None ○ Very mild ○ Mild ○ Moderate ○ Severe ○ 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)? ○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ 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?	○	○	○	○	○	○
b. Have you been a very nervous person?	○	○	○	○	○	○
c. Have you felt so down in the dumps that nothing could cheer you up?	○	○	○	○	○	○
d. Have you felt calm and peaceful?	○	○	○	○	○	○
e. Did you have a lot of energy?	○	○	○	○	○	○
f. Have you felt downhearted and blue?	○	○	○	○	○	○
g. Did you feel worn out?	○	○	○	○	○	○
h. Have you been a happy person?	○	○	○	○	○	○
i. Did you feel tired?	○	○	○	○	○	○

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.)?

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ 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	○	○	○	○	○
b. I am as healthy as anybody I know	○	○	○	○	○
c. I expect my health to get worse	○	○	○	○	○
d. My health is excellent	○	○	○	○	○

17. 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?	○	○
b. Do you have **more** trouble than usual remembering recent events?	○	○
c. Do you have **more** trouble than usual remembering a short list of items, such as a shopping list?	○	○
d. Do you have trouble remembering things from one second to the next?	○	○
e. Do you have difficulty in understanding or following spoken instructions?	○	○
f. Do you have **more** trouble than usual following a group conversation or a plot in a TV program due to your memory?	○	○

18. Have you ever had migraine headaches?

○ No, please proceed to the contact information at the bottom of this page

○ Yes, please proceed to the next question

19. At what age did your migraine headaches first begin?

○ ≤10 years old ○ 11-20 years old ○ 21-30 years old ○ 31-50 years old ○ >50 years old

20. How often have you experienced aura before a migraine headache?

○ Never ○ Sometimes ○ Always

21. Do you ever experience aura which is NOT followed by a migraine headache?

○ No ○ Yes → **Is this aura similar to the aura you experience prior to a migraine headache?**

○ Yes, it is similar ○ No, it is not similar ○ Some auras are similar and some are not similar

○ I do not experience aura prior to my migraine headaches

22. In the past year, have you had migraine headaches?

○ No, please go to questions 22a and 22b ○ Yes → **What was the frequency of your migraine headaches in the past year?**

↓

○ Daily ○ Weekly ○ Monthly ○ Every other month

○ Less than 6 times per year

22a. At what age did your migraine headaches stop?

○ ≤50 ○ 51-55 ○ 56-60 ○ 61-65 ○ 66-70 ○ >70 years old

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

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

YOUR HOME 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:** _____ **ZIP:** _____

PHONE NO: _____

THIS CONTACT IS: ○ Relative ○ Friend ○ Neighbor ○ 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:

_____

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

31461

WOMEN'S HEALTH STUDY

16 /

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.**

Is the DOB above correct? ○ Yes ○ No → **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	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? ○ No ○ Yes stress test? ○ No ○ Yes	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
c. Myocardial infarction (heart attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA or PCI) or stent	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
e. Coronary bypass surgery (CABG)	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
f. Congestive heart failure	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
g. Atrial fibrillation	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
h. Intermittent claudication	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
i. Peripheral artery disease (not varicose veins)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Pulmonary embolism (PE)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
k. Deep vein thrombosis (DVT)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. Stroke	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	○ No ○ Yes →	MO/YR of surgery: ☐☐ / ☐☐
o. Melanoma	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
p. Non-melanoma skin cancer What type? ○ basal cell ○ squamous cell ○ unknown type	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Breast cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Lung cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
s. Colon cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
t. Other cancer (not including any of the above cancers) SITE: _____	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
u. Colon polyp	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
v. Diabetes mellitus (NEWLY diagnosed)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐

2. (continued) NEWLY DIAGNOSED WITHIN THE PAST YEAR? → 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			

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: ☐☐ / ☐☐

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				
	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-999 mg O 1000+ mg O unknown	O	O	O	O	O
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
d. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O

