HARVARD MEDICAL SCHOOL **NURSES' HEALTH STUDY**

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This is your ID ➡

Dear Colleague:

As the Nurses' Health Study enters its 32nd year, I am more excited than ever about the contributions the study is making to our understanding of the many issues surrounding women's health. As always, these many developments are possible only because of your continued enthusiastic involvement.

The hundreds of research articles that have been published using Nurses' Health Study data are a tribute to the great value of your participation. Results from our work are regularly featured in major scientific journals and the mainstream press. This information helps shape national health guidelines and recommendations. Going forward, we are continuing to focus on how to decrease the risk of cancer, heart disease and other major chronic diseases in women. In addition, we are increasing our efforts to address issues of great importance to older women, such as how to maintain cognitive function and maximize quality of life. As such, your ongoing participation remains critical to help current and future generations of women live healthier lives.

The attached questionnaire continues our biennial follow-up. As always, your answers will be kept strictly confidential and used for medical statistical purposes only. Your prompt reply is helpful and greatly appreciated.

You are an original member of the Nurses' Health Study and as such, you are an indispensable colleague in our research. Whether you are retired or still working and whether your health has been excellent or if you have been ill, your response is equally important. In short, **no matter what your circumstances, we want to hear from you!**

It is with our deepest gratitude that we thank you again for the ongoing commitment and care that you have generously provided as we continue to learn about women's health.

Best Regards,

Susan E Hankinson

Susan Hankinson, RN, Sc.D.
Principal Investigator

Do you have an e-mail address?
If you do, please print your e-mail address in the box so that we may send you occasional updates on the progress of the Nurses' Health Study.

Please print neatly and differentiate numbers and letters (e.g., 1 vs l or i, Ø vs O, 5 vs S)

We will not release your e-mail address to anyone!

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INSTRUCTIONS

Please use an ordinary No. 2 pencil to answer all questions. Fill in the appropriate response circles completely. The form is designed to be read by optical-scanning equipment, so it is important that you keep any write-in responses **within** the spaces provided and erase any incorrect marks completely. If you have comments, please write them on a separate piece of paper.

Please fill in the circles completely. **Do not mark this way:** ✓ ✗ ◒

EXAMPLE 1:

Write your weight in the boxes…

…and fill in the circle corresponding to the figure at the head of each column.

1. What is your current weight?

POUNDS: 1 4 0

NOTE: It is important that you write in your weight in addition to completing the corresponding circles. This allows us to confirm that the correct circles have been filled in.

EXAMPLE 2:

Mark "Yes" bubble and Year of Diagnosis bubble for each illness you have had diagnosed.

14. Since June 2006, have you had any of these clinician-diagnosed illnesses?

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

	Yes	BEFORE JUNE 1 2006	JUNE '06 TO MAY 2008	AFTER JUNE 1 2008
Fibrocystic/other benign breast disease	●	●	○	○
Confirmed by breast biopsy? (N) No ● Yes				
Breast cancer	●	○	●	○
Cancer of the uterus (endometrium)	(Y)	○	○	○

- **Carefully remove the cover letter (to preserve confidentiality) and return the questionnaire in the enclosed postage-paid envelope.**
- **If your name and address as printed on this questionnaire are no longer correct or are incomplete, or if you are providing your e-mail address, please make any necessary changes on the letter and return it to us.**
- **Thank you for completing the 2008 Nurses' Health Study Questionnaire.**

Federal research regulations require us to include the following information:
There are no direct benefits to you from participating in this study.
The risk of breach of confidentiality associated with participation in this study is very small.
Your choice to participate in this study is completely voluntary and you may decline or withdraw at any time without penalty.
Although complete information is important to the study, you may skip any question you do not wish to answer.
You will not receive monetary compensation for participating.
If you have any questions regarding your rights as a research participant, you are encouraged to call a representative of the Human Subjects Committee at the Brigham and Women's Hospital (617-424-4100).

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PLEASE USE PENCIL!

