NURSES' HEALTH STUDY II

HARVARD MEDICAL SCHOOL

HARVARD SCHOOL of PUBLIC HEALTH

• Harvard School of Public Health • 677 Huntington Avenue • Boston, Massachusetts 02115 • (617) 432-2279 •

Dear Colleague:

On behalf of our research group, I again want to express my gratitude for your participation in the Nurses' Health Study II. The accuracy and completeness of the information you provide is truly impressive, and we are confident that this study will provide answers to many critical questions about lifestyle factors, diet, and oral contraceptive use. Analyses of these factors in relation to breast cancer and several other diagnoses will begin soon. We have already begun to analyze information on several common conditions and will report findings to you in our next newsletter.

The enclosed questionnaire continues our every-other-year follow-up. You will note that we ask about your current status for many of the same questions that we posed earlier. We also ask about new medical diagnoses and conditions.

We hope that you give this questionnaire the same attention and care that you did in completing the earlier forms. The validity of this major research undertaking depends directly on complete and accurate follow-up information for all study members. We know that some participants are no longer in active nursing. However, your continued participation is critical regardless of current employment status. As always, the information you provide is strictly confidential and will be used only for medical statistical purposes.

Thank you again for your invaluable participation in this study. We will be sending you the next edition of our newsletter in June of 1994 to update you on the progress of the investigation.

Sincerely,

Walter Willett

Walter Willett, M.D.
Professor of Epidemiology and Nutrition

P.S. Your updated questionnaire information is needed to maintain the validity of this study. Your reply within the next two weeks would be greatly appreciated.

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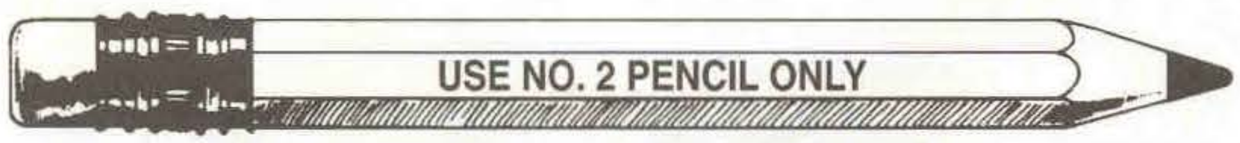
INSTRUCTIONS

Please use an ordinary No. 2 pencil to answer all questions. Fill in the appropriate response circles completely, or write the requested information in the boxes provided. Note that some questions ask for information **since June 1991**, some ask for **current status**, and some ask about events over **longer periods**. The form is designed to be read by optical-scanning equipment, so it is important that you make **NO STRAY MARKS** and keep any write-in responses **within** the spaces provided. Should you need to change a response, erase the incorrect mark completely. If you have comments, please write them on a separate piece of paper.



EXAMPLE 1:

Write in your weight in the boxes...

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

Please fill in the circle completely, do not mark this way: ✓ ✗

1. Current Weight

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

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 darkened.

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

11. Since June 1991, have you had any of these physician-diagnosed illnesses?

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

		YEAR OF DIAGNOSIS		
		Before June 1 1991	June 91 to May 93	After June 1 1993
Stroke (CVA) or TIA	●	○	○	●
Melanoma	Ⓨ	○	○	○
Basal cell skin cancer	●	○	●	○

Thank you for completing the 1993 Nurses' Health Study II Questionnaire.

Please tear off the cover letter (to preserve confidentiality) and return the questionnaire in the enclosed postage paid envelope.

If you need to make any changes or corrections to your name/address you may do so on the cover letter and enclose it with your completed questionnaire.

1. PLEASE USE PENCIL!

CURRENT WEIGHT (POUNDS)

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

2. We would like to update your pregnancy history from the time of the first questionnaire in 1989 to the present.

a) Since September 1, 1989 have you been pregnant?
○ No - go to question 3 ○ Yes

b) Are you currently pregnant?
○ No ○ Yes – continue with part c, but do not fill in a bubble for current pregnancy

c) For each pregnancy *ending* after September 1, 1989, fill in a response bubble for the year during which each pregnancy *ended.*

