

HARVARD
MEDICAL
SCHOOL

NURSES' HEALTH STUDY II



HARVARD
SCHOOL of
PUBLIC HEALTH

• Channing Laboratory • 181 Longwood Avenue • Boston, Massachusetts 02115 •
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Dear Colleague:

Many thanks for your commitment to women's health research as a participant in the Nurses' Health Study II. The enclosed **brief** questionnaire continues our every-other-year follow-up.

The validity of this major research undertaking depends directly on complete and accurate follow-up information for all study members. Your continued participation is critical whether or not you are currently active in nursing. As always, the information you provide is strictly confidential and will be used only for medical statistical purposes.

We understand how busy you are; however, we would be **extremely** grateful if we could receive your reply to this questionnaire in the next two weeks. Thank you again for your valuable participation in this study.

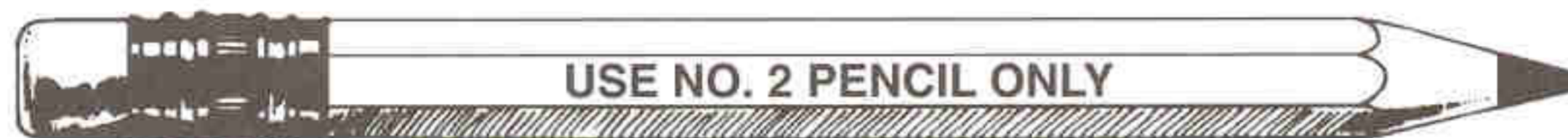
Sincerely,

Walter Willett

Professor of Epidemiology,
Nutrition, and Medicine

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, and write any comments on a separate page.



EXAMPLE 1:

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

11. 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 type="radio"/>
Melanoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Basal cell skin cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

EXAMPLE 2:

Keep handwriting within the borders of the response box.

	YEAR OF DIAGNOSIS			Please specify:
	BEFORE JUNE 1 1995	JUNE 95 TO MAY 97	AFTER JUNE 1 1997	
Other major illness or surgery since June 1995: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	APPENDICITIS W/APPENDECTOMY

Thank you for completing the 1997 Nurses' Health Study II Short Form.

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. What is your current weight? lbs.

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

2. Do you currently smoke cigarettes?

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

1	6	97	A
2	7	98	B
3	8	99	C
4	9	11	D
5	10	12	E

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

None Tubal ligation Foam/Jelly/Sponge Condom Depo-Provera Norplant
 Vasectomy Oral contraceptive Intrauterine device Rhythm/NFP Diaphragm/Cervical cap Other

4. SINCE JUNE 1995, have you used oral contraceptives (OC's)?

Yes → a. How many months did you use OC's during the 24-month period between June 1995 and June 1997?
 1 month or less 2-4 5-9 10-14 15-19 20-24 months

b. How many months did you use OC's during the period between June 1997 and the present?
 1 month or less 2-4 5-9 10-14 15-19 20+ months

5. SINCE JUNE 1995, have you been pregnant?

No - go to question 6 Yes

a. Are you currently pregnant?

No Yes - Continue with part b, but do NOT fill in a bubble in part b for your current pregnancy.

b. 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"/>

6. 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

7. 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

8. Have your 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
<input type="text"/>

b. For what reason did your periods cease?

Natural
 Surgical
 Radiation or chemotherapy

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

9. Have you EVER had surgery to remove your uterus or ovaries? (Mark all that apply.)

No Uterus removed Both ovaries removed One ovary removed

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

No → Please continue with the questions on the back of this form

Yes, currently → What type of hormone did you use?
 Estrogen only Estrogen and progesterone Other

Specify type:
<input type="text"/>

Yes, but not currently

Please continue on the back of this form →

11. 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

1	1	1	1	1	1	1
2	2	2	2	2	2	2
4	4	4	4	4	4	4
8	8	8	8	8	8	8
P	P	P	P	P	P	P

Myocardial infarction (heart attack)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Angina pectoris	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Confirmed by angiogram? <input type="radio"/> No <input type="radio"/> Yes
Coronary bypass/angioplasty	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Stroke (CVA) or TIA	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Deep vein thrombosis/Pul. embolism	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Elevated cholesterol	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Melanoma	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Basal cell skin cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Squamous cell skin cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fibrocystic/other benign breast disease	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Confirmed by breast biopsy? <input type="radio"/> No <input type="radio"/> Yes Confirmed by aspiration? <input type="radio"/> No <input type="radio"/> Yes
Breast cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other cancer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Specify site: <input type="text"/>
Colon or rectal polyp (benign)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Ulcerative colitis/Crohn's disease	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Gastric or duodenal ulcer	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Gallstones	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Did you have symptoms? <input type="radio"/> No <input type="radio"/> Yes How diagnosed? <input type="radio"/> X-ray or ultrasound <input type="radio"/> Other
Cholecystectomy	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
High blood pressure	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> pregnancy-related <input type="radio"/> not pregnancy-related
Toxemia/Pre-eclampsia of pregnancy	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> gestational <input type="radio"/> not pregnancy-related
Hydatidiform mole of pregnancy	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Ectopic pregnancy	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Endometriosis, 1st diagnosis	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Confirmed by laparoscopy? <input type="radio"/> No <input type="radio"/> Yes
Uterine fibroids, 1st diagnosis	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Confirmed by pelvic exam? <input type="radio"/> No <input type="radio"/> Yes Confirmed by ultrasound or hysterectomy? <input type="radio"/> No <input type="radio"/> Yes
Polycystic ovarian syndrome	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Premenstrual syndrome (PMS)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Kidney stones	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Multiple sclerosis	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Asthma, doctor-diagnosed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Active TB (X-ray confirmed)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Graves' Disease/Hyperthyroidism	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hypothyroidism	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Thyroid nodule (benign)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Interstitial cystitis (not UTI)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pneumonia, x-ray confirmed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Herniated lumbar disk, CT/MRI confirmed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
SLE (systemic lupus)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Rheumatoid arthritis, doctor diagnosed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rheumatoid factor <input type="radio"/> negative/unknown <input type="radio"/> positive
Other arthritis	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other major illness or surgery since June 1995:	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	Please specify: <input type="text"/>

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. Is this your correct date of birth?

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

13. Please name someone at a DIFFERENT PERMANENT ADDRESS to whom we might write in the event we are unable to contact you:

Name:
Address: