



HARVARD
MEDICAL
SCHOOL

NURSES' HEALTH STUDY II



HARVARD
SCHOOL of
PUBLIC HEALTH

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Dear Colleague:

On behalf of our research group, I thank you for your participation in the Nurses' Health Study II. The accuracy and completeness of the information you and your fellow participants provide will enable the study to answer many critical questions about the health effects of lifestyle factors, diet, and oral contraceptive use. Analyses of these factors in relation to breast cancer and several other diagnoses are currently underway.

The enclosed questionnaire continues our every-other-year follow-up. We hope that you give this questionnaire the same attention and care that you have given to the earlier forms. The validity of this major research undertaking depends directly on complete and accurate follow-up information for all study members.

Our aim is to find ways to maintain good health and prevent serious illness in women. Your continued participation is critical whether or not you are currently employed as a nurse. As always, the information you provide is strictly confidential and will be used only for medical statistical purposes.

Many thanks for your valuable participation. We will be sending you the next edition of our Nurses' Health Study newsletter in June 1998 to update you on our progress.

Sincerely,

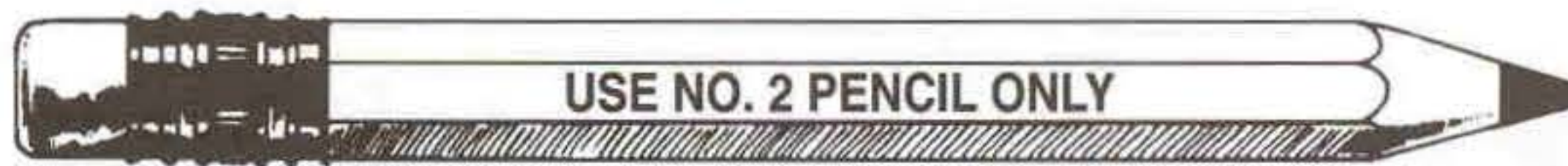
Walter Willett

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

P.S. We hope you can complete the attached questionnaire in the next two weeks. Your involvement, since the study began in 1989, is greatly appreciated!

INSTRUCTIONS

Please use an ordinary No. 2 pencil to 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 1995**, 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 make **NO STRAY MARKS** and keep write-in responses **within** the spaces provided. If you change a response, erase the incorrect mark completely. Write any comments on a separate page.



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
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	2	2
3	3	<input checked="" type="radio"/>
4	<input checked="" type="radio"/>	4
5	5	5
6	6	6
	7	7
	8	8
	9	9

NOTE: Be sure to 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.

15. Since June 1995, have you had any of these physician-diagnosed illnesses?

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

	YEAR OF DIAGNOSIS		
	BEFORE JUNE 1 1995	JUNE 95 TO MAY 97	AFTER JUNE 1 1997
Elevated Cholesterol	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Melanoma	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Basal cell skin cancer	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Thank you for completing the 1997 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 changes or corrections to your name/address, please note them on the cover letter and enclose it with your completed questionnaire.

1. PLEASE USE PENCIL! 2. a. SINCE JUNE 1995, 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 in part c for your current pregnancy.

c. For each pregnancy ending after JUNE 1, 1995, fill in a response bubble for the year during which each pregnancy ended.

Calendar Year	Pregnancies lasting 6 months or more		Pregnancies lasting less than 6 months	
	SINGLE BIRTHS	TWINS/TRIPLETS	MISCARRIAGES	INDUCED ABORTIONS
6/1/95 - 12/31/95	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1996	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1997	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1998+	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Do you CURRENTLY use any of these forms of contraception? (Mark all that apply.)

- None Oral contraceptive Condom Diaphragm/Cervical cap
 Vasectomy Foam/Jelly/Sponge Rhythm/NFP Norplant
 Intrauterine Device Depo Provera Other
 Tubal Ligation - Type? Cautery/Coagulation Ligation Clip/ring/band Other/Don't know

4. SINCE JUNE 1995, have you used oral contraceptives (OCs)?

Yes → a. How many months did you use OCs during the 24-month period between June 1995 and June 1997?

No 1 month or less 2-4 5-9 10-14 15-19 20-24 months

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. SINCE JUNE 1995, have you tried to become pregnant for more than one year without success?