Calendar Year	Pregnancies lasting 6 months or more: Single Birth	Pregnancies lasting 6 months or more: Twins/Triplets	Pregnancies lasting less than 6 months (include miscarriages/ induced abortions)
9/1/89 - 12/31/89	○	○	○
1990	○	○	○
1991	○	○	○
1992	○	○	○
1993	○	○	○
1994	○	○	○

3. Do you CURRENTLY use any of these forms of contraception? (Mark all that apply.)
○ None ○ Oral contraceptive ○ Norplant ○ Diaphragm/Cervical cap ○ Tubal ligation ○ Foam/Jelly/Sponge
○ Condom ○ Intrauterine device ○ Rhythm/NFP ○ Vasectomy ○ Depo Provera ○ Other

4. SINCE JUNE 1991, have you used oral contraceptives (OC's)?
○ Yes → a) How many months have you used OC's since June 1991?
○ 1 or less months ○ 2 - 4 ○ 5 - 9 ○ 10 - 14 ○ 15 - 19 ○ 20 or more months
○ No
b) Please indicate the brand and type of OC used longest during this time period. Refer to the OC Brand Code Sheet enclosed with this questionnaire and write the code in this box. →

5. What is the current usual length of your menstrual cycle (interval from first day of period to first day of next period)?
○ < 21 days ○ 21-25 ○ 26-31 ○ 32-39 ○ 40-50 ○ 51+ days or too irregular to estimate

6. What is the current usual pattern of your menstrual cycles (when not pregnant or lactating)?
○ Extremely regular (no more than 1-2 days before or after expected) ○ Very regular (within 3-4 days)
○ Regular (within 5-7 days) ○ Usually irregular ○ Always irregular ○ No periods

7. Have your menstrual periods ceased PERMANENTLY?
○ No: Premenopausal
○ Yes: No menstrual periods → a) Age natural periods ceased?
○ Yes: Had menopause but now have periods induced by hormones
○ Not sure

AGE

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

→ b) For what reason did your periods cease?
○ SURGERY: If due to surgery, were your ovaries removed?
○ Yes, both ○ Only uterus removed ○ One only
○ RADIATION or CHEMOTHERAPY
○ NATURAL: If natural (non-surgical) menopause, have you had subsequent surgery to remove ovaries or uterus?
○ No ○ One ovary removed ○ Uterus removed ○ Both ovaries removed

8. SINCE JUNE 1991, have you used female replacement hormones (other than oral contraceptives)?
○ No
○ Yes, currently → a) How many months have you used them since JUNE 1991?
○ Yes, discontinued
○ 1-4 mo. ○ 5-9 ○ 10-14 ○ 15-19 ○ 20+ months

b) Mark the types of hormones you have used the longest during this period.
Estrogen: ○ Oral Premarin ○ Estrace ○ Ogen ○ Patch Estrogen ○ Vaginal Estrogen ○ Other Estrogen
Progesterone/Progestin (e.g., Provera): ○ Oral ○ Vaginal ○ Other (specify below)
Other type of hormones used, please specify: →

c) If you used oral conjugated estrogen (e.g., Premarin) what dose did you usually take?
○ .30 mg/day or less (Green) ○ .625 mg/day (Brown) ○ .9 mg/day (White) ○ 1.25 mg/day (Yellow)
○ More than 1.25 mg/day ○ Dose unknown ○ Did not take oral conjugated estrogen

d) If you used oral Medroxy Progesterone (e.g., Provera, Cycrin), what dose did you usually take?
○ < 5 mg ○ 5-9 mg ○ 10 mg ○ More than 10 mg ○ Dose unknown ○ Not used