1. What is your current weight?

2. Do you currently smoke cigarettes?
No / Yes → How many/day? 1–4 / 5–14 / 15–24 / 25–34 / 35–44 / 45+

3. Have you had your uterus removed?
No / Yes → **Date of surgery:** Before June 1, 2006 / After June 1, 2006

4. Have you ever had either of your ovaries surgically removed?
No / Yes → **a) How many ovaries do you have remaining?** None / One

5. On average, how often in the past year have you experienced any amount of accidental bowel leakage?
a) **Liquid stool:** Never / Less than 1/month / 1–3/month / About once/week / Several times/week / Nearly daily
b) **Solid stool:** Never / Less than 1/month / 1–3/month / About once/week / Several times/week / Nearly daily

6. Do you ever use any kind of pad for protection against leaking urine or stool?
Yes / No

7. During the last 12 months, how often have you leaked or lost control of your urine?
Never / Less than once/month / Once/month / 2–3 times/month / About once/week / Almost every day

i) **When you lose your urine, how much usually leaks?**
A few drops / Enough to wet your underwear / Enough to wet your outerclothing / Enough to wet the floor

ii) **When you lose urine, what is the usual cause?**
a) Coughing, sneezing, laughing, or doing physical activity / b) A sudden and urgent need to go to the bathroom / c) Both a) and b) equally / d) In other circumstances

8. *Since June 2006,* have you used Evista (raloxifene) or Nolvadex (tamoxifen)?
Yes → a) **How many months have you used each drug during the 24 month period between June 2006 and June 2008?**
No

Evista	Not Used	1–4 months	5–9	10–14	15–19	20–24 months	Used only after 6/08
Nolvadex	Not Used	1–4 months	5–9	10–14	15–19	20–24 months	Used only after 6/08

b) **Are you currently using Evista or Nolvadex?** No, not currently / Yes, Evista / Yes, Nolvadex

9. Are you currently using any over-the-counter (e.g., "herbal," "natural," or soy-based) preparations for hormone replacement or to treat post-menopausal symptoms? (Do NOT include food sources like tofu, soy milk, etc.)
No / Yes → **What type(s)?** Soy estrogen products / Natural progesterone cream or wild yam cream / Dong quai (e.g., Rejuvex) / Black cohosh (e.g., Remifemin) / Other

10. Since June 2006, have you used prescription female hormones?
Yes → a) **How many months did you use hormones since June 2006?**
No

1–4 months / 5–9 / 10–14 / 15–19 / 20–25 / 26–30 / 31–35 / 36+ months

b) **Are you *currently* using them (within the last month)?** Yes / No **If No, skip to Part e.**

c) **Mark the type(s) of hormones you are *CURRENTLY* using:**

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

Estrogen: Oral Premarin / Patch Estrogen / Vaginal Estrogen / Ogen / Estrace / Estratest / Other Estrogen (specify in box below)

Progesterone/Progestin: Provera/Cycrin/MPA / Vaginal / Micronized (e.g., Prometrium) / Other progesterone (specify type in box below)

Other hormones *CURRENTLY* used (e.g., Tri-est), Specify:

d) **Since June 2006, how many months have you used the preparation(s) you marked in Part c?**
1–4 months / 5–9 / 10–14 / 15–19 / 20–25 / 26–30 / 31–35 / 36+ months

e) **If you used oral conjugated estrogen (e.g., Premarin) what dose did you usually take?**
.30 mg/day or less / .45 mg/day / .625 mg/day / .9 mg/day / 1.25 mg/day or higher / Unsure / Did not take oral conjugated estrogen

f) **If you used oral medroxyprogesterone (e.g., Provera, Cycrin), what dose did you usually take?**
2.5 mg or less / 5–9 mg / 10 mg / More than 10 mg / Unsure / Not used

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

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

11. Do you usually use a cane or walker? No / Yes

12. Do you have difficulty with your balance? No / Yes

13. Number of times you have fallen to the ground in the past year:
None / 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 or more

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14. Since June 2006, have you had any of these clinician-diagnosed illnesses?