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?	O	O
b. Do you have **more** trouble than usual remembering recent events?	O	O
c. Do you have **more** trouble than usual remembering a short list of items, such as a shopping list?	O	O
d. Do you have trouble remembering things from one second to the next?	O	O
e. Do you have difficulty in understanding or following spoken instructions?	O	O
f. Do you have **more** trouble than usual following a group conversation or a plot in a TV program due to your memory?	O	O

8. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

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

9. 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

10. What is your usual walking pace outdoors?

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

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

	AVERAGE HOURS PER WEEK								
	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	O	O	O	O	O	O	O	O	O
b. Sitting at home while watching TV/VCR/DVD or using the computer	O	O	O	O	O	O	O	O	O
c. Other sitting at home (e.g., reading, meal times, at desk)	O	O	O	O	O	O	O	O	O

12. What is your CURRENT weight? ☐☐☐ pounds

13. What is your CURRENT height? ☐ feet AND ☐☐ inches

14. What is your CURRENT blood pressure (mmHg)? ☐☐☐ systolic (upper #) / ☐☐☐ diastolic (lower #) O Don't know my blood pressure

15. What is your CURRENT total cholesterol (mg/dl) if checked within the past year?

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 past year

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

YOUR HOME 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: ☐☐ **ZIP:** ☐☐☐☐☐

PHONE NUMBER: (☐☐☐) ☐☐☐ - ☐☐☐☐

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, or you would now be willing to share your e-mail address, please provide your updated e-mail address below:

_____

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

31508

WOMEN'S HEALTH STUDY

17 /

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.**

Is the DOB above correct? ○ Yes ○ No → **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	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? ○ No ○ Yes stress test? ○ No ○ Yes	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
c. Myocardial infarction (heart attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA or PCI) or stent	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
e. Coronary bypass surgery (CABG)	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
f. Congestive heart failure	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
g. Atrial fibrillation	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
h. Intermittent claudication	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
i. Peripheral artery disease (not varicose veins)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Pulmonary embolism (PE)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
k. Deep vein thrombosis (DVT)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. Stroke	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	○ No ○ Yes →	MO/YR of surgery: ☐☐ / ☐☐
o. Melanoma	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
p. Non-melanoma skin cancer What type? ○ basal cell ○ squamous cell ○ unknown type	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Breast cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Lung cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
s. Colon cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
t. Other cancer (not including any of the above cancers) SITE: _____	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
u. Colon polyp	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
v. Diabetes mellitus (NEWLY diagnosed)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐

Office use: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

(OVER)

2. (continued) NEWLY DIAGNOSED WITHIN THE PAST YEAR? → 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				

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

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

4. Have you EVER been diagnosed by 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 did you FIRST get the vaccine? (MO/YR) ☐☐ / ☐☐

b. Which vaccine 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	O	O	O	O	O
b. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
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	O	O	O	O	O
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	O	O	O	O	O

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 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

12. What is your CURRENT weight? ☐☐☐ pounds

13. What is your CURRENT height? ☐ feet AND ☐☐ inches

14. What is your CURRENT blood pressure (mmHg)? ☐☐☐ systolic (upper #) / ☐☐☐ diastolic (lower #) O Don't know my blood pressure

15. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES: On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

16. What is your CURRENT total cholesterol (mg/dl) if checked within the past year?

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 past year

17. What is your CURRENT HDL-CHOLESTEROL (mg/dl) 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

Questions 18-24 are from the RAND SF-36 Short Form Survey

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

19. 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?	O	O
b. Do you have **more** trouble than usual remembering recent events?	O	O
c. Do you have **more** trouble than usual remembering a short list of items, such as a shopping list?	O	O
d. Do you have trouble remembering things from one second to the next?	O	O
e. Do you have difficulty in understanding or following spoken instructions?	O	O
f. Do you have **more** trouble than usual following a group conversation or a plot in a TV program due to your memory?	O	O

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

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)?