e) 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

9. Have you had a tubal ligation?
○ No
○ Yes → At what age? ○ <25 ○ 25-29 ○ 30-34 ○ 35-39 ○ 40-44 ○ 45+

1	1	1	1	1	1	1	1	2	3	4
2	2	2	2	2	2	2	5	6	7	8
4	4	4	4	4	4	4	9	10	11	12
8	8	8	8	8	8	8		93	94	95
P	P	P	P	P	P	P	A	B	C	D

THIS IS YOUR ID

10. Is this your correct date of birth?

○ Yes ○ No → **If no, please write correct date.** Month / Day / Year

11. Since June 1991, have you had any of these physician-diagnosed illnesses?

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

		YEAR OF DIAGNOSIS: Before June 1 1991	June 91 to May 93	After June 1 1993	
Myocardial infarction (heart attack)	(Y)	○	○	○	1
Angina pectoris	(Y)	○	○	○	2
Confirmed by angiography? (N) No (Y) Yes					a
Stroke (CVA) or TIA	(Y)	○	○	○	3
Melanoma	(Y)	○	○	○	4
Basal cell skin cancer	(Y)	○	○	○	5
Squamous cell skin cancer	(Y)	○	○	○	6
Fibrocystic/other benign breast dis.	(Y)	○	○	○	7
Confirmed by breast biopsy? (N) No (Y) Yes					a
Confirmed by aspiration? (N) No (Y) Yes					b
Breast cancer	(Y)	○	○	○	8
Other cancer:	(Y)	○	○	○	9
Specify site of other cancer:					
High blood pressure (excluding during pregnancy)	(Y)	○	○	○	10
Diabetes: Gestational	(Y)	○	○	○	11
Diabetes: Not pregnancy-related	(Y)	○	○	○	12
Elevated cholesterol	(Y)	○	○	○	13
Deep vein thrombosis/Pul. embolism	(Y)	○	○	○	14
Rheumatoid arthritis, doctor diagnosed	(Y)	○	○	○	15
Rheumatoid factor ○ Negative/Unknown ○ Positive					a
Other arthritis	(Y)	○	○	○	16
Colon or rectal polyp (benign)	(Y)	○	○	○	17
Gastric or duodenal ulcer	(Y)	○	○	○	18
Cholecystectomy	(Y)	○	○	○	19
Gall stones	(Y)	○	○	○	20
a) Did you have symptoms? (N) No (Y) Yes					a
b) How diagnosed? ○ X-ray or ultrasound ○ Other					b
Polycystic ovaries	(Y)	○	○	○	21
Premenstrual syndrome (PMS)	(Y)	○	○	○	22
Vaginal yeast infection	(Y)	○	○	○	23
Kidney stones	(Y)	○	○	○	24
Pneumonia, X-ray confirmed	(Y)	○	○	○	25
Multiple sclerosis	(Y)	○	○	○	26
Hydatidiform mole (of pregnancy)	(Y)	○	○	○	27
Asthma, Physician Dx	(Y)	○	○	○	28
Ulcerative colitis/Crohn's	(Y)	○	○	○	29
Migraine headaches	(Y)	○	○	○	30
Other major illness or surgery since June, 1991	(Y)	○	○	○	31

Please specify other major illness or surgery:

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

12. Have you EVER had any of these physician-diagnosed illnesses?

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

		YEAR OF DIAGNOSIS: Before Sept 1989	Sept 89 to May 91	June 91 to May 93	After June 1 1993	
Ectopic pregnancy	(Y)	○	○	○	○	1
High blood pressure (pregnancy-related)	(Y)	○	○	○	○	2
Toxemia/Pre-eclampsia of pregnancy	(Y)	○	○	○	○	3
SLE (systemic lupus)	(Y)	○	○	○	○	4
Active TB (X-ray confirmed)	(Y)	○	○	○	○	5
Graves' Disease	(Y)	○	○	○	○	6
Other Hyperthyroidism	(Y)	○	○	○	○	7
Hypothyroidism	(Y)	○	○	○	○	8
Thyroid nodule (benign)	(Y)	○	○	○	○	9
Mitral valve prolapse	(Y)	○	○	○	○	10
Confirmed by echocardiogram? (N) No (Y) Yes						a
Herniated lumbar disk	(Y)	○	○	○	○	11
Confirmed by CT or MRI? (N) No (Y) Yes						a
Other chronic back problem	(Y)	○	○	○	○	12
Endometriosis - 1st Dx	(Y)	○	○	○	○	13
Confirmed by laparoscopy? (N) No (Y) Yes						a
Uterine fibroid(s) - 1st Dx	(Y)	○	○	○	○	14
Confirmed by pelvic exam? (N) No (Y) Yes						a
Confirmed by ultrasound/hysterectomy? (N) No (Y) Yes						b