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

Illness		YEAR OF DIAGNOSIS: BEFORE JUNE 1 2006	JUNE '06 TO MAY 2008	AFTER JUNE 1 2008
Fibrocystic/other benign breast disease	Y	○	○	○
Confirmed by breast biopsy? N No Y Yes				
Breast cancer	Y	○	○	○
Cancer of the uterus (endometrium)	Y	○	○	○
Cancer of the ovary	Y	○	○	○
Colon or rectal polyp (benign)	Y	○	○	○
Cancer of the colon or rectum	Y	○	○	○
Cancer of the lung	Y	○	○	○
Melanoma	Y	○	○	○
Basal cell skin cancer	Y	○	○	○
Squamous cell skin cancer	Y	○	○	○
Chronic lymphocytic leukemia	Y	○	○	○
Other cancer	Y	○	○	○
Specify site of other cancer (e.g., liver, pancreas, etc.)				
Diabetes mellitus	Y	○	○	○
Elevated cholesterol	Y	○	○	○
High blood pressure	Y	○	○	○
Myocardial infarction (heart attack)	Y	○	○	○
Hospitalized for MI? N No Y Yes				
Angina pectoris	Y	○	○	○
Confirmed by angiogram? N No Y Yes				
Coronary bypass, angioplasty, or stent	Y	○	○	○
Congestive heart failure	Y	○	○	○
Stroke (CVA)	Y	○	○	○
TIA (Transient ischemic attack)	Y	○	○	○
Peripheral artery disease or claudication of legs (not varicose veins)	Y	○	○	○
Confirmed by angiogram/surgery? N No Y Yes				
Carotid surgery (Endarterectomy)	Y	○	○	○
Pulmonary embolus	Y	○	○	○
Atrial fibrillation	Y	○	○	○
ICD-Implantable Defibrillator	Y	○	○	○
Osteoporosis	Y	○	○	○
Hip replacement	Y	○	○	○
Hip fracture	Y	○	○	○
Graves' Disease/Hyperthyroidism	Y	○	○	○
Glaucoma	Y	○	○	○
Macular degeneration of retina	Y	○	○	○
Cataract—1st Diagnosis (Dx)	Y	○	○	○
Cataract extraction	Y	○	○	○
Alzheimer's disease	Y	○	○	○
Parkinson's disease	Y	○	○	○
Ulcerative colitis/Crohn's	Y	○	○	○
Barrett's esophagus	Y	○	○	○
Kidney stones	Y	○	○	○
SLE (systemic lupus)	Y	○	○	○
Rheumatoid arthritis, clinician Dx	Y	○	○	○
Gout	Y	○	○	○
Depression, clinician Dx	Y	○	○	○
Other major illness or surgery since June 2006	Y	○	○	○

Please specify: Date:

15. Have you *ever* had any of these clinician-diagnosed illnesses or procedures?

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

Illness		YEAR OF FIRST DIAGNOSIS: 1997 or Before	1998–2001	2002–2005	2006–2007	2008+
Lou Gehrig's disease/ Amyotrophic Lateral Sclerosis	Y	○	○	○	○	○
Multiple sclerosis	Y	○	○	○	○	○
Pernicious anemia/ B12 deficiency	Y	○	○	○	○	○
Shingles	Y	○	○	○	○	○
Increased eye pressure in either eye (over 25 mm/Hg)	Y	○	○	○	○	○
Osteoarthritis	Y	○	○	○	○	○
Sleep apnea	Y	○	○	○	○	○
Psoriasis	Y	○	○	○	○	○
Psoriatic arthritis	Y	○	○	○	○	○
Pneumonia, x-ray confirmed	Y	○	○	○	○	○
Asthma, Dr. Diagnosed	Y	○	○	○	○	○
Emphysema or Chronic bronchitis, Dr Dx	Y	○	○	○	○	○
Gastric or Duodenal ulcer	Y	○	○	○	○	○
Hyperparathyroidism	Y	○	○	○	○	○

16. In the past two years have you had: ***(If yes, mark all that apply.)***

	No	Yes, for screening	Yes, for symptoms
A physical exam?	N	Y	Y
Exam by eye doctor?	N	Y	Y
Mammogram?	N	Y	Y
Fasting blood sugar?	N	Y	Y

Upper endoscopy (esophagus/stomach) N No Y Yes

(Virtual) CT Colonoscopy? N No Y Yes

Colonoscopy? N No Y Yes

Sigmoidoscopy? N No Y Yes

Initial reason(s) you had Colonoscopy/Sigmoidoscopy?