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

6. SINCE JUNE 1995, have you taken Clomid (Clomiphene) or Pergonal/Metrodin to induce ovulation?

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

7. Have your natural menstrual periods ceased PERMANENTLY?

- No: Premenopausal
 Yes: No menstrual periods
 Yes: Had menopause but now have periods induced by hormones
 Not sure (e.g., started hormones prior to cessation of periods)

a. AGE natural periods ceased:

AGE	

b. For what reason did your periods cease?

- Natural
 Surgical
 Radiation or chemotherapy

8. Have you had your uterus removed?

No Yes → Date of surgery: Before June 1, 1995 After June 1, 1995

9. Have you ever had either of your ovaries surgically removed?

No Yes → How many ovaries do you have remaining? None One

10. SINCE JUNE 1995, have you used female replacement hormones (other than oral contraceptives)?

Yes → a. How many months did you use them during the 24-month period between JUNE 1995 and JUNE 1997?

1-4 mo. 5-9 10-14 15-19 20-24 mo.

b. Are you currently using them (within the last month)? Yes, currently No, not currently

c. Mark the types of hormones you have used the longest during this period.

Estrogen: Oral Premarin Estrace Ogen
 Vaginal Estrogen Patch Estrogen Other Estrogen

Progesterone/Progestin (e.g., Provera): Oral Vaginal Other (specify below)

Other type of hormones used, please specify: →

d. 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

e. 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 Dose unknown Not used

f. What was your pattern of hormone use (Days per Month)?

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

Progesterone: Days/Month Not used <1 day/mo 1-8 days 9-18 19-26 27+ days/mo

11. Do you currently smoke cigarettes?

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

1	1	1	1	1	1	1	1	6	97	A
2	2	2	2	2	2	2	2	7	98	B
4	4	4	4	4	4	4	4	8	99	C
6	6	6	6	6	6	6	4	9	11	D
P	P	P	P	P	P	P	5	10	12	E

← THIS IS YOUR ID

12. Is this your correct date of birth? →

Yes No → If no, please write correct date. / /

13. Regular Medication (mark if used regularly in past 2 years)

- Acetaminophen (e.g., Tylenol)
Days/week: 1 2-3 4-5 6+ days
- Aspirin or aspirin-containing products (e.g., Alka-Seltzer with aspirin)
Days/week: 1 2-3 4-5 6+ days
- Non-steroidal anti-inflammatory (e.g., Ibuprofen, Advil, Midol, Aleve)
Days/week: 1 2-3 4-5 6+ days
- Thyroid hormone replacement (e.g., Synthroid, Levothroid)
- Thiazide diuretic (e.g., Dyazide, HCTZ, Hygroton, Diuril)
- Any other medication to treat hypertension
- Cimetidine (Tagamet)
- Other H2 blocker (e.g., Zantac, Pepcid, Axid)
- Tamoxifen In Tamoxifen study (randomized trial)
- Tricyclic antidepressants (e.g., Elavil, Tofranil, Pamelor)
- Prozac Zoloft Paxil
- Minor tranquilizers (e.g., Valium, Xanax, Ativan, Librium)
- Other regular medication (no need to specify)
- No regular medication

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

RELATIVE'S AGE AT FIRST DIAGNOSIS

	Before age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
Ovarian Cancer?					
<input type="radio"/> No					
Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sister	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast Cancer?					
<input type="radio"/> No					
Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
One Sister	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Additional Sister	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Maternal Grandmother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paternal Grandmother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon or Rectal Cancer?					
<input type="radio"/> No					
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
One Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Additional Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Melanoma?					
<input type="radio"/> No					
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Myocardial Infarction?					
<input type="radio"/> No					
Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Father	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke?					
<input type="radio"/> No					
Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Father	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes?					
<input type="radio"/> No					
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney Stones?					
<input type="radio"/> No					
Parent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. Since June, 1995, have you had any of these physician-diagnosed illnesses?