13. Current Medication (mark if used regularly) 13

- ○ No regular medication
- ○ Acetaminophen, 2+ times/week (e.g., Tylenol)
- ○ Aspirin, (e.g., Anacin, Bufferin, Alka-Seltzer, etc.)
  - Days/week: ○ <1 day ○ 1 - 2 ○ 3 - 4 ○ 5 - 7 days D
- ○ Other anti-inflammatory analgesics, 2+ times/week (e.g., Ibuprofen, Indocin, Naprosyn, Advil)
- ○ Thiazide diuretic (e.g., Hygroton, Dyazide, HCTZ, Diuril)
- ○ Any anti-hypertensive medication
- ○ Thyroid hormone replacement (e.g, Synthroid, Levothroid)
- ○ Minor Tranquilizers (e.g., Valium, Xanax, Ativan, Librium)
- ○ Major Tranquilizers (e.g., Stelazine, Thorazine, Haldol, Prolixin, Mellaril, Trilafon)

14. Have you ever taken any of the following medications? 14

a) Tetracycline: a
- ○ Yes → For how long? ○ <1 yr. ○ 1-2 ○ 3-4 ○ 5+yrs 1
- ○ No Age @ 1st use: ○ <15 ○ 15-19 ○ 20-29 ○ 30+ 2

b) Oral Acutaine: b
- ○ Yes → For how long? ○ <1 yr. ○ 1-2 ○ 3-4 ○ 5+yrs 1
- ○ No Age @ 1st use: ○ <15 ○ 15-19 ○ 20-29 ○ 30+ 2

c) Tricyclic antidepressants (e.g., Elavil, Norpramin, Tofranil, Pamelor, Sinequan, Vivactil, Surmontil): c
- ○ Yes → For how long? ○ <1 yr. ○ 1-2 ○ 3-4 ○ 5+yrs 1
- ○ No Age @ 1st use: ○ <15 ○ 15-19 ○ 20-29 ○ 30+ 2

d) Prozac (Fluoxetine) or Zoloft (Sertraline): d
- ○ Yes → For how long? ○ <1 yr. ○ 1-2 ○ 3-4 ○ 5+yrs 1
- ○ No

15. a) Your TB skin test since 1989? 15 a
- ○ Pos ○ Neg ○ Not done ○ BCG prior to 1989

b) If ever positive, conversion date: b
- ○ Before 1989 ○ 1989+ ○ Never positive

c) If ever positive, were you treated with INH? c
- ○ Yes ○ No ○ Never positive

16. Since June 1991, have you tried to become pregnant for more than one year without success? 16

○ Yes → What was the cause? (Mark all that apply.) a
○ No
○ Tubal blockage ○ Ovulatory disorder ○ Endometriosis ○ Cervical mucous factors
○ Spouse/Partner ○ Not investigated ○ Not found ○ Other

17. Have you ever taken Clomid (Clomiphene) or Pergonal to induce ovulation? 17

○ Yes → a) In how many months was Clomid used: ○ 0 months ○ 1 ○ 2-3 ○ 4-5 ○ 6-11 ○ 12+ months a
○ No b) In how many months was Pergonal used: ○ 0 months ○ 1 ○ 2-3 ○ 4-5 ○ 6-11 ○ 12+ months b

18. Have you ever had a miscarriage or induced abortion before the sixth month of pregnancy? 18

Miscarriage:	○ No	○ Yes: at what age(s)	○ <18	○ 18-20	○ 21-23	○ 24-26	○ 27-29	○ 30-34	○ 35+	a
Induced Abortion:	○ No	○ Yes: at what age(s)	○ <18	○ 18-20	○ 21-23	○ 24-26	○ 27-29	○ 30-34	○ 35+	b

19. Since June 1991, how many months have you worked ROTATING night shifts (at least 3 nights/month in addition to other days and evenings in that month)? 19

○ None ○ 1-4 months ○ 5-9 ○ 10-14 ○ 15-19 ○ 20+ months

20. Which best describes your current employment status? 20

○ Inpatient or ER Nurse ○ Outpatient/Community ○ OR Nurse ○ Nursing Education ○ Student
○ Nursing Administration ○ Other Nursing ○ Non-nursing employment ○ Fulltime Homemaker ○ Disabled

21. How many times per week do you engage in physical activity long enough to perspire heavily (including swimming)? 21

○ Less than once/week ○ Once/week ○ 2-3 times/week ○ 4-6 times/week ○ 7 or more times/week

