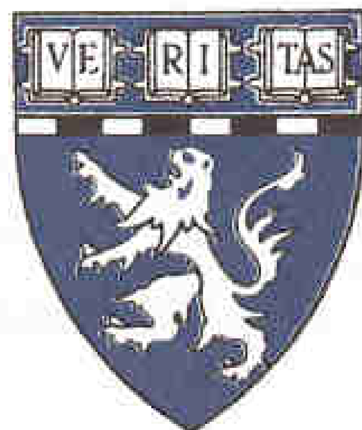
HARVARD MEDICAL SCHOOL **NURSES' HEALTH STUDY**



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Dear Colleague:

On behalf of the Nurses' Health Study research group I am most grateful for the detailed information you have provided over the past 18 years. Whether or not you are still active in nursing, your continued input is extremely valuable to our further understanding of factors influencing the health of women.

The attached **very brief** questionnaire asks only for the most important information necessary for maintaining our records. We have made it as short as possible in the hope that you will take just a few minutes to complete the form.

In the past year we have reported that women taking vitamin E supplements have reduced risk of cardiovascular disease[(1)], and that women who have had a tubal ligation are at a decreased risk of ovarian cancer[(2)]. Previous responses also indicated that a diet high in folate is related to a lower risk of colon polyps[(3)], and that low intake of vegetables is associated with an increased risk of breast cancer[(4)].

Please complete and return the enclosed questionnaire at your earliest convenience. Once again, let me express my deepest gratitude for the contribution you have made to this study. Already these efforts have yielded much useful information, and with your participation we can continue to study the factors which are important for maintaining optimum health.

Sincerely,

Frank E. Speizer, M.D.
Principal Investigator

P.S. Your past responses have been very important. However, due to the many unresolved questions concerning women's health, **your reply now is more important than ever!**

[1] N Engl J Med 1993; 328: 1450-1456
[2] JAMA 1993; 270: 2813-2818
[3] J Natl Cancer Inst 1993; 85: 875-884
[4] N Engl J Med 1993; 329: 234-240

1. What is your date of birth? MONTH / DAY / YEAR

2. Current Weight: ______ lbs.

3. Have your menstrual periods ceased permanently? ☐ No ☐ Yes ➡ Was this: ☐ Natural ☐ Surgical

4. Do you currently use female hormones (e.g., Premarin)? ☐ No ☐ Yes ➡ ☐ Estrogen only ☐ Estrogen & Progesterone ☐ Other

5. Have you had your uterus removed? ☐ No ☐ Yes ➡ At what age? ______ Age

6. Have you had your ovaries removed? ☐ No ☐ One only ☐ Both removed ➡ At what age(s)? ______ Age

7. Do you currently smoke cigarettes? ☐ No ☐ Yes

8. Since June 1992, have you had any of these physician-diagnosed illnesses?

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".

	Illness	Yes	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 1992	JUNE '92 to MAY '94	After JUNE 1, 1994	
a	Diabetes Mellitus	Y ➡	☐	☐	☐	② ③ ③a ④ ⑤ ⑤a ⑥ ⑥a ⑦ ⑧
b	Elevated Cholesterol	Y ➡	☐	☐	☐	
c	High Blood Pressure	Y ➡	☐	☐	☐	
d	Fibrocystic or other Benign Breast Disease	Y ➡	☐	☐	☐	➡ Confirmed by breast biopsy? ☐ Yes ☐ No
e	Breast Cancer	Y ➡	☐	☐	☐	
f	Cancer of the Uterus (endometrium)	Y ➡	☐	☐	☐	
g	Melanoma	Y ➡	☐	☐	☐	
h	Other Skin Cancer	Y ➡	☐	☐	☐	➡ Was this: ☐ Basal Cell ☐ Squamous Cell ☐ Other
i	Colon or Rectal Polyps (benign)	Y ➡	☐	☐	☐	
j	Cancer of the Colon or Rectum	Y ➡	☐	☐	☐	
k	Other Cancer (e.g., lung, ovary, etc.)	Y ➡	☐	☐	☐	➡ Specify other cancer site:
l	Myocardial Infarction (heart attack)	Y ➡	☐	☐	☐	➡ Were you hospitalized for this MI? ☐ Yes ☐ No
m	Angina Pectoris	Y ➡	☐	☐	☐	➡ Confirmed by angiogram? ☐ Yes ☐ No
n	Coronary Artery Bypass or Coronary Angioplasty	Y ➡	☐	☐	☐	
o	Stroke (CVA)	Y ➡	☐	☐	☐	⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
p	Transient Ischemic Attack (TIA)	Y ➡	☐	☐	☐	
q	Carotid Surgery (Endarterectomy)	Y ➡	☐	☐	☐	
r	Alzheimer's Disease	Y ➡	☐	☐	☐	
s	Fracture of the Hip or Wrist	Y ➡	☐	☐	☐	➡ Please specify date, site, and circumstances on reverse side of survey.
t	Osteoporosis	Y ➡	☐	☐	☐	
u	Asthma (Doctor diagnosed)	Y ➡	☐	☐	☐	➡ Do you have: Emphysema or Chronic Bronchitis ☐ Yes ☐ No
v	Parkinson's Disease (Ever diagnosed)	Y ➡	☐	☐	☐	
w	Multiple Sclerosis or A.L.S. (Circle one)	Y ➡	☐	☐	☐	Ⓜ Ⓐ Ⓤ
x	Glaucoma	Y ➡	☐	☐	☐	
y	Macular Degeneration of Retina	Y ➡	☐	☐	☐	
z	Cataract (1st diagnosis)	Y ➡	☐	☐	☐	
aa	Cataract Extraction	Y ➡	☐	☐	☐	
bb	Kidney Stones	Y ➡	☐	☐	☐	
cc	Other Major Illness Since June 1992 (e.g., Pulmonary Embolus, Cholecystectomy, etc.)	Y ➡	☐	☐	☐	➡ Specify other major illness or surgery:

Margin codes: da, ha, la, ma, ua

Continue on Back

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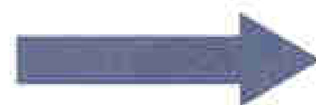
6a

6b



Please indicate the name of someone at a DIFFERENT PERMANENT ADDRESS to whom we might write in the event we are unable to contact you:

Name: ______________________

Address: ______________________

____

Y N

Please Specify Date, Site, and Circumstances of Hip or Wrist Fracture Below:

Was this a fracture of: ☐ Hip ☐ Wrist

SS V W X Y Z