**HARVARD MEDICAL SCHOOL** **NURSES' HEALTH STUDY**

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www.NursesHealthStudy.org

**This is your ID** ➡

**Dear Colleague:**

We are delighted that you have continued to be a part of the Nurses' Health Study. As we enter our 36th year, hundreds of new findings are summarized in research papers based on NHS data. Each one is a tribute to the great value of our work together. These developments are possible only because of your continued enthusiastic involvement.

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. Your ongoing participation remains critical to help current and future generations of women live healthier lives. Results from our work are regularly featured in major scientific journals and the mainstream press. This information helps shape national health guidelines and recommendations.

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

As an original member of the Nurses' Health Study, you are an indispensable colleague in our research. Whether you are retired or 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 how to improve women's health.

Best Regards,

Susan Hankinson, RN, Sc.D.
Senior 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!

**Would you be interested in the option of doing your future NHS questionnaires online?** ○ No ○ Yes

3/8" spine perf

# INSTRUCTIONS

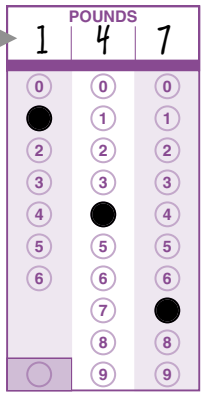

Please use an ordinary No. 2 pencil to answer all questions. Fill in the appropriate response circles completely. The form is designed to be read by optical-scanning equipment, so it is important that you keep any write-in responses **within** the spaces provided and erase any incorrect marks completely.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

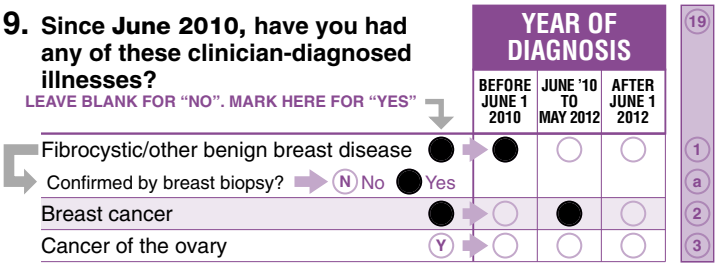



NOTE: It is important that you write in your weight in addition to completing the corresponding circles. This allows us to confirm that the correct circles have been filled in.

**EXAMPLE 2:** **Mark "Yes" bubble and Year of Diagnosis bubble for each illness you have had diagnosed.**

**19. Since June 2010, have you had any of these clinician-diagnosed illnesses?**

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




- **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 2012 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).

3/8" spine perf

**PLEASE USE PENCIL!**

**1. What is your current weight?**

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

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

**3. Have you had your uterus removed?** (3)
○ No ○ Yes → **Date of surgery:** ○ Before June 1, 2010 ○ After June 1, 2010 (a)

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

**5. Do you have a hearing problem?** (5)
○ No ○ Mild ○ Moderate ○ Severe

**At what age did you first notice a change in your hearing?**
○ <30 ○ 30–39 ○ 40–44 ○ 45–49 ○ 50–54 ○ 55–59 ○ 60–69 ○ Age 70+

**6. In the past 12 months, have you had ringing, roaring, or buzzing in your ears?** (6)
○ Never ○ Once/week or less ○ A few days/wk ○ Daily

**At what age did this first begin?**
○ <30 ○ 30–39 ○ 40–49 ○ 55–59 ○ 60–69 ○ Age 70+

**7. *Since June 2010,* have you used Evista (raloxifene) or Nolvadex (tamoxifen)?** (7)
○ Yes → **a) How many months have you used each drug during the 24 month period between June 2010 and June 2012?** (a)
○ No
Evista ○ Not Used ○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months ○ Used only after 6/12 (E)
Nolvadex ○ Not Used ○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months ○ Used only after 6/12 (N)
**b) Are you currently using Evista or Nolvadex?** ○ No, not currently ○ Yes, Evista ○ Yes, Nolvadex (b)

**8. Since June 2010, have you used prescription female hormones?** (Not including over-the-counter/herbal/soy preparations.) (8)
○ Yes → **a) How many months did you use hormones since June 2010?** (a)
○ 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 d.** (b)
**c) Mark the type(s) of hormones you are *CURRENTLY* using:** (c)
**Estrogen/ Combination**
○ Prempro ○ Oral Premarin or conjugated estrogens ○ Patch Estrogen ○ Vaginal Estrogen
○ Estrace ○ Estrogen gels, creams, or sprays on skin ○ Estratest ○ Ogen
○ Other Estrogen (specify in box below)
**Progesterone/Progestin:** ○ Provera/Cycrin/MPA ○ Vaginal ○ Micronized (e.g., Prometrium)
○ Other progesterone (specify type)
**Other hormones *CURRENTLY* used (e.g., Tri-est), Specify:** →
**d) If you used oral conjugated estrogen (e.g., Premarin) since June 2010, what dose did you usually take?** (d)
○ .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