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

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

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

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

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 address , please provide your updated e-mail address below:

_____

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

61945

WOMEN'S HEALTH STUDY

18 /

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.**

Is the DOB above correct? ○ Yes ○ No → **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	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? ○ No ○ Yes stress test? ○ No ○ Yes	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
c. Myocardial infarction (heart attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA or PCI) or stent	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
e. Coronary bypass surgery (CABG)	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
f. Congestive heart failure	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
g. Atrial fibrillation	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
h. Intermittent claudication	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
i. Peripheral artery disease (not varicose veins)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Pulmonary embolism (PE)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
k. Deep vein thrombosis (DVT)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. Stroke	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	○ No ○ Yes →	MO/YR of surgery: ☐☐ / ☐☐
o. Melanoma	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
p. Non-melanoma skin cancer What type? ○ basal cell ○ squamous cell ○ unknown type	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Breast cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Lung cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
s. Colon cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
t. Other cancer (not including any of the above cancers) SITE: _____	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
u. Colon polyp	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
v. Diabetes mellitus (NEWLY diagnosed)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐

Office use: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

PLEASE CONTINUE ON THE NEXT PAGE

2. (continued) NEWLY DIAGNOSED WITHIN THE PAST YEAR? → 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			

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

4. What is your CURRENT weight? ☐☐☐ pounds

5. What is your CURRENT height? ☐ feet AND ☐☐ inches

6. What is your CURRENT blood pressure (mmHg)? ☐☐☐ systolic (upper #) / ☐☐☐ diastolic (lower #) O Don't know my blood pressure

7. Do you CURRENTLY smoke cigarettes? O No O Yes → **IF YES:** On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

8. Did you receive the influenza (flu) vaccine after August 2021? O No O Yes

9. Have you EVER been diagnosed by a doctor or healthcare professional as having had or probably having had the coronavirus (COVID-19)? O No O Yes

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

b. Have you EVER been hospitalized due to COVID-19? O No O Yes

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

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

10. Have you EVER been tested for the coronavirus (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 POSITIVE result? O No O Yes

b. Please provide the date (MO/YR) of your FIRST POSITIVE test: ☐☐ / ☐☐

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

IF YES: a. When did you FIRST get the vaccine? (MO/YR) ☐☐ / ☐☐ → Date of SECOND dose, if applicable: ☐☐ / ☐☐

b. Which vaccine did you receive? O Moderna O Pfizer-BioNTech O Johnson & Johnson

c. Have you received a booster shot? O No O Yes

IF YES: Which booster did you receive? O Moderna O Pfizer-BioNTech O Johnson & Johnson

PLEASE CONTINUE ON THE NEXT PAGE

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				Is this symptom CURRENTLY present?
	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	
a. Fever	O	O	O	O	O	O Yes
b. Persistent cough	O	O	O	O	O	O Yes
c. Chills or sweats	O	O	O	O	O	O Yes
d. Headache	O	O	O	O	O	O Yes
e. Sore throat	O	O	O	O	O	O Yes
f. Hoarseness	O	O	O	O	O	O Yes
g. Loss of smell or taste	O	O	O	O	O	O Yes
h. Shortness of breath/difficulty breathing	O	O	O	O	O	O Yes
i. Chest pain/tightness	O	O	O	O	O	O Yes
j. Muscle aches	O	O	O	O	O	O Yes
k. Abdominal pain	O	O	O	O	O	O Yes
l. Diarrhea	O	O	O	O	O	O Yes
m. Confusion or "brain fog"	O	O	O	O	O	O Yes
n. Malaise- a general feeling of illness, discomfort, uneasiness	O	O	O	O	O	O Yes
o. Sleep disturbance	O	O	O	O	O	O Yes
p. Unusual fatigue	O	O	O	O	O	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				
	None	1-3	4-10	11-20	21+
a. Multivitamins	O	O	O	O	O
b. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
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	O	O	O	O	O
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	O	O	O	O	O
e. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
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	O	O	O	O	O
g. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
h. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O