22. In how many months did you practice breast self-examination in the past year? 22

○ None ○ One month ○ 2-3 ○ 4-6 ○ 7-11 ○ 12 months

23. Since June 1991, have you had: 23

	No	Yes, for screening	Yes, for symptoms
Mammogram	○	○	○
Breast exam by clinician	○	○	○
Colonoscopy/Sigmoidoscopy	○	○	○
Pap smear	○	○	○

24. How many months <u>in total</u> (all births combined) did you breast feed? 24

○ Did not breast feed ○ <1 month ○ 1-3 mo. ○ 4-6 mo. ○ 7-11 mo. ○ 12-17 mo.
○ No children ○ 18-23 mo. ○ 24-35 mo. ○ 36-47 mo. ○ 48+ mo. ○ Cannot remember

25. Between the ages of 18 and 30 (excluding illness and pregnancy-related changes): 25

a) What was your: **Minimum weight** _____ lbs. **Maximum weight** _____ lbs. a

b) Between the ages of 18 and 30, how many times did you lose each of the following amounts of weight on purpose? MN

5-9 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
10-19 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
20-49 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
50+ pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times

MX b

26. Within the last 4 years (excluding illness and pregnancy-related changes): 26

a) What was your: **Minimum weight** _____ lbs. **Maximum weight** _____ lbs. a

MN

b) Within the last 4 years, how many times did you lose each of the following amounts of weight on purpose?

5-9 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
10-19 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
20-49 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
50+ pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times

MX b

c) What primary method(s) did you use for your most recent weight loss of 10 or more pounds? (Mark all that apply) c

○ Did not lose 10 or more pounds ○ Diet pills ○ Increased exercise
○ Low calorie diet ○ Commercial weight loss program ○ Decreased alcohol intake
○ Low fat diet ○ Gastric surgery/intestinal bypass ○ Resumed/increased smoking
○ Skipped meals/fasted ○ Other
○ Weight loss was unintentional (e.g., illness, unusual stress, depression)

27. Do you currently smoke cigarettes? 27

○ No ○ Yes → How many per day? ○ 1-4 ○ 5-14 ○ 15-24 ○ 25-34 ○ 35-44 ○ 45 or more a

28. What was the cup size of your bra when you were 20 years old? (Estimate if you did not wear a bra.) 28

○ A or smaller ○ B ○ C ○ D or larger

29. How many biological sisters do you have? 29

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

30. Did your mother or any of your sisters have ovarian cancer? 30

○ No ○ Yes → ○ Mother ○ Sister ○ Both a

31. When your mother was pregnant with you, did she take DES (Diethylstilbestrol) or other hormones? 31

○ Don't know ○ No ○ Yes → ○ DES ○ Other hormones a

Please Continue on Page 4

32. In which state were you born?
In which state did you live at age 15?
In which state did you live at age 30?

33. During summers how many times per week were you outdoors in a swimsuit:
a) as a teenager? ◯ <1/week ◯ 1/week ◯ 2/week ◯ Several/week ◯ Daily
b) in the past summer? ◯ <1/week ◯ 1/week ◯ 2/week ◯ Several/week ◯ Daily

34. When you were outside at the pool or beach, what percent of the time did you wear sunscreen:
a) as a teenager? ◯ Not in sun ◯ 0% ◯ 25% ◯ 50% ◯ 75% ◯ 100%
b) in the past summer? ◯ Not in sun ◯ 0% ◯ 25% ◯ 50% ◯ 75% ◯ 100%

35. Is your biological mother still living?
◯ Yes ◯ No → a) At what age did she die? ◯ <50 ◯ 50-59 ◯ 60-69 ◯ 70-79 ◯ 80+
b) Was this due to: ◯ Heart Disease ◯ Cancer ◯ Trauma/Accident/Suicide ◯ Other

36. Is your biological father still living?
◯ Yes ◯ No → a) At what age did he die? ◯ <50 ◯ 50-59 ◯ 60-69 ◯ 70-79 ◯ 80+
b) Was this due to: ◯ Heart Disease ◯ Cancer ◯ Trauma/Accident/Suicide ◯ Other

37. What is your current marital status?
◯ Married ◯ Divorced/Separated ◯ Widowed ◯ Never Married

38. What is your current living arrangement?
◯ Alone ◯ With husband/partner ◯ With other family ◯ Other

39. Do you currently take a multi-vitamin? (Please report additional individual vitamins in question 40.)
◯ No ◯ Yes
a) How many do you take per week? ◯ 2 or fewer ◯ 3-5 ◯ 6-9 ◯ 10 or more
b) What specific brand do you usually use? (Please specify exact Brand and Type.)