- ○ Visible blood
- ○ Occult fecal blood
- ○ Abdominal pain
- ○ Diarrhea/constipation
- ○ Family history of colon cancer
- ○ Barium enema
- ○ Follow-up of (virtual) CT colonoscopy
- ○ Prior polyps
- ○ Asymptomatic or routine screening

17. Blood Cholesterol (most recent, within last 5 years):

○ Unknown/Not checked within 5 yrs ○ <140 mg/dl ○ 140–159 ○ 160–179 ○ 180–199 ○ 200–219 ○ 220–239 ○ 240–269 ○ 270-299 ○ 300–329 ○ 330+ mg/dl

18. Current usual blood pressure (if checked within 2 years):

Systolic: ○ Unknown/Not checked within 2 years ○ <105 mmHg ○ 105–114 ○ 115–124 ○ 125–134 ○ 135–144 ○ 145–154 ○ 155–164 ○ 165–174 ○ 175+

Diastolic: ○ Unknown/Not checked within 2 years ○ <65 mmHg ○ 65–74 ○ 75–84 ○ 85–89 ○ 90–94 ○ 95–104 ○ 105+

19. Your resting pulse rate: (please take after sitting for 5 min.)

○ Unsure ○ <55/min ○ 55–59 ○ 60–64 ○ 65–69 ○ 70–74 ○ 75–79 ○ 80–84 ○ 85–89 ○ 90–99 ○ 100 or more

20. Is this your correct date of birth?

○ Yes
○ No → **If no, please write correct date.** MONTH / DAY / YEAR

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21. Regular Medication *(Mark if used regularly in past 2 years.)*

- Acetaminophen (e.g., Tylenol)
  - Days/week: 1 / 2–3 / 4–5 / 6+ days
  - Total tabs/wk: 1–2 / 3–5 / 6–14 / 15+ tab
- "Baby" or low dose aspirin (100 mg or less/tablet)
  - Days/week: 1 / 2–3 / 4–5 / 6+ days
  - Total tabs/wk: 1–2 / 3–5 / 6–14 / 15+ tab
- Aspirin or aspirin-containing products (325 mg or more/tablet)
  - Days/week: 1 / 2–3 / 4–5 / 6+ days
  - Total tabs/wk: 1–2 / 3–5 / 6–14 / 15+ tab
- Ibuprofen (e.g., Advil, Motrin, Nuprin)
  - Days/week: 1 / 2–3 / 4–5 / 6+ days
  - Total tabs/wk: 1–2 / 3–5 / 6–14 / 15+ tab
- COX-2 inhibitors (Celebrex)
  - Days/week: 1 / 2–3 / 4–5 / 6+ days
- Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)
- Thiazide diuretic / Lasix / Potassium
- Calcium blocker (e.g., Calan, Procardia, Cardizem, Norvasc)
- Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)
- ACE Inhibitors (e.g., Capoten, Vasotec, Zestril)
- Angiotensin receptor blocker [e.g., valsartan (Diovan), losartan (Cozaar), irgesartan (Avapro)]
- Other anti-hypertensive (e.g., clonidine, doxazosin)
- Coumadin / Plavix / Digoxin / Antiarrhythmic
- "Statin" cholesterol-lowering drug:
  - Mevacor (lovastatin) / Zocor (simvastatin) / Crestor
  - Pravachol (pravastatin) / Lipitor (atorvastatin) / Other
- Other cholesterol-lowering drug [e.g., niacin, Lopid (gemfibrozil), Tricor (fenofibrate), Questran (cholestyramine), Colestid, Zetia]
- Steroids taken orally (e.g., Prednisone, Decadron, Medrol)
- Insulin / Metformin
- Other Oral hypoglycemic medication
- SSRIs (Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox)
- Other antidepressants (e.g., Elavil, Tofranil, Pamelor)
- Minor tranquilizers (e.g., Valium, Xanax, Ativan, Librium)
- Prilosec, Nexium, Prevacid (lansoprazole), Protonix, Aciphex
- H2 blocker (e.g., Pepcid, Tagamet, Zantac, Axid)
- Aricept / Namenda
- Fosamax, Actonel, or other bisphosphonate
- Ambien, Sonata or Lunesta
- Other prescription sleep meds. (e.g., Trazodone, Rozerem)
- Other regular medications (no need to specify)

22. During the past 4 years, what is the TOTAL amount of time you used antibiotics? (Exclude skin creams, mouthwash or isoniazid.)

- None
- Less than 15 days
- 15 days to 2 months
- 2 to 4 months
- 4 months to 2 years
- 2 to 3 years
- Over 3 years

a) What was the most common reason that you used an antibiotic?