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

PLEASE CONTINUE ON THE NEXT PAGE

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

17. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

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

18. 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

19. What is your usual walking pace outdoors?

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

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

	AVERAGE HOURS PER WEEK								
	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	O	O	O	O	O	O	O	O	O
b. Sitting at home while watching TV/VCR/DVD or using the computer	O	O	O	O	O	O	O	O	O
c. Other sitting at home (e.g., reading, meal times, at desk)	O	O	O	O	O	O	O	O	O

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 address , please provide your updated e-mail address below:

_____

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

36537

WOMEN'S HEALTH STUDY

19 /

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.**

Is the DOB above correct? ○ Yes ○ No → **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	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris **If YES**, confirmed by: angiogram/cardiac cath? ○ No ○ Yes stress test? ○ No ○ Yes	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
c. Myocardial infarction (heart attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA or PCI) or stent	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
e. Coronary bypass surgery (CABG)	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
f. Congestive heart failure	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
g. Atrial fibrillation	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
h. Intermittent claudication	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
i. Peripheral artery disease (not varicose veins)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Pulmonary embolism (PE)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
k. Deep vein thrombosis (DVT)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. Stroke	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	○ No ○ Yes →	MO/YR of surgery: ☐☐ / ☐☐
o. Melanoma	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
p. Non-melanoma skin cancer What type? ○ basal cell ○ squamous cell ○ unknown type	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Breast cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Lung cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
s. Colon cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
t. Other cancer (not including any of the above cancers) SITE: _____	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
u. Colon polyp	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
v. Diabetes mellitus (NEWLY diagnosed)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐

Office use: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

PLEASE CONTINUE ON THE NEXT PAGE

2. (continued) NEWLY DIAGNOSED WITHIN THE PAST YEAR? → 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				
gg. Coronavirus (COVID-19)	O No	O Yes →	MO/YR of diagnosis:	/
If YES: a. Was this confirmed by a positive COVID-19 test?	O No	O Yes		
b. Were you hospitalized?	O No	O Yes →	MO/YR of hospitalization:	/
c. Did you require treatment in an Intensive Care Unit (ICU)?	O No	O Yes		

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?

		Duration of symptom				Is this symptom CURRENTLY present?
	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	
a. Fever	O	O	O	O	O	O Yes
b. Persistent cough	O	O	O	O	O	O Yes
c. Chills or sweats	O	O	O	O	O	O Yes
d. Headache	O	O	O	O	O	O Yes
e. Sore throat	O	O	O	O	O	O Yes
f. Hoarseness	O	O	O	O	O	O Yes
g. Loss of smell or taste	O	O	O	O	O	O Yes
h. Shortness of breath/difficulty breathing	O	O	O	O	O	O Yes
i. Chest pain/tightness	O	O	O	O	O	O Yes
j. Muscle aches	O	O	O	O	O	O Yes
k. Abdominal pain	O	O	O	O	O	O Yes
l. Diarrhea	O	O	O	O	O	O Yes
m. Confusion or "brain fog"	O	O	O	O	O	O Yes
n. Malaise - a general feeling of illness, discomfort, uneasiness	O	O	O	O	O	O Yes
o. Sleep disturbance	O	O	O	O	O	O Yes
p. Unusual fatigue	O	O	O	O	O	O Yes

PLEASE CONTINUE ON THE NEXT PAGE

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

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

	Date: MO/YR	Vaccine Received
a. FIRST vaccine	☐☐ / ☐☐	○ Moderna ○ Pfizer-BioNTech ○ Johnson & Johnson
b. SECOND vaccine	☐☐ / ☐☐	○ Moderna ○ Pfizer-BioNTech ○ Johnson & Johnson
c. FIRST booster shot	☐☐ / ☐☐	○ Moderna ○ Pfizer-BioNTech
d. SECOND booster shot	☐☐ / ☐☐	○ Moderna ○ Pfizer-BioNTech
e. THIRD booster shot	☐☐ / ☐☐	○ Moderna ○ Pfizer-BioNTech