40. Not counting multi-vitamins, do you regularly take any of the following preparations:

		AMOUNT PER DAY
a) Beta-carotene?	◯ No ◯ Yes →	◯ Less than 8,000 IU per day ◯ 8,000 to 12,000 IU ◯ 13,000 to 22,000 IU ◯ 23,000 IU or more ◯ Amount unknown
b) Vitamin A? (excluding carotene)	◯ No ◯ Yes →	◯ Less than 8,000 IU per day ◯ 8,000 to 12,000 IU ◯ 13,000 to 22,000 IU ◯ 23,000 IU or more ◯ Amount unknown
c) Vitamin C?	◯ No ◯ Yes, seasonal only ◯ Yes, most months	◯ Less than 400 mg. ◯ 400 to 700 mg. ◯ 750 to 1,250 mg. ◯ 1300 mg. or more ◯ Amount unknown
d) Vitamin E?	◯ No ◯ Yes →	◯ Less than 100 IU ◯ 100 to 250 IU ◯ 300 to 500 IU ◯ 600 IU or more ◯ Amount unknown
e) Calcium? (elemental)	◯ No ◯ Yes →	◯ Less than 400 mg per day ◯ 400 to 800 mg. ◯ 900-1,200 mg. ◯ 1,300 mg. or more ◯ Amount unknown
f) Folic acid?	◯ No ◯ Yes	◯ Less than 100 mg. ◯ 100 to 300 mg. ◯ 301-500 mg. ◯ 501 mg. or more ◯ Amount unknown

41. 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:

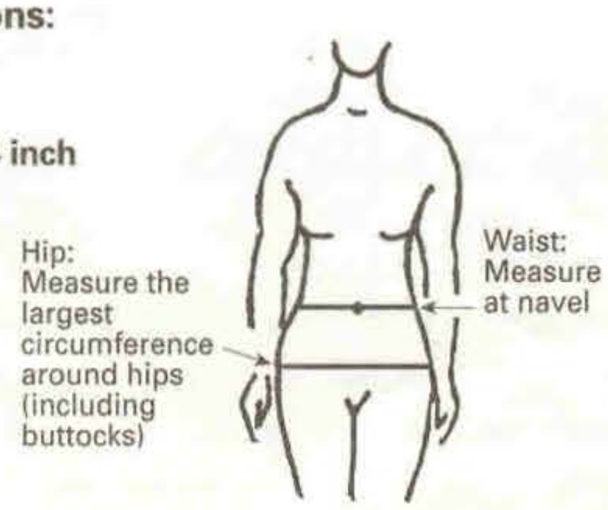
Name: _____

Address: _____

42. Question 42, which should only be answered if a tape measure is convenient, asks about body measurements. This information will be more accurate if you follow these suggestions:

- Make measurements while standing
- Avoid measuring over bulky clothing
- Try to record answers to the nearest 1/4 inch (do not estimate)

If a tape measure is not available, please leave blank.



WAIST			HIP		
Inches		Fraction	Inches		Fraction
		4			4
0	0	0	0	0	0
1	1	1/4	1	1	1/4
2	2	2/4	2	2	2/4
3	3	3/4	3	3	3/4
4	4		4	4	
5	5		5	5	
6	6		6	6	
	7			7	
	8			8	
	9			9	