	Leave blank for NO, mark here for YES →	YEAR OF DIAGNOSIS			X
		Before June 1 1995	June 95 to May 97	After June 1 1997	
Myocardial infarction (heart attack)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1
Angina pectoris	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2
Confirmed by angiography?	<input type="radio"/> No <input type="radio"/> Yes				a
Coronary bypass/angioplasty	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	3
Stroke (CVA) or TIA	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	4
Deep vein thrombosis/Pul. embolism	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	5
Elevated cholesterol	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	6
Melanoma	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	7
Basal cell skin cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	8
Squamous cell skin cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	9
Fibrocystic/other benign breast disease	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	10
Confirmed by breast biopsy?	<input type="radio"/> No <input type="radio"/> Yes				a
Confirmed by aspiration?	<input type="radio"/> No <input type="radio"/> Yes				b
Breast cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	11
Other cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	12
Specify site of other cancer: →					
Colon or rectal polyp (benign)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	13
Ulcerative colitis/Crohn's	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	14
Gastric or duodenal ulcer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	15
Gallstones	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	16
Did you have symptoms?	<input type="radio"/> No <input type="radio"/> Yes				a
How diagnosed?	<input type="radio"/> X-ray or ultrasound <input type="radio"/> Other				b
Cholecystectomy	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17
High blood pressure (not pregnancy related)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	18
Pregnancy-related high blood pressure	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	19
Toxemia/Pre-eclampsia of pregnancy	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20
Diabetes: Not pregnancy-related	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21
Diabetes: Gestational	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	22
Hydatidiform mole of pregnancy	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	23
Ectopic pregnancy	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	24
Endometriosis—1st diagnosis	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	25
Confirmed by laparoscopy?	<input type="radio"/> No <input type="radio"/> Yes				a
Uterine fibroids—1st diagnosis	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	26
Confirmed by pelvic exam?	<input type="radio"/> No <input type="radio"/> Yes				a
Confirmed by ultrasound/hysterectomy?	<input type="radio"/> No <input type="radio"/> Yes				b
Polycystic ovarian syndrome	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	27
Premenstrual syndrome (PMS)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	28
Kidney stones	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	29
Multiple sclerosis	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	30
Asthma, doctor diagnosed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	31
Active TB (X-ray confirmed)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	32
Graves' Disease/Hyperthyroidism	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	33
Hypothyroidism	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	34
Thyroid nodule (benign)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	35
Interstitial cystitis (not UTI)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	36
Pneumonia, x-ray confirmed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	37
Herniated lumbar disk, CT/MRI confirmed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	38
SLE (systemic lupus)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	39
Rheumatoid arthritis, doctor diagnosed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	40
Rheumatoid factor	<input type="radio"/> negative/unknown <input type="radio"/> positive				a
Other arthritis	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	41
Other major illness or surgery since June, 1995	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	42

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

16. 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 or hiking outdoors (include walking to work)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jogging (slower than 10 minutes/mile)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Running (10 minutes/mile or faster)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bicycling (include stationary machine)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Calisthenics/Aerobics/Aerobic Dance/Rowing Machine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tennis, Squash, Racquetball	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lap swimming	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other aerobic recreation (e.g., lawn mowing)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. 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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Standing or walking around at home? (hrs./week)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sitting at work or away from home or while driving? (hrs./week)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sitting at home while watching TV/VCR? (hrs./week)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other sitting at home (e.g., reading, meal times, at desk)? (hrs./week)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

18. What is your usual walking pace outdoors?

- 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)
 Unable to walk

19. 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

20. Please indicate any season(s) when your exercise is greatly reduced:

- Don't exercise regularly
 Spring
 Summer
 Fall
 Winter
 Exercise regularly all year

21. Do you have a serious chronic physical condition which impairs your ability to exercise?

- No
 Yes

22. During the past summer, how many times per week were you outdoors in a swimsuit?

- Less than once per week
 Once per week
 Twice per week
 Several times per week
 Daily

23. During the past summer when you were outside at the pool or beach, what percent of the time did you use sunscreen?

- Not in sun
 0%
 25%
 50%
 75%
 100%

24. What was the result of your TB skin test since June 1995?

- Not done since June 1995
 Positive
 Negative
 Had BCG vaccination

25. Would you be willing to complete an additional questionnaire on your diet during high school?

- Yes
 No

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

26. Do you currently take a multi-vitamin? (Please report other individual vitamins in question 27)

- No
 Yes

a) How many do you take per week?