**9. 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?** (9)
○ None ○ 1 to 2 hours ○ 3 to 5 hours ○ 6 to 10 hours ○ 11 to 15 hours ○ 16 or more hours

**10. How often do you go to religious meetings or services?** (10)
○ More than once a week ○ Once a week ○ 1 to 3 times per month ○ Less than once per month ○ Never or almost never

**11. Apart from your children, how many relatives do you have with whom you feel close?** (11)
○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 9 ○ 10 or more

**12. How many close friends do you have?** (12)
○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 9 ○ 10 or more

**13. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with?** (13)
○ Yes → **a) How often do you see or talk to this person?** (a)
○ No
○ Daily ○ Weekly ○ Monthly ○ Several times/year ○ Once/year or less

**14. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?** (14)
○ None of the time ○ A little of the time ○ Some of the time ○ Most of the time ○ All of the time

**15. How many people can you count on to provide you with emotional support?** (15)
○ None ○ One ○ Two ○ Three or more

**16. Do you usually use a cane, walker or wheelchair/scooter?** (16)
○ No ○ Cane ○ Walker ○ Wheelchair/scooter

**17. Do you have difficulty with your balance?** (17)
○ No ○ Occasionally ○ Often

**18. Number of times you have fallen to the ground in the past year:** (18)
○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 or more

**Were any of the falls on the stairs inside your home?**
○ No ○ Yes



3/8" spine perf

## 19. Since June 2010, have you had any of these clinician-diagnosed illnesses?

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

| | | YEAR OF DIAGNOSIS: BEFORE JUNE 1 2010 | JUNE '10 TO MAY 2012 | AFTER JUNE 1 2012 | |
|---|---|---|---|---|---|
| Fibrocystic/other benign breast disease | Y | ○ | ○ | ○ | 1 |
| Confirmed by breast biopsy? N No Y Yes | | | | | a |
| Breast cancer | Y | ○ | ○ | ○ | 2 |
| Cancer of the ovary | Y | ○ | ○ | ○ | 3 |
| Colon or rectal polyp (benign) | Y | ○ | ○ | ○ | 4 |
| Cancer of the colon or rectum | Y | ○ | ○ | ○ | 5 |
| Cancer of the lung | Y | ○ | ○ | ○ | 6 |
| Melanoma | Y | ○ | ○ | ○ | 7 |
| Basal cell skin cancer | Y | ○ | ○ | ○ | 8 |
| Squamous cell skin cancer | Y | ○ | ○ | ○ | 9 |
| Chronic lymphocytic leukemia | Y | ○ | ○ | ○ | 10 |
| Other cancer | Y | ○ | ○ | ○ | 11 |
| Specify site of other cancer (e.g., endometrium, pancreas) | | | | | |
| Diabetes mellitus | Y | ○ | ○ | ○ | 12 |
| Elevated cholesterol | Y | ○ | ○ | ○ | 13 |
| High blood pressure | Y | ○ | ○ | ○ | 14 |
| Myocardial infarction (heart attack) | Y | ○ | ○ | ○ | 15 |
| Hospitalized for MI? N No Y Yes | | | | | a |
| Angina pectoris | Y | ○ | ○ | ○ | 16 |
| Confirmed by angiogram? N No Y Yes | | | | | a |
| Coronary bypass, angioplasty, or stent | Y | ○ | ○ | ○ | 17 |
| Congestive heart failure | Y | ○ | ○ | ○ | 18 |
| Stroke (CVA) | Y | ○ | ○ | ○ | 19 |
| TIA (Transient ischemic attack) | Y | ○ | ○ | ○ | 20 |
| Peripheral artery disease or claudication of legs (not varicose veins) | Y | ○ | ○ | ○ | 21 |
| Carotid surgery (Endarterectomy) | Y | ○ | ○ | ○ | 22 |
| Pulmonary embolus | Y | ○ | ○ | ○ | 23 |
| Atrial fibrillation | Y | ○ | ○ | ○ | 24 |
| ICD-Implantable Defibrillator | Y | ○ | ○ | ○ | 25 |
| Osteoporosis | Y | ○ | ○ | ○ | 26 |
| Hip replacement | Y | ○ | ○ | ○ | 27 |
| Hip fracture | Y | ○ | ○ | ○ | 28 |
| Hyperparathyroidism | Y | ○ | ○ | ○ | 29 |
| Glaucoma | Y | ○ | ○ | ○ | 30 |
| Macular degeneration of retina | Y | ○ | ○ | ○ | 31 |
| Cataract—1st Diagnosis (Dx) | Y | ○ | ○ | ○ | 32 |
| Cataract extraction | Y | ○ | ○ | ○ | 33 |
| Parkinson's disease | Y | ○ | ○ | ○ | 34 |
| Ulcerative colitis/Crohn's | Y | ○ | ○ | ○ | 35 |
| Gastric or duodenal ulcer | Y | ○ | ○ | ○ | 36 |
| Barrett's esophagus | Y | ○ | ○ | ○ | 37 |
| Kidney stones | Y | ○ | ○ | ○ | 38 |
| SLE (systemic lupus) | Y | ○ | ○ | ○ | 39 |
| Rheumatoid arthritis, clinician Dx | Y | ○ | ○ | ○ | 40 |
| Gout | Y | ○ | ○ | ○ | 41 |
| Depression, clinician Dx | Y | ○ | ○ | ○ | 42 |
| Other major illness or surgery since June 2010 | Y | ○ | ○ | ○ | 43 |