- Respiratory infection / UTI / Acne/Rosacea
- Chronic bronchitis / Dental / Other

23. Have you ever had gastrointestinal bleeding that required hospitalization or a transfusion?

- Yes → **a) What was the site of the bleeding?** *(Mark all that apply.)*
  - Esophagus / Stomach / Duodenum
  - Colon/rectum / Other / Site unknown

  b) What year(s) did this happen? *(Mark all that apply.)*
  - Before 1990 / '90–'93 / '94–'97 / '98–'99
  - 2000–'01 / 2002–'03 / 2004–'05 / 2006+
- No

24. Have any of the following biological relatives had...

Relative's Age at First Diagnosis (Do not count half siblings.)

Condition	No	Relative	Before age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age unknown
Ovarian Cancer?	No	Sister (Y)					
		Daughter (Y)					
Breast Cancer?	No	One Sister (Y)					
		Additional Sister (Y)					
		Daughter (Y)					
Colon or Rectal Cancer?	No	One Sibling (Y)					
		Additional Sibling (Y)					
		Offspring (Y)					
Pancreatic Cancer?	No	Parent (Y)					
		Sibling (Y)					
Melanoma?	No	Parent (Y)					
		Sibling (Y)					
		Offspring (Y)					
Cancer of the Uterus? (exclude fibroids and cervical cancer)	No	Mother (Y)					
		Sister (Y)					
		Offspring (Y)					
Kidney Cancer?	No	Parent (Y)					
		Sibling (Y)					

Relative's Age at First Diagnosis (Do not count half siblings.)

Condition	No	Relative	Before age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age unknown
Myocardial Infarction?	No	Brother (Y)					
		Sister (Y)					
		Offspring (Y)					
Stroke (CVA)?	No	Mother (Y)					
		Father (Y)					
		Sibling (Y)					
Multiple Sclerosis (MS)?	No	Mother (Y)					
		Father (Y)					
		Sibling (Y)					
		Offspring (Y)					
Parkinson's Disease?	No	Mother (Y)					
		Father (Y)					
		Sibling (Y)					
Rheumatoid Arthritis or Lupus (SLE)?	No	Parent (Y)					
		Sibling (Y)					
		Offspring (Y)					

25. What is your *current* status?

- Married / Divorced / Widowed
- Domestic Partnership / Separated / Never married

26. Your living arrangement: *(Mark all that apply.)*

- Alone
- With spouse or partner
- With other family
- Assisted living facility
- Nursing home
- Other

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27. What is your *current* work status: *(Mark all that apply.)*

- Retired
- Full-time non-nursing employment
- Nursing full-time
- Disabled
- Homemaker
- Part-time non-nursing employment
- Nursing part-time

28. How many hours each week do you participate in any groups such as a social or work group, church-connected group, self-help group, charity, public service or community group?

- None
- 1 to 2 hours
- 3 to 5 hours
- 6 to 10 hours
- 11 to 15 hours
- 16 or more hours

29. How often do you go to religious meetings or services?

- More than once a week
- Once a week
- 1 to 3 times per month
- Less than once per month
- Never or almost never

30. Apart from your children, how many relatives do you have with whom you feel close?

- None
- 1 to 2
- 3 to 5
- 6 to 9
- 10 or more

31. How many close friends do you have?

- None
- 1 to 2
- 3 to 5
- 6 to 9
- 10 or more

32. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with?

- No
- Yes → **a) How often do you see or talk to this person?**
  - Daily
  - Weekly
  - Monthly
  - Several times/year
  - Once/year or less

33. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?

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

34. How many people can you count on to provide you with emotional support?

- None
- One
- Two
- Three or more

35. What is your usual walking pace outdoors?

- Unable to walk
- Easy, casual (less than 2 mph)
- Normal, average (2–2.9 mph)
- Brisk pace (3–3.9 mph)
- Very brisk/ striding (4 mph or faster)

36. How many flights of stairs (not individual steps) do you climb daily?

- 2 flights or less
- 3–4
- 5–9
- 10–14
- 15 or more flights

37. DURING THE PAST YEAR, what was your average time PER WEEK spent at each of the following recreational activities?

	TIME PER WEEK									
	Zero	1–4 Min.	5–19 Min.	20–59 Min.	One Hour	1–1.5 Hrs.	2–3 Hrs.	4–6 Hrs.	7–10 Hrs.	11+ Hrs.
Walking for exercise or walking to work										
Jogging (slower than 10 minutes/mile)										
Running (10 minutes/mile or faster)										
Bicycling (include stationary machine)										
Tennis, squash, racquetball										
Lap swimming										
Other aerobic exercise (aerobic, dance, ski or stair machine, etc.)										
Lower intensity exercise (yoga, stretching, toning)										
Other vigorous activities (e.g., lawn mowing)										
Weight training or resistance exercises — **Arm weights**										
(Include free weights or machines such as Nautilus) — **Leg weights**										