AGE	30	15	0
AL	◯	◯	◯
AK	◯	◯	◯
AZ	◯	◯	◯
AR	◯	◯	◯
CA	◯	◯	◯
(Northern)			
CA	◯	◯	◯
(Southern)			
CO	◯	◯	◯
CT	◯	◯	◯
DE	◯	◯	◯
DC	◯	◯	◯
FL	◯	◯	◯
GA	◯	◯	◯
HI	◯	◯	◯
ID	◯	◯	◯
IL	◯	◯	◯
IN	◯	◯	◯
IA	◯	◯	◯
KS	◯	◯	◯
KY	◯	◯	◯
LA	◯	◯	◯
ME	◯	◯	◯
MD	◯	◯	◯
MA	◯	◯	◯
MI	◯	◯	◯
MN	◯	◯	◯
MS	◯	◯	◯
MO	◯	◯	◯
MT	◯	◯	◯
NE	◯	◯	◯
NV	◯	◯	◯
NH	◯	◯	◯
NJ	◯	◯	◯
NM	◯	◯	◯
NY	◯	◯	◯
NC	◯	◯	◯
ND	◯	◯	◯
OH	◯	◯	◯
OK	◯	◯	◯
OR	◯	◯	◯
PA	◯	◯	◯
PR	◯	◯	◯
RI	◯	◯	◯
SC	◯	◯	◯
SD	◯	◯	◯
TN	◯	◯	◯
TX	◯	◯	◯
UT	◯	◯	◯
VA	◯	◯	◯
VT	◯	◯	◯
WA	◯	◯	◯
WV	◯	◯	◯
WI	◯	◯	◯
WY	◯	◯	◯
Non US	◯	◯	◯

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PLEASE GO TO PAGE 5 AND BEGIN BY WRITING YOUR ID NUMBER FROM PAGE 2

C B A

Please copy your ID from page 2 to here.

ID: ☐☐☐☐☐☐–☐

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
0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | For Office Use Only A
0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9

Many participants have pointed out that stress, personal and family relationships, and other aspects of quality of life are important factors relating to health. We have added the following questions to learn more about these areas. (As always, all of your responses will remain strictly confidential.)

43. **These questions are about how you feel and how things have been with you *during the past 4 weeks*.**
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the *past 4 weeks* ... *(Mark one response on each line.)*	All of the time	Most of the time	A Good Bit of the time	Some of the time	A Little of the time	None of the time
Did you feel full of pep?	○	○	○	○	○	○
Have you been a very nervous person?	○	○	○	○	○	○
Have you felt so down in the dumps nothing could cheer you up?	○	○	○	○	○	○
Have you felt calm and peaceful?	○	○	○	○	○	○
Did you have a lot of energy?	○	○	○	○	○	○
Have you felt downhearted and blue?	○	○	○	○	○	○
Did you feel worn out?	○	○	○	○	○	○
Have you been a happy person?	○	○	○	○	○	○
Did you feel tired?	○	○	○	○	○	○

44. **During the *past 4 weeks*, how much of the time has your *physical health or have emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?**
○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

45. **Please choose the answer that best describes how true or false each of the following statements is for you.** *(Mark one response on each line.)*

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
Over the past 4 weeks, I have felt about the same as I have felt during the past year	○	○	○	○	○
I seem to get sick a little easier than other people	○	○	○	○	○
I am as healthy as anybody I know	○	○	○	○	○
I expect my health to get worse	○	○	○	○	○
My health is excellent	○	○	○	○	○

46. **The following items are about activities you might 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, such as running, lifting heavy objects, participating in strenuous sports	○	○	○
Moderate activities, such as moving a table, pushing a vacuum, bowling, or golfing	○	○	○
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	○	○	○

47. **During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of any *emotional problems* (such as feeling depressed or anxious)?** *(Mark one response on each line.)*
a) Cut down the amount of time you spent on work or other activities ○ Yes ○ No
b) Accomplished less than you would like ○ Yes ○ No
c) Didn't do work or other activities as carefully as usual ○ Yes ○ No

48. **During the *past 4 weeks*, to what extent has your physical health or have emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?**
○ Not at all ○ Slightly ○ Moderately ○ Quite a bit ○ Extremely

49. **How much *bodily* pain have you had during the *past 4 weeks*?**
○ None ○ Very mild ○ Mild ○ Moderate ○ Severe ○ Very severe

50. **During the *past 4 weeks*, how much did *bodily pain* interfere with your normal work (including both work outside the home and housework)?**
○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