Please specify: Date:

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

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

| | | YEAR OF FIRST DIAGNOSIS: 2001 or Before | 2002–2005 | 2006–2009 | 2010–2011 | 2012+ | |
|---|---|---|---|---|---|---|---|
| Lou Gehrig's disease/ Amyotrophic Lateral Sclerosis | Y | ○ | ○ | ○ | ○ | ○ | 20 |
| Non-Alzheimer dementia (e.g., Lewy body, vascular, FTD) | Y | ○ | ○ | ○ | ○ | ○ | |
| Alzheimer's disease | Y | ○ | ○ | ○ | ○ | ○ | |
| Shingles | Y | ○ | ○ | ○ | ○ | ○ | |
| Increased eye pressure in either eye (over 25 mm/Hg) | Y | ○ | ○ | ○ | ○ | ○ | |
| Osteoarthritis | Y | ○ | ○ | ○ | ○ | ○ | |
| Sleep apnea, Dr. Dx | Y | ○ | ○ | ○ | ○ | ○ | |
| Asthma, Dr. Dx | Y | ○ | ○ | ○ | ○ | ○ | |
| Emphysema or Chronic bronchitis, Dr. Dx | Y | ○ | ○ | ○ | ○ | ○ | |
| Vitiligo, Dr. Dx | Y | ○ | ○ | ○ | ○ | ○ | |
| Alopecia areata Dr. Dx | Y | ○ | ○ | ○ | ○ | ○ | |
| Cholecystectomy | Y | ○ | ○ | ○ | ○ | ○ | |
| Vertebral (spine) fracture, X-ray confirmed | Y | ○ | ○ | ○ | ○ | ○ | |
| Deep vein thrombosis | Y | ○ | ○ | ○ | ○ | ○ | |
| Hypothyroidism | Y | ○ | ○ | ○ | ○ | ○ | |

## 21. 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 | 21 |
| Exam by eye doctor? | N | Y | Y | |
| Mammogram? | N | Y | Y | |
| Fasting blood sugar? | N | Y | Y | |
| Upper endoscopy | 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?** a

- ○ 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

## 22. Is this your correct date of birth?

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

## 23. 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+

## 24. 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

## 25. How many natural teeth do you currently have (with or without crowns)?

○ None ○ 1–10 ○ 11–16 ○ 17–24 ○ 25–32

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**26. Regular Medication** *(Mark if used regularly in past 2 years.)* (26)

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

Celebrex (COX-2 inhibitors)
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., Diovan, Losartan, Avapro)

Other anti-hypertensive (e.g., clonidine, doxazosin)

Coumadin | Pradaxa | Plavix

Digoxin | Antiarrhythmic

"Statin" cholesterol-lowering drug:
Mevacor (lovastatin) | Zocor (simvastatin) | Crestor
Pravachol (pravastatin) | Lipitor (atorvastatin) | Other

Other cholesterol-lowering drug

Steroids taken orally (e.g., Prednisone, Decadron, Medrol)

