HARVARD MEDICAL SCHOOL **NURSES' HEALTH STUDY**

Please reply to:
Channing Laboratory
181 Longwood Avenue
Boston MA 02115-5804
(617) 525-2279 Fax (617) 525-2008
E-mail: NHS@NursesHealthStudy.org

Dear Colleague:

Thank you for your participation in one of the preeminent studies of women's health, the Nurses' Health Study. Your responses, beginning 27 years ago, have helped women everywhere to live longer, healthier lives. Your continued involvement is extremely valuable as we continue to examine how lifestyle and family history interact to affect women's health.

The attached **very brief** questionnaire asks only for the most important information necessary for maintaining our records. We have made it as short as possible in the hope that you will take just a few minutes to complete the form.

We value **each** member of the Nurses' Health Study as a colleague in our research, regardless of your employment (or retirement) status. Also, 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 need to hear from you!

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

Sincerely,

Frank E. Speizer, M.D.
Principal Investigator

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

Do you have internet 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 not 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 your menstrual periods ceased permanently?** ☐ Yes ☐ No ☐ Not sure

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

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

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

(2) (3) (4) (5) (5a) (6) (7)

7. **Since June 2000, have you had any of these physician-diagnosed illnesses?**

Cardiovascular

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	Y	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 2000	JUNE '00 to MAY '02	After JUNE 1, 2002
Elevated Cholesterol	Y ➡	☐	☐	☐
High Blood Pressure	Y ➡	☐	☐	☐
Myocardial Infarction (heart attack) ➡ Were you hospitalized for this MI? ○ Yes ○ No	Y ➡	☐	☐	☐
Angina ○ Yes ➡ Confirmed by angiogram? ○ No	Y ➡	☐	☐	☐
Coronary Artery Bypass or Coronary Angioplasty	Y ➡	☐	☐	☐
Stroke (CVA)	Y ➡	☐	☐	☐
Transient Ischemic Attack (TIA)	Y ➡	☐	☐	☐
Carotid Artery Surgery (Endarterectomy)	Y ➡	☐	☐	☐
Peripheral Artery Disease (not varicose veins)	Y ➡	☐	☐	☐
Pulmonary Embolus	Y ➡	☐	☐	☐
Congestive Heart Failure	Y ➡	☐	☐	☐
Atrial Fibrillation, Dr. Dx	Y ➡	☐	☐	☐

Eye Diseases

	Y	BEFORE JUNE 1, 2000	JUNE '00 to MAY '02	After JUNE 1, 2002
Glaucoma	Y ➡	☐	☐	☐
Macular Degeneration of Retina	Y ➡	☐	☐	☐
Cataract (1st diagnosis)	Y ➡	☐	☐	☐
Cataract Extraction	Y ➡	☐	☐	☐

Musculoskeletal

	Y	BEFORE JUNE 1, 2000	JUNE '00 to MAY '02	After JUNE 1, 2002
Hip or Wrist Fracture Specify Date, Site, and Circumstances on reverse side of this form	Y ➡	☐	☐	☐
Hip Replacement	Y ➡	☐	☐	☐
Osteoporosis	Y ➡	☐	☐	☐
Rheumatoid Arthritis, Dr. Dx	Y ➡	☐	☐	☐
SLE (systemic lupus)	Y ➡	☐	☐	☐

Cancer/Other Diseases

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	Y	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 2000	JUNE '00 to MAY '02	After JUNE 1, 2002
Cancer of the Uterus (endometrium)	Y ➡	☐	☐	☐
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 ➡	☐	☐	☐
Colon or Rectal Polyps (benign)	Y ➡	☐	☐	☐
Colon or Rectal Cancer	Y ➡	☐	☐	☐
Other Cancer (e.g. Lung, Ovary, etc.)	Y ➡	☐	☐	☐

Specify other cancer site:

	Y	BEFORE JUNE 1, 2000	JUNE '00 to MAY '02	After JUNE 1, 2002
Diabetes Mellitus	Y ➡	☐	☐	☐
Alzheimer's Disease	Y ➡	☐	☐	☐
Parkinson's Disease	Y ➡	☐	☐	☐
Multiple Sclerosis	Y ➡	☐	☐	☐
Depression, Dr. Dx	Y ➡	☐	☐	☐
Kidney Stones	Y ➡	☐	☐	☐
Cholecystectomy	Y ➡	☐	☐	☐
Asthma (Doctor Diagnosed)	Y ➡	☐	☐	☐
Emphysema or Chronic Bronchitis	Y ➡	☐	☐	☐
Other Major Illness or Surgery	Y ➡	☐	☐	☐

Include for example: Ulcerative colitis/Crohn's, Epilepsy, Gout, Hypothyroidism, Hyperthyroidism, Restless leg syndrome, Chronic renal failure, etc.

Specify other major illness or surgery:

Continue on Back

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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: _____

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

- **Was this a fracture of:** ☐ Hip ☐ Wrist

F

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

- **Circumstances:**

SS V W X Y Z

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