- 2 or less
 3-5
 6-9
 10 or more

b) What specific brand do you usually use? →

Specify exact brand and type

27. Do you take the following separate preparations? DO NOT COUNT THE CONTENTS OF MULTI-VITAMINS REPORTED ABOVE.

a) Vitamin A	<input type="radio"/> No <input type="radio"/> Yes, seasonal only → <input type="radio"/> Yes, most months	Dose per day:	<input type="radio"/> Less than 8,000 IU	<input type="radio"/> 8,000 to 12,000 IU	<input type="radio"/> 13,000 to 22,000 IU	<input type="radio"/> 23,000 IU or more	<input type="radio"/> Don't know
b) Beta-Carotene	<input type="radio"/> No <input type="radio"/> Yes →	Dose per day:	<input type="radio"/> Less than 8,000 IU	<input type="radio"/> 8,000 to 12,000 IU	<input type="radio"/> 13,000 to 22,000 IU	<input type="radio"/> 23,000 IU or more	<input type="radio"/> Don't know
c) Vitamin C	<input type="radio"/> No <input type="radio"/> Yes, seasonal only → <input type="radio"/> Yes, most months	Dose per day:	<input type="radio"/> Less than 400 mg.	<input type="radio"/> 400 to 700 mg.	<input type="radio"/> 750 to 1,250 mg.	<input type="radio"/> 1,300 mg. or more	<input type="radio"/> Don't know
d) Vitamin B ₆	<input type="radio"/> No <input type="radio"/> Yes →	Dose per day:	<input type="radio"/> Less than 10 mg.	<input type="radio"/> 10 to 39 mg.	<input type="radio"/> 40 to 79 mg.	<input type="radio"/> 80 mg. or more	<input type="radio"/> Don't know
e) Vitamin E	<input type="radio"/> No <input type="radio"/> Yes →	Dose per day:	<input type="radio"/> Less than 100 IU	<input type="radio"/> 100 to 250 IU	<input type="radio"/> 300 to 500 IU	<input type="radio"/> 600 IU or more	<input type="radio"/> Don't know
f) Calcium (include Tums etc.)	<input type="radio"/> No <input type="radio"/> Yes → (500 mg. Ca. Carbonate = 200 mg. elemental)	Dose per day: (elemental)	<input type="radio"/> Less than 400 mg.	<input type="radio"/> 400 to 900 mg.	<input type="radio"/> 901 to 1,300 mg.	<input type="radio"/> 1,301 mg. or more	<input type="radio"/> Don't know
g) Iron	<input type="radio"/> No <input type="radio"/> Yes → (325 mg. Ferrous Sulfate = 65 mg. elemental iron)	Dose per day: (elemental)	<input type="radio"/> Less than 41 mg.	<input type="radio"/> 41 to 80 mg.	<input type="radio"/> 81 to 150 mg.	<input type="radio"/> 151 mg. or more	<input type="radio"/> Don't know
h) Do you take any of these other supplements regularly?	<input type="radio"/> Selenium <input type="radio"/> B-Complex vitamin <input type="radio"/> Cod liver oil <input type="radio"/> Zinc <input type="radio"/> Garlic pills <input type="radio"/> Brewer's yeast <input type="radio"/> Vitamin D <input type="radio"/> Magnesium <input type="radio"/> Niacin <input type="radio"/> Potassium <input type="radio"/> Folic acid						

28. 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: _____

29a. For each child to whom you have given birth, answer each section below as best you can, even if you cannot remember exactly.

Mark here if you have never given birth and go to Question 30.

Begin Here

Table with 9 columns: Please consider a twin birth as one birth, About what month after delivery did your menstrual periods return?, Did you use any medication to suppress lactation?, Did you breastfeed at least 1 month?, Start giving formula or purchased milk at least once daily, Start giving solid food at least once daily, Start pumping breastmilk at least 4 days/week, Go at least 6 hours at night without breastfeeding, Stop breastfeeding altogether. Rows for 1st, 2nd, 3rd, and 4th birth.

b. If more than four children were breastfed, mark the total number of months you breastfed all other children combined:

- 0-2 months, 3-5, 6-8, 9-11, 12-18, 19+ months

30. During how many pregnancies did you have nausea and vomiting severe enough to require IV fluid or medical treatment?

- 0 pregnancies, 1, 2, 3, 4, 5+ pregnancies

31. During the past 2 years, what is the difference between your highest and lowest weight (excluding illness and pregnancy)?

- No change, 2-4 lbs, 5-9 lbs, 10-14 lbs, 15-29 lbs, 30-49 lbs, 50+ lbs

32. During the past 2 years, have you had unintentional weight loss (e.g., due to illness, unusual stress, depression)?

- No, Yes, 2-4 lbs, 5-9 lbs, 10-14 lbs, 15-29 lbs, 30-49 lbs, 50+ lbs

33. During the past 2 years, what primary methods have you used to control your weight?

- None, Exercise, Calorie restriction, Low-fat diet, Medication/diet pills, Commercial diet program, Commercial diet supplement, Crash diet/fasting, Cigarette smoking, Gastric surgery, Other

34. During the past 2 years, have you taken any of the following prescription weight loss medications? (Mark all that apply.) (If taking "fen-phen," mark both fenfluramine and phentermine)

- fenfluramine (Pondin), phentermine (Fastin), dexfenfluramine (Redux), never took these medications

For how many months did you take this medication?

