HARVARD MEDICAL SCHOOL **NURSES' HEALTH STUDY**

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Do you have e-mail?
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 <u>not</u> release your e-mail address to anyone!

NURSES' HEALTH STUDY - HARVARD MEDICAL SCHOOL

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

2. **Current Weight:** _____ lbs.

3. **Have you had your uterus or ovaries removed?** ☐ No ☐ Uterus removed ☐ Both ovaries removed ☐ One ovary removed

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

5. **Do you currently smoke cigarettes?** ☐ No ☐ Yes

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6. **Since June 2012, have you had any of these clinician-diagnosed illnesses?**

Cardiovascular

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".		YEAR OF DIAGNOSIS: BEFORE JUNE 1, 2012	JUNE '12 to MAY '14	After JUNE 1, 2014
Elevated Cholesterol	Y ➡	☐	☐	☐
High Blood Pressure	Y ➡	☐	☐	☐
Myocardial Infarction (heart attack) ➡ Were you hospitalized for this MI? ○ Yes ○ No	Y ➡	☐	☐	☐
Angina ➡ Confirmed by angiogram? ○ Yes ○ No	Y ➡	☐	☐	☐
Coronary Artery Bypass, Angioplasty, or Stent	Y ➡	☐	☐	☐
Stroke (CVA)	Y ➡	☐	☐	☐
Transient Ischemic Attack (TIA)	Y ➡	☐	☐	☐
Carotid Artery Surgery (Endarterectomy)	Y ➡	☐	☐	☐
Peripheral Artery Disease (not varicose veins)	Y ➡	☐	☐	☐
Pulmonary Embolus / DVT	Y ➡	☐	☐	☐
Congestive Heart Failure	Y ➡	☐	☐	☐
Atrial Fibrillation, Dr. Dx	Y ➡	☐	☐	☐
ICD-Implantable Cardiac Defibrillator	Y ➡	☐	☐	☐

Eye Diseases

		BEFORE JUNE 1, 2012	JUNE '12 to MAY '14	After JUNE 1, 2014
Glaucoma	Y ➡	☐	☐	☐
Macular Degeneration of Retina	Y ➡	☐	☐	☐
Cataract (1st diagnosis)	Y ➡	☐	☐	☐
Cataract Extraction	Y ➡	☐	☐	☐

Musculoskeletal

		BEFORE JUNE 1, 2012	JUNE '12 to MAY '14	After JUNE 1, 2014
Hip Fracture Specify Date, Site, and Circumstances on reverse side of this form	Y ➡	☐	☐	☐
Hip Replacement	Y ➡	☐	☐	☐
Vertebral Fracture	Y ➡	☐	☐	☐
Osteoporosis	Y ➡	☐	☐	☐
Rheumatoid Arthritis / Lupus	Y ➡	☐	☐	☐

Cancer/Other Diseases

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".		YEAR OF DIAGNOSIS: BEFORE JUNE 1, 2012	JUNE '12 to MAY '14	After JUNE 1, 2014
Fibrocystic or other Benign Breast Disease ➡ Confirmed by breast biopsy? ○ Yes ○ No	Y ➡	☐	☐	☐
Breast Cancer	Y ➡	☐	☐	☐
Melanoma	Y ➡	☐	☐	☐
Squamous Cell Skin Cancer	Y ➡	☐	☐	☐
Basal Cell Skin Cancer	Y ➡	☐	☐	☐
Leukemia or Lymphoma	Y ➡	☐	☐	☐
Colon or Rectal Polyps (benign)	Y ➡	☐	☐	☐
Colon or Rectal Cancer	Y ➡	☐	☐	☐
Other Cancer	Y ➡	☐	☐	☐

Specify other cancer site (e.g., uterus, ovary, lung, etc.):

		BEFORE JUNE 1, 2012	JUNE '12 to MAY '14	After JUNE 1, 2014
Diabetes Mellitus	Y ➡	☐	☐	☐
Alzheimer's / Dementia	Y ➡	☐	☐	☐
Parkinson's Disease	Y ➡	☐	☐	☐
Lou Gehrig's Disease / Amyotrophic Lateral Sclerosis	Y ➡	☐	☐	☐
Depression, Dr. Dx	Y ➡	☐	☐	☐
Kidney Stones	Y ➡	☐	☐	☐
Fatty Liver Disease and/or Cirrhosis	Y ➡	☐	☐	☐
Ulcerative Colitis / Crohn's or Microscopic Colitis	Y ➡	☐	☐	☐
Gout	Y ➡	☐	☐	☐
Barrett's Esophagus	Y ➡	☐	☐	☐
Other Major Illness or Surgery Since June 2012	Y ➡	☐	☐	☐

Include for example:
Gastric/Duodenal Ulcer, GI bleeding, Asthma, COPD, Diverticulitis, Celiac disease, Hyperparathyroidism, MS, Shingles, etc.

Specify other major illness or surgery:

Continue on Back

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PERF

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

Y
N

Name: _____

Address: _____

_____

Phone/Email: _____

Did you need any help from someone else to complete this questionnaire?

○ No ○ Yes, I received help from someone else but I provided most of the input

○ Yes, someone else completed it on my behalf with minimal input from me

If Yes: **I needed help with: (Mark all that apply.)**

○ Vision ○ Writing ○ Memory ○ Other

Who helped?

○ Husband/Partner ○ Child ○ Other

Please elaborate in the space below and include your name, address, telephone number or email address, and your relationship to the participant. Please explain briefly why your help was needed (e.g., macular degeneration, Parkinson's, dementia, etc.)

PERF

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Please specify the date and circumstances of your hip fracture (including fractures at the femoral head and neck, greater trochanter, and intertrochanteric).

- **Date of hip fracture:** Month _____ Year _____
- **Circumstances:**

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