Insulin | Metformin (glucophage) | Actos

Other oral hypoglycemic medication

Opioid pain meds. (e.g., codeine, Percocet, Vicodin, tramadol)

SSRIs (Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox, fluoxetine, citalopram)

Tricyclics (e.g., amitriptyline, nortriptyline, imipramine)

SNRIs/Other antidepressants (Wellbutrin, Effexor, Remeron, Cymbalta, venlafaxine, bupropion)

Minor tranquilizers (e.g., Valium, alprazolam, lorazepam)

Prilosec, Nexium, Prevacid (lansoprazole), Protonix, Aciphex

H2 blocker (e.g., Pepcid, Zantac, ranitidine, famotidine)

Aricept, Exelon, Razadyne | Namenda

Fosamax, Actonel, or other bisphosphonate

Thyroid hormone (e.g., Synthroid, Levothroid, extract)

Ambien, Sonata, Lunesta or zolpidem

Other prescription sleep meds. (e.g., Trazodone, Rozerem)

Other regular medications (no need to specify)

**27. During the past 4 years, what is the TOTAL amount of time you used antibiotics? (Exclude skin creams, mouthwash or isoniazid.)** (27)
None | 1 to 15 days | 15 days to 2 months | 2-4 months | 4 months to 2 years | 2 to 3 years | Over 3 years

**28. Over the past year, have you had a discussion with any of your healthcare providers about the kind of medical care you would want if you were faced with a serious illness?** (28)
No, and I do not intend to do so anytime soon
No, but I have considered doing so
Yes, I have discussed these matters with my healthcare provider

**29. Have you established any form of advance care planning for yourself in the event of serious illness?** *(Mark all that apply.)* (29)
Health care proxy/durable power of attorney for healthcare
Physician Orders for Life Sustaining Treatment (POLST)
Living will | Not sure | Other | None of these

**30. Have any of the following biological relatives had breast cancer?** (30)
Sister | Daughter: diagnosed before age 50
Daughter: age 50+ | None of these relatives

**31. Have any of the following biological relatives had ovarian cancer?** (31)
Sister | Daughter | None of these relatives

**32. Have any of your siblings, your children, or your parents been diagnosed with Ulcerative Colitis or Crohns disease?** (32)
No | Yes, ulcerative colitis | Yes, Crohns disease

**33. Have you ever been diagnosed with diverticulosis of the colon without diverticulitis or diverticular bleeding?** (33)
No | Yes

**34. Have you ever been diagnosed with diverticulitis of the colon that required antibiotics or hospitalization?** (34)
No | Yes →
a. **Total number of episodes:** (a)
1 | 2 | 3 | 4 | 5+
b. **Year(s) of all episodes:** (b)
< 1992 | '92–'93 | '94–'95 | '96–'97
'98–'99 | '00–'01 | '02–'03 | '04–'05
'06–'07 | '08–'09 | '10–'11 | 2012+
c. **Surgery for diverticulitis?** (c) No | Yes

**35. Have you ever been diagnosed with diverticular bleeding that required blood transfusion and/or hospitalization?** (35)
No | Yes →
a. **Total number of episodes:** (a)
1 | 2 | 3 | 4 | 5+
b. **Year(s) of all episodes:** (b)
< 1992 | '92–'93 | '94–'95 | '96–'97
'98–'99 | '00–'01 | '02–'03 | '04–'05
'06–'07 | '08–'09 | '10–'11 | 2012+
c. **Surgery for diverticular bleeding?** (c)
No | Yes

**36. Have you ever had gastrointestinal bleeding that required hospitalization or a transfusion?** (36)
Yes → a. **Sites:** (a) Esophagus | Stomach | Duodenum | Colon/Rectum | Other | Site(s) unknown
No
b. **What years?** (b) Before 2006 | '06–'07 | '08–'09 | '10–'11 | 2012 or later

**37. What is your marital status?** (37)
Married | Divorced | Widowed
Domestic Partnership | Separated | Never married

**38. Do you live in any of the following special residential settings?** (38)
Nursing home | Assisted living facility
Senior / retirement housing or community exclusively for people age 55+
None of the above

**39. Your living arrangement:** *(Mark all that apply.)* (39)
Alone | With spouse or partner
With other family | With other people
With pet(s)

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**40.** 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

**41.** 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

**42.** How frequently do you have a bowel movement?

○ More than twice a day ○ Twice a day ○ Daily ○ Every other day ○ Every 3–4 days ○ Every 5 days or less