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

	TIME PER WEEK								
	Zero Hrs.	One Hour	2–5 Hrs.	6–10 Hrs.	11–20 Hrs.	21–40 Hrs.	41–60 Hrs.	61–90 Hrs.	Over 90 Hrs.
Standing or walking around at work or away from home? (hrs./week)									
Standing or walking around at home? (hrs./week)									
Sitting at work or away from home or while driving? (hrs./week)									
Sitting at home while watching TV/VCR? (hrs./week)									
Other sitting at home (e.g., reading, meal times, at desk)? (hrs./week)									

39. The following items are about activities you might currently do during a typical day. Does your health now limit you in these activities? If so, how much? *(Mark one response on each line.)*

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, like running, lifting heavy objects, strenuous sports			
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf			
Lifting or carrying groceries			
Climbing *several* flights of stairs			
Climbing *one* flight of stairs			
Bending, kneeling, or stooping			
Walking *more than a mile*			
Walking *several blocks*			
Walking *one* block			
Bathing or dressing yourself			

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40. Please mark Yes or No for each of the following statements:

Shops, stores and markets are within easy walking distance of my home.	Yes	No
There are sidewalks on most of the streets in my neighborhood.	Yes	No
The crime rate in my neighborhood makes it unsafe to go on walks at night.	Yes	No
My neighborhood has free or low cost recreation facilities, such as parks, walking trails, bike paths, rec. centers, playgrounds, public swimming pools, etc.	Yes	No
I walk around my neighborhood twice a week or more for leisure or exercise.	Yes	No

41. Choose the best answer for how you felt the *past month*:

Are you basically satisfied with your life?	Yes	No
Have you dropped many of your activities and interests?	Yes	No
Do you feel that your life is empty?	Yes	No
Do you often get bored?	Yes	No
Are you in good spirits most of the time?	Yes	No
Are you afraid that something bad is going to happen to you?	Yes	No
Do you feel happy most of the time?	Yes	No
Do you often feel helpless?	Yes	No
Do you prefer to stay at home, rather than going out and doing new things?	Yes	No
Do you feel you have more problems with memory than most?	Yes	No
Do you think it is wonderful to be alive now?	Yes	No
Do you feel pretty worthless the way you are now?	Yes	No
Do you feel full of energy?	Yes	No
Do you feel that your situation is hopeless?	Yes	No
Do you think that most people are better off than you are?	Yes	No

42. Can you rise from a chair 5 times in a row, without using your arms? Yes No

43. How often do you deliberately take a nap during the day?

Never / Less than once a week / Several times a week / Daily / More than once per day

44. What is the chance of your dozing off in each of the following situations?

	CHANCE OF DOZING			
	No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g., a theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

45. On average, over a 24 hour period, do you sleep:

<5 hours / 5 hrs / 6 hrs / 7 hrs / 8 hrs / 9 hrs / 10+ hours

46. Do you feel that your sleep duration is adequate?

No → **What is the major reason that your sleep duration is *inadequate*? *(Mark one answer.)***
- Work/family activities or schedule
- Leisure/social activities: reading/TV/computer, etc.
- Medical problem (e.g., pain, breathing difficulties)
- Just can't get to or stay asleep (worrying or insomnia)

Yes

47. Do you snore?

Every night / Most nights / A few nights a week / Occasionally / Almost never / Don't know

48. On average, how often are your daily activities affected because you are sleepy during the day?

Almost every day / 1–3 days/week / 4–6 days/week / Rarely / Never

49. Do you have a hearing problem?

No / Mild / Moderate / Marked, no hearing aid / Severe, use a hearing aid

50. In the past 12 months, have you had ringing, roaring, or buzzing in your ears?

Never / Once/month or less / 2–3 times/month / About once/week / Several days/week / Almost every day or daily

51. Have you ever been diagnosed with diverticulosis or diverticulitis of the colon or rectum?

Yes → **a) Have you ever had diverticulitis that required antibiotics or hospitalization?**

No / Yes → **Year(s)?** Before 1990 / '90–'91 / '92–'93 / '94–'95 / '96–'97 / '98–'99 / 2000–'01 / 2002–'03 / 2004–'05 / 2006–'07 / 2008+

b) Have you ever had diverticular bleeding that required hospitalization?

