HARVARD MEDICAL SCHOOL **NURSES' HEALTH STUDY**

Please reply to:
Channing Laboratory
181 Longwood Avenue
Boston MA 02115-5804
(617) 525-2279 Fax (617) 525-2008

Dear Colleague:

Thank you for your participation in one of the preeminent studies of women's health, the Nurses' Health Study. Your continued involvement is extremely valuable, regardless of your employment or retirement status. With your help, we are continuing to investigate factors which promote good health in 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.

We know that you will give this questionnaire the same careful consideration as you have given our forms since you first participated in 1976. As always, all information is kept strictly confidential.

It is with our deepest gratitude that we thank you for the time and care which you have continued to offer to further the study of women's health. Thanks again.

Sincerely,

Frank E. Speizer, M.D.
Principal Investigator

P.S. Your prompt reply will help us continue to examine the many unresolved questions concerning the health of women. Please take just a moment to complete this short form!

NURSES' HEALTH STUDY - HARVARD MEDICAL SCHOOL

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 1996**, have you had any of these physician-diagnosed illnesses?

2 3 3a 4 4a 5 5a 6 6a 7 8

Cardiovascular

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 1996	JUNE '96 to MAY '98	After JUNE 1, 1998
Elevated Cholesterol ☐ Y ➡	☐	☐	☐
High Blood Pressure ☐ Y ➡	☐	☐	☐
Myocardial Infarction (heart attack) ☐ Y ➡ ➡ Were you hospitalized for this MI? ○ Yes ○ No	☐	☐	☐
Angina Pectoris ☐ Y ➡ ➡ Confirmed by angiogram? ○ Yes ○ No	☐	☐	☐
Coronary Artery Bypass or Coronary Angioplasty ☐ Y ➡	☐	☐	☐
Stroke (CVA) ☐ Y ➡	☐	☐	☐
Transient Ischemic Attack (TIA) ☐ Y ➡	☐	☐	☐
Carotid Artery Surgery (Endarterectomy) ☐ Y ➡	☐	☐	☐
Peripheral Artery Disease (not varicose veins) ☐ Y ➡	☐	☐	☐
Pulmonary Embolus ☐ Y ➡	☐	☐	☐

Have you ever been diagnosed with Congestive Heart Failure?
○ No ○ Yes, before 1984 ○ Yes, 1984 or later

Eye Diseases

	BEFORE JUNE 1, 1996	JUNE '96 to MAY '98	After JUNE 1, 1998
Glaucoma ☐ Y ➡	☐	☐	☐
Macular Degeneration of Retina ☐ Y ➡	☐	☐	☐
Cataract (1st diagnosis) ☐ Y ➡	☐	☐	☐
Cataract Extraction ☐ Y ➡	☐	☐	☐

Musculoskeletal

	BEFORE JUNE 1, 1996	JUNE '96 to MAY '98	After JUNE 1, 1998
Hip or Wrist Fracture ☐ Y ➡ Specify Date, Site, and Circumstances on reverse side of this form	☐	☐	☐
Hip Replacement ☐ Y ➡	☐	☐	☐
Osteoporosis ☐ Y ➡	☐	☐	☐

Cancer/Benign Tumors

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 1996	JUNE '96 to MAY '98	After JUNE 1, 1998
Cancer of the Uterus (endometrium) ☐ Y ➡	☐	☐	☐
Fibrocystic or other Benign Breast Disease ☐ Y ➡ ➡ Confirmed by breast biopsy? ○ Yes ○ No	☐	☐	☐
Breast Cancer ☐ Y ➡	☐	☐	☐
Melanoma ☐ Y ➡	☐	☐	☐
Squamous Cell Skin Cancer ☐ Y ➡	☐	☐	☐
Basal Cell Skin Cancer ☐ Y ➡	☐	☐	☐
Colon or Rectal Polyps (benign) ☐ Y ➡	☐	☐	☐
Colon or Rectal Cancer ☐ Y ➡	☐	☐	☐
Other Cancer (e.g. Lung, Ovary, etc.) ☐ Y ➡	☐	☐	☐

Specify other cancer site:

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

Other Diseases

	BEFORE JUNE 1, 1996	JUNE '96 to MAY '98	After JUNE 1, 1998
Diabetes Mellitus ☐ Y ➡	☐	☐	☐
Alzheimer's Disease ☐ Y ➡	☐	☐	☐
Parkinson's Disease ☐ Y ➡	☐	☐	☐
Multiple Sclerosis ☐ Y ➡	☐	☐	☐
A.L.S. ☐ Y ➡	☐	☐	☐
Interstitial Cystitis (Dx by cystoscopy) ☐ Y ➡	☐	☐	☐
Kidney Stones ☐ Y ➡	☐	☐	☐
Cholecystectomy ☐ Y ➡	☐	☐	☐
Asthma (Doctor Diagnosed) ☐ Y ➡	☐	☐	☐
Emphysema or Chronic Bronchitis ☐ Y ➡	☐	☐	☐
Other Major Illness or surgery (since June 1996) ☐ Y ➡	☐	☐	☐

Specify other major illness or surgery:

Continue on Back

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6a

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6b

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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: _____ Y N

Address: _____

_____

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

Was this a fracture of: ☐ Hip ☐ Wrist F

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SS V W X Y Z

Note: Please be specific regarding circumstances (e.g., "Fell from chair I was standing on")