**43.** In the past 3 months, how often did you have hard or lumpy stools?

○ Never or rarely ○ Occasionally ○ About 25% of the time ○ About 50% ○ About 75% ○ Almost always

**44.** In the past 3 months, how often did you have loose, mushy or watery stools?

○ Never or rarely ○ Occasionally ○ About 25% of the time ○ About 50% ○ About 75% ○ Almost always

**45.** How often do you use a laxative (such as softeners, bulking agents, fiber supplements or suppositories)?

○ Never ○ < Once/month ○ 1–3 times/month ○ Once/week ○ 2–3 times/wk ○ 4–5 times/wk ○ Daily ○ 2+ times/day

**46.** How often in the past year have you experienced any amount of accidental bowel leakage? Answer a) and b)

a) **Liquid stool:** ○ Never ○ Less than 1/month ○ 1–3/month ○ About once/wk ○ Several times/wk ○ Nearly daily

b) **Solid stool:** ○ Never ○ Less than 1/month ○ 1–3/month ○ About once/wk ○ Several times/wk ○ Nearly daily

**47.** Have you talked to your healthcare provider about leaking urine or accidental bowel leakage? *(Mark all that apply.)*

○ No I have not ○ Yes, about leaking urine ○ Yes, about bowel leakage

**48.** 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)

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

○ None ○ 2 flights or less ○ 3–4 ○ 5–9 ○ 10–14 ○ 15 or more flights

**50.** 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 for transportation/errands | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Running or jogging | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| 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 (Include free weights or machines such as Nautilus) — Arm weights | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Weight training or resistance exercises (Include free weights or machines such as Nautilus) — Leg weights | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**51.** 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/DVD/video? (hrs./week) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Other sitting at home (e.g., reading, meal times, at desk)? (hrs./week) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**52.** 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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**53. Choose the best answer for how you felt the *past month*:** (53)

| | | |
|---|---|---|
| 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 |

**54. During the last four weeks, how much of the time did emotional problems (e.g., feeling depressed or anxious) interfere with your regular daily activities or social activities (like visiting with friends or relatives)?** (54)

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

**55. Can you rise from a chair 5 times in a row, without using your arms? (Try if unsure.)** (55)

◯ Yes ◯ No

**56. On average, over a 24 hour period, do you sleep:** (56)

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

**57. Do you snore?** (57)

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

**58. Has your spouse (or sleep partner) ever told you that you appear to "act out your dreams" while sleeping (punched or flailed arms in the air, shouted or screamed), which has occurred at least three times?** (58)

◯ No ◯ Yes ◯ I do not have a sleep partner

**59 a. Do you regularly provide care to your disabled or ill spouse/partner?** (59)

◯ No ◯ Yes → **Number of hours per week?** ◯ 1–8 hours ◯ 9–20 hrs ◯ 21–35 hrs ◯ 36–72 hrs ◯ 73+ hrs (a)

**b. Outside of your employment, do you regularly provide care to a disabled or ill other person?**

◯ No ◯ Yes → **Number of hours per week?** ◯ 1–8 hours ◯ 9–20 hrs ◯ 21–35 hrs ◯ 36–72 hrs ◯ 73+ hrs (b)

**c. How *stressful* would you say it is to provide care to the individuals mentioned above?**

◯ Not applicable ◯ Not at all ◯ Just a little bit ◯ Moderately ◯ Extremely ◯ Don't know (c)

**d. How *rewarding* would you say it is to provide care to the individuals mentioned above?**

◯ Not applicable ◯ Not at all ◯ Just a little bit ◯ Moderately ◯ Extremely ◯ Don't know (d)

**60. In the past year, have you experienced pain, in the same part of the body, that lasted for 4 or more months?** (60)

◯ Yes → **In the most recent month, please rate the average severity, in the one area with the most pain, on a scale of 0 to 10, with "0" being "no pain" and "10" being "the worst pain you can imagine."**

◯ No

(no pain) ◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10 (worst pain you can imagine)

**61. During the past year, how many times have you been hospitalized for 2 nights or more?** (61)

◯ None ◯ 1 time ◯ 2–3 times ◯ 4 or more times

**62. In the last year, how often have you had heartburn or acid-reflux?** (62)

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

**63. Please indicate the extent to which you agree or disagree with the following statements.** (63)

| | 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. | ◯ | ◯ | ◯ | ◯ | ◯ |

**64. Since June 2010, have any of the following events occurred?** (64)

| | | |
|---|---|---|
| Death of your spouse | ◯ Yes | ◯ No |
| Death of another close family member | ◯ Yes | ◯ No |
| Major conflict or problems in relationships with relatives, friends, or neighbors | ◯ Yes | ◯ No |
| A significant negative change in your financial, business or work situation | ◯ Yes | ◯ No |
| Death of a close friend | ◯ Yes | ◯ No |
| A significant negative change in your living conditions | ◯ Yes | ◯ No |