51. **During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your *physical health*?** *(Mark one response on each line.)*
a) Cut down the amount of time you spent on work or other activities ○ Yes ○ No
b) Accomplished less than you would like ○ Yes ○ No
c) Were limited in the kind of work or other activities ○ Yes ○ No
d) Had difficulty performing the work or other activities (for example, it took extra effort) ○ Yes ○ No

PLEASE CONTINUE ON PAGE 6

52. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor 52

53. Do you have an unreasonable fear of being in enclosed spaces such as stores, elevators, etc.? 53
○ Often ○ Sometimes ○ Never

54. Do you find yourself worrying about getting some incurable illness? ○ Often ○ Sometimes ○ Never 54

55. Are you scared of heights? ○ Very ○ Moderately ○ Not at all 55

56. Do you feel panicky in crowds? ○ Always ○ Sometimes ○ Never 56

57. Do you worry unduly when relatives are late coming home? ○ Yes ○ No 57

58. Do you feel more relaxed indoors? ○ Definitely ○ Sometimes ○ Not particularly 58

59. Do you dislike going out alone? ○ Yes ○ No 59

60. Do you feel uneasy traveling on buses or trains even when they are not crowded? 60
○ Very ○ A little ○ Not at all

61. If you are retired or stopped working due to illness/injury, at what age were you last in paid employment? 61
○ Still working ○ < Age 25 ○ 25 - 29 ○ 30 - 34 ○ 35 - 39 ○ Age 40 or older

62. If you have been employed within the past 2 years, the following questions relate to your current or most recent job: 62

○ Not employed in last 2 years

Please choose the answer which best describes the degree to which you agree or disagree with each of the following statements.	Strongly Disagree	Disagree	Agree	Strongly Agree
My job requires that I learn new things	○	○	○	○
My job involves a lot of repetitive work	○	○	○	○
My job requires me to be creative	○	○	○	○
My job allows me to make a lot of decisions on my own	○	○	○	○
My job requires a high level of skill	○	○	○	○
On my job, I have very little freedom to decide how I do my work	○	○	○	○
I get to do a variety of different things on my job	○	○	○	○
I have a lot of say about what happens on my job	○	○	○	○
I have an opportunity to develop my own special abilities	○	○	○	○
My job requires working very fast	○	○	○	○
My job requires working very hard	○	○	○	○
My job requires lots of physical effort	○	○	○	○
I am not asked to do an excessive amount of work	○	○	○	○
I have enough time to get the job done	○	○	○	○
My job security is good	○	○	○	○
I am free from conflicting demands that others make	○	○	○	○
People I work with are competent in doing their jobs	○	○	○	○
People I work with take a personal interest in me	○	○	○	○
People I work with are friendly	○	○	○	○
People I work with are helpful in getting the job done	○	○	○	○

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not Applicable	a
a) My supervisor is concerned about the welfare of those under her	○	○	○	○	○	
My supervisor pays attention to what I am saying	○	○	○	○	○	
My supervisor is helpful in getting the job done	○	○	○	○	○	
My supervisor is successful in getting people to work together	○	○	○	○	○	

b) How long have you worked in the job you described above? b
○ < 6 months ○ 6 months - 11 months ○ 1 - 2 years ○ 3 - 4 years ○ 5 - 9 years ○ 10 or more years

c) How many hours per week do you work, on average, in your job? c
○ < 15 hours ○ 15 - 20 ○ 21 - 40 ○ 41 - 60 ○ 61 - 80 ○ More than 80 hours per week

63. How many hours per week do you spend in housework (including cooking, cleaning, shopping for food, doing laundry and dishes, doing repairs, paying bills, making arrangements and caring for children)? 63
○ 0 - 19 hours ○ 20 - 39 ○ 40 - 59 ○ 60 - 79 ○ 80 - 100 hours

64. Thinking of all the things that are done in your household, what percentage do you personally do? 64
○ 0 - 25 percent ○ 26 - 39 ○ 40 - 60 ○ 61 - 74 ○ 75 - 99 ○ 100 percent

65. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with? 65 a
○ Yes → a) How often do you see or talk with this person? X Y
○ No ○ Daily ○ Weekly ○ Monthly ○ Several times/year ○ Once/year or less L

THANK YOU! Please return the questionnaire in the enclosed postage-paid envelope to: Walter Willett, M.D. Nurses' Health Study II 677 Huntington Avenue Boston, MA 02115

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