No / Yes → **Year(s)?** Before 1990 / '90–'91 / '92–'93 / '94–'95 / '96–'97 / '98–'99 / 2000–'01 / 2002–'03 / 2004–'05 / 2006–'07 / 2008+

No

3/8" spine perf

52. In the last year, how often have you had heartburn or acid-reflux?

◯ None in the past year ◯ Less than once a month ◯ About once a month ◯ About once a week
◯ Several times a week ◯ Daily

53. During the past 4 weeks, have you had any hot flashes or night sweats?

◯ No ◯ Yes ➡ **If yes, were they *(mark one)*:** ◯ Mild ◯ Moderate ◯ Severe

54. At the beginning of menopause, did you have hot flashes or night sweats? (If you took estrogen, consider the time period before starting treatment.)

◯ Yes ➡ **a) Were they *(mark one)*:** ◯ Mild ◯ Moderate ◯ Severe
◯ No **b) How long did these symptoms last?** ◯ Less than 5 years ◯ 5–9 years ◯ 10 years or longer

55. Do you have any siblings (living or deceased) whose age compared to yours is: *(Mark all that apply.)*

◯ No siblings (only child) ◯ Less than 2 years older than you ◯ 2 to 5 years older than you ◯ 5+ years older than you
◯ Less than 2 years younger than you ◯ 2 to 5 years younger than you ◯ 5+ years younger than you

56. The following question asks about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as sweets, starches, salty snacks, fatty foods, sugary drinks, and others.

In the past 12 MONTHS, how often were each of these statements true for you?	Never	Once per month	2-4 times per month	2-3 times per week	4+ times per week
I find myself consuming certain foods even though I am no longer hungry.	◯	◯	◯	◯	◯
I worry about cutting down on certain foods.	◯	◯	◯	◯	◯
I feel sluggish or fatigued from overeating.	◯	◯	◯	◯	◯
I have spent time dealing with negative feelings from overeating certain foods, instead of spending time in important activities such as time with family, friends, work, or recreation.	◯	◯	◯	◯	◯
I have had physical withdrawal symptoms such as agitation and anxiety when I cut down on certain foods. (Do NOT include caffeinated drinks: coffee, tea, cola, energy drinks, etc.)	◯	◯	◯	◯	◯
My behavior with respect to food and eating causes me significant distress.	◯	◯	◯	◯	◯
Issues related to food and eating decrease my ability to function effectively (daily routine, job/school, social or family activities, health difficulties).	◯	◯	◯	◯	◯

IN THE PAST 12 MONTHS...	No	Yes
I kept consuming the same types or amounts of food despite significant emotional and/or physical problems related to my eating.	◯	◯
Eating the same amount of food does not reduce negative emotions or increase pleasurable feelings the way it used to.	◯	◯

57. Since June 2004, did you receive an influenza vaccination?

◯ Yes ➡ **a) In which winter flu seasons? *(Mark all that apply.)***
◯ No ◯ 2004/2005 ◯ 2005/2006 ◯ 2006/2007 ◯ 2007/2008 ◯ 2008/2009

58. Do you currently take a multi-vitamin?

◯ Yes ➡ **a) How many do you take per week?**
◯ No ◯ 2 or less ◯ 3–5 ◯ 6–9 ◯ 10 or more

59. Please indicate the extent to which you agree or disagree with the following statements.

	Disagree strongly	Disagree a little	Neither agree nor disagree	Agree a little	Agree strongly
In uncertain times I usually expect the best.	◯	◯	◯	◯	◯
If something can go wrong with me, it will.	◯	◯	◯	◯	◯
I'm always optimistic about my future.	◯	◯	◯	◯	◯
I hardly ever expect things to go my way.	◯	◯	◯	◯	◯
I rarely count on good things happening to me.	◯	◯	◯	◯	◯
Overall, I expect more good things to happen to me than bad.	◯	◯	◯	◯	◯

60. 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: ______________________

____

Phone or E-mail: ______________________

Thank you! Please return form to: Susan Hankinson, Sc.D., 181 Longwood Avenue, Boston, MA 02115.