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**65. Over the last 4 weeks, how often have you been bothered by any of the following problems?**

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious or on edge | ○ | ○ | ○ | ○ |
| Not being able to stop or control worrying | ○ | ○ | ○ | ○ |
| Worrying too much about different things | ○ | ○ | ○ | ○ |
| Trouble relaxing | ○ | ○ | ○ | ○ |
| Being so restless that it is hard to sit still | ○ | ○ | ○ | ○ |
| Becoming easily annoyed or irritable | ○ | ○ | ○ | ○ |
| Feeling afraid as if something awful might happen | ○ | ○ | ○ | ○ |

**66. Please answer Yes or No for each of the following questions about your memory:**

| | | |
|---|---|---|
| Have you recently experienced any change in your ability to remember things? | ○ Yes | ○ No |
| Do you have more trouble than usual remembering recent events? | ○ Yes | ○ No |
| Do you have more trouble than usual remembering a short list of items, such as a shopping list? | ○ Yes | ○ No |
| Do you have trouble remembering things from one second to the next? | ○ Yes | ○ No |
| Do you have any difficulty in understanding or following spoken instructions? | ○ Yes | ○ No |
| Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory? | ○ Yes | ○ No |
| Do you have trouble finding your way around familiar streets? | ○ Yes | ○ No |

**67. Please rate your ability to do the following activities.** ***(Mark one answer per row.)***

| Are you able to . . . | Without Help | With Some Help | Unable |
|---|---|---|---|
| a. **Get to places out of walking distance** | ○ Drive car, or travel alone on bus, train, or taxi | ○ Need someone to help you or go with you | ○ Unable to travel except by ambulance, etc. |
| b. **Go shopping for groceries or clothes (assuming you had transportation)** | ○ Can shop by yourself, assuming you had transportation | ○ Need someone to help you on all shopping trips | ○ Completely unable to do any shopping |
| c. **Prepare your own meals** | ○ Plan and cook full meals yourself | ○ Can prepare some things. Unable to cook full meals | ○ Completely unable to prepare any meals |
| d. **Do your own housework** | ○ Can clean floors, bathroom, etc. | ○ Need help with heavy housework & cleaning | ○ Completely unable to do any housework |
| e. **Handle your own money** | ○ Write checks, pay bills, etc. by yourself | ○ Can manage day-to-day buying. Need help with checkbook & paying bills | ○ Completely unable to handle money |
| f. **Handle your medications** | ○ Able to keep track of and take meds yourself | ○ Need someone to help manage medications | ○ Completely unable to manage medications |

**68. Do you drive an automobile?**

○ Yes ○ No, I never did ○ No, not anymore → **When did you stop?** ○ Last 4 yrs. ○ Last 8 yrs. ○ Over 8 yrs. ago

**69. In a typical week during the past year, on how many days did you consume an alcoholic beverage of any type?**

○ No days ○ 1 day/week ○ 2 days/wk ○ 3 days/wk ○ 4 days/wk ○ 5 days/wk ○ 6 days/wk ○ 7 days/wk

**70. In a typical month, what is the largest number of drinks of beer, wine, and/or liquor you have in one day?**

○ None ○ 1–2 drinks/day ○ 3–5 ○ 6–9 ○ 10–14 ○ 15 or more drinks/day

**71. In a typical week during the past year, how often did you drink alone?**

○ Never or don't drink ○ <1/month ○ 1–2/week ○ 3–5/week ○ almost every day

**72. Do you have any problems with your sense of smell, such as not being able to smell things or things not smelling the way they are supposed to for at least 3 months?**

○ No ○ Yes ○ Don't know

**73. Have you ever attempted suicide?**

○ No ○ Yes →

a) **Did you require medical attention in an emergency department or hospital?** ○ No ○ Yes

b) **Please indicate your age(s) when you attempted suicide:**

○ Before age 18 ○ 18–30 ○ 31–45 ○ 46–60 ○ 61–75 ○ 76–84 ○ 85+

National Suicide Prevention Hotline 1-800-273-8255

**74. 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: Nurses' Health Study, 181 Longwood Ave, Boston, MA 02115.

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