- < 2 months, 2-4, 5-9, 10-14, 15-19, 20-24, 25+ months

35. For each alcoholic beverage, what percent is consumed with meals?

- Beer, White Wine, Red Wine, Liquor. Options: Don't drink, Less than 25%, 25-49%, 50-74%, 75% or more

36. In the past two years, have you had: (If Yes, mark all that apply.)

Table with 3 columns: NO, YES, FOR SCREENING, YES, FOR SYMPTOMS. Rows: Colonoscopy/Sigmoidoscopy, Mammogram, Bimanual pelvic exam

THANK YOU! PLEASE RETURN IN ENCLOSED ENVELOPE TO: DR. WALTER WILLETT, NHSII 181 LONGWOOD AVENUE BOSTON, MA 02115

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
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

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37. Following are questions about your physical activity at various times in your life and at various intensity levels. For each age range below, please estimate the **average** amount of time that you spent in these activities. We recognize that this is a difficult task, but we ask that you **average** your activity over seasons and years during the given age categories.

a) Walking to and from School or Work								b) TV Watching								
Average hours per WEEK								Average hours per WEEK								
School or Work	None	0.5	1-2	3-4	5-6	7-10	11+	None	1	2-5	6-10	11-20	21-40	41-60	61-90	91+
Grades 7-8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grades 7-8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grades 9-12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grades 9-12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ages 18-22	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ages 18-22	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ages 23-29	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ages 23-29	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ages 30-34	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ages 30-34	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

c) Strenuous Recreational Activity								d) Moderate Recreational Activity							
Average hours per WEEK								Average hours per WEEK							
None	0.5	1-2	3-4	5-6	7-10	11+	None	0.5	1-2	3-4	5-6	7-10	11+		
Grades 7-8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grades 7-8	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Grades 9-12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grades 9-12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Ages 18-22	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ages 18-22	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Ages 23-29	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ages 23-29	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Ages 30-34	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ages 30-34	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

e) Which category best describes your **work outside the home** during each of the age ranges listed below?
 If you had more than one job during an age range, please report on the job you held the longest.

	Not Employed	Mostly Sitting	Mostly Standing	Mostly Walking, w/Little Lifting	Mostly Walking, w/Much Lifting	Heavy Manual Labor
Ages 23-29	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ages 30-34	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current employment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

38. 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, such as running, lifting heavy objects, participating in strenuous sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting or carrying groceries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing several flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing one flight of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending, kneeling, or stooping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking more than a mile	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking several blocks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking one block	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bathing or dressing yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

39. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been a very nervous person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt so down in the dumps nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have a lot of energy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt downhearted and blue?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel worn out?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been a happy person?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel tired?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

40. During the **past 4 weeks**, how much of the time has your **physical health or 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

41. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I seem to get sick a little easier than other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am as healthy as anybody I know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I expect my health to get worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My health is excellent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

42. 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

43. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- Not at all Slightly Moderately Quite a bit Extremely

44. How much **bodily pain** have you had during the **past 4 weeks**?

- None Very mild Mild Moderate Severe Very severe

45. 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

46. 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

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

48. What is your current marital status?

- Married Divorced/Separated Widowed Never Married

49. What is your current living arrangement? (Mark all that apply.)

- Alone With husband/partner With children With other family Other

50. Since June 1995, how many months have you worked **ROTATING** night shifts (at least 3 nights/month in addition to other days and evenings in that month)?

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

51. Which best describes your current employment status?

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

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

- Not employed in past 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My job involves a lot of repetitive work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My job requires me to be creative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My job allows me to make a lot of decisions on my own	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My job requires a high level of skill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
On my job, I have very little freedom to decide how I do my work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get to do a variety of different things on my job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have a lot of say about what happens on my job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have an opportunity to develop my own special abilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My job requires working very fast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My job requires working very hard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My job requires lots of physical effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am not asked to do an excessive amount of work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have enough time to get the job done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My job security is good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am free from conflicting demands that others make	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>