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

6. What is your CURRENT weight? ☐☐☐ pounds

7. What is your CURRENT height? ☐ feet AND ☐☐ inches

8. What is your CURRENT blood pressure (mmHg)? ☐☐☐ systolic (upper #) / ☐☐☐ diastolic (lower #) ○ Don't know my blood pressure

9. What is your CURRENT total cholesterol (mg/dl) if checked within the past 2 years?

○ <140 mg/dl ○ 140-159 ○ 160-179 ○ 180-199 ○ 200-219 ○ 220-239 ○ 240-249
○ 250-259 ○ 260-269 ○ 270-279 ○ 280-299 ○ 300-329 ○ 330+ ○ unknown/not checked in 2 yrs

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

○ <30 mg/dl ○ 30-39 ○ 40-49 ○ 50-59 ○ 60-69 ○ 70-79
○ 80-89 ○ 90-99 ○ 100+ ○ unknown/not checked in 2 yrs

11. Do you CURRENTLY smoke cigarettes? ○ No ○ Yes → **IF YES:** On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

12. Have you EVER been diagnosed with fatty liver disease? ○ No ○ Yes → **IF YES,** MO/YR of diagnosis: ☐☐ / ☐☐

IF YES, confirmed by: liver biopsy? ○ No ○ Yes liver imaging? ○ No ○ Yes

13. Have you EVER been diagnosed with liver cirrhosis? ○ No ○ Yes **IF YES,** MO/YR of diagnosis: ☐☐ / ☐☐

14. Have you EVER been diagnosed with chronic viral hepatitis? ○ No ○ 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	○	○	○	d. Fasting blood sugar	○	○	○
b. Sigmoidoscopy	○	○	○	e. Eye exam	○	○	○
c. Mammogram	○	○	○	f. Bone density exam (DEXA)	○	○	○

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.

	DAYS USED IN THE PAST MONTH				
	None	1-3	4-10	11-20	21+
a. Multivitamins	O	O	O	O	O
b. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
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	O	O	O	O	O
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	O	O	O	O	O
e. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
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	O	O	O	O	O
g. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
h. Non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O

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

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 O None of the time

PLEASE CONTINUE ON THE NEXT PAGE

22. 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	O	O
b. **Accomplished less** than you would like	O	O
c. Were limited in the **kind** of work or other activities	O	O
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	O	O

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	O	O
b. Didn't do work or other activities as **carefully** as usual	O	O

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

25. 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?	O	O
b. Do you have **more** trouble than usual remembering recent events?	O	O
c. Do you have **more** trouble than usual remembering a short list of items, such as a shopping list?	O	O
d. Do you have trouble remembering things from one second to the next?	O	O
e. Do you have difficulty in understanding or following spoken instructions?	O	O
f. Do you have **more** trouble than usual following a group conversation or a plot in a TV program due to your memory?	O	O

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-mail 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 ◯ 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

h. Month of diagnosis

- ◯ January
- ◯ February
- ◯ March
- ◯ April
- ◯ May
- ◯ June
- ◯ July
- ◯ August
- ◯ September
- ◯ October
- ◯ November
- ◯ December

h. Year of diagnosis

- ◯ 2024
- ◯ 2023
- ◯ 2022
- ◯ 2021
- ◯ Before 2021
- ◯ Unknown

i. Peripheral artery disease (not varicose veins)

- ◯ Yes
- ◯ No

i. Month of diagnosis

- ◯ January
- ◯ February
- ◯ March
- ◯ April
- ◯ May
- ◯ June
- ◯ July
- ◯ August
- ◯ 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
- ◯ December

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

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. Please specify type:	_____

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

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
- ◯ 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