This is your ID

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 II. Example: NHS2@channing.harvard.edu

Please print neatly and differentiate numbers and letters (e.g., 1 vs l or i, β vs O, 5 vs S).

We will not release your e-mail address to anyone!
Federal research regulations require us to include the following information:

There are no direct benefits to you from participating in this study. The risk of breach of confidentiality associated with participation in this study is very small. Your choice to participate in this study is completely voluntary and you may decline or withdraw at any time without penalty. You may skip any question you do not wish to answer. You will not receive monetary compensation for participating. If you have any questions regarding your rights as a research participant, you are encouraged to call a representative of the Human Subjects Committee at the Harvard School of Public Health (617-384-5480).
17. Since June 2011, have you had any of these clinician-diagnosed illnesses?  

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

- Myocardial infarction (heart attack)
- Angina pectoris
- Coronary bypass, angioplasty, or stent
- Transient ischemic attack (TIA)
- Stroke (CVA)
- Pulmonary embolus
- Fibrocystic/others benign breast disease
- Breast cancer
- Cancer of the uterus (endometrium)
- Cancer of the ovary
- Colon or rectal polypl (benign)
- Cancer of the colon or rectum
- Melanoma
- Basal cell skin cancer
- Squamous cell skin cancer

Specify site of other cancer:

- Ulcerative colitis/Crohn’s
- Gastric or duodenal ulcer
- Barrett’s esophagus

Gallstones

Did you have symptoms?  No  Yes

Diabetes mellitus

Elevated cholesterol

High blood pressure

Endometriosis—1st diagnosis

Confirmed by laparoscopy?  No  Yes

Kidney stones

Multiple Sclerosis

Asthma, Clinician diagnosed

Emphysema/Chronic bronchitis

Graves’ disease/Hyperthyroidism

Hypothyroidism

Hyperparathyroidism

Gout

SLE (systemic lupus)

Rheumatoid arthritis

Other arthritis

Depression, Clinician diagnosed

Parkinson’s disease

Gastric banding/bypass

Fractures: Wrist or Colles’ Fracture

Hip Fracture

Other major illness or surgery since June 2011

Please specify: Date:

18. Have you ever had any of these clinician-diagnosed illnesses?  

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

- Meningioma
- Atrial fibrillation
- Heart failure (CHF)
- Deep vein thrombosis
- Osteoporosis/osteopenia
- Psoriasis
- Severe acne
- Eczema (atopic dermatitis)
- Shingles
- Peripheral neuropathy
- Fatty liver

Confirmed by liver biopsy?  No  Yes

Liver cirrhosis

Hepatitis (type B or C)

Macular degeneration

Glaucoma

Cataracts

Hip replacement

Non-Alzheimer’s dementia

e.g. Lewy body, vascular, FTD

Alzheimer’s disease

Vertebral Fracture

If Yes, was fracture due to trauma?

Yes  Was this a result of:  Traffic accident

No  A fall from an elevated position (standing on a chair, etc.)

Unsure  A fall while standing/walking (e.g., trip & fall)

Other: 

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

Yes for screening  Yes for symptoms

A physical exam?

Exam by eye doctor?

Mammogram (or other breast imaging)?

Fasting blood sugar?

Upper endoscopy

(Virtual) CT Coloscopy?

Colonoscopy?

Sigmoidoscopy?

Initial reason(s) you had Colonoscopy/Sigmoidoscopy?

- Visible blood
- Occult fecal blood
- Abdominal pain
- Diarrhea/constipation
- Family history of colon cancer
- Barium enema
- Follow-up of (virtual) CT colonoscopy
- Prior polyps
- Asymptomatic or routine screening

Was this a result of:

- A fall from an elevated position (standing on a chair, etc.)
- A fall while standing/walking (e.g., trip & fall)
- Other:

20. Resting pulse rate:  (take after sitting for 5 min.)

- 229 or higher
- 150–159
- 140–149
- 130–139
- 120–129
- 110–119
- 100–109
- 90–99
- 80–89
- 70–79
- 60–64

Unsure

21. Current usual blood pressure (if checked within 2 years):  

Systolic:

○ Unknown/Not checked within 2 years
○ <105 mmHg
○ 105–114
○ 115–124
○ 125–134
○ 135–144
○ 145–154
○ 155–164
○ 165–174
○ 175+

Diastolic:

○ Unknown/Not checked within 2 years
○ <65 mmHg
○ 65–74
○ 75–84
○ 85–89
○ 90–94
○ 95–104
○ 105+

22. Is this your correct date of birth?  

Yes  No  

If no, please write correct date.  

MONTH / DAY / YEAR
23. Regular Medication (Mark if used regularly in past 2 years.)

- Acetaminophen (e.g., Tylenol)
  - Days/week: 1 2–3 4–5 6+ days
  - Total tabs/wk: 1–2 3–5 6–14 15+ tablets
- Baby” or low dose aspirin (100 mg or less/tablet)
  - Days/week: 1 2–3 4–5 6+ days
  - Total tabs/wk: 1–2 3–5 6–14 15+ tablets
- Aspirin or aspirin-containing products (325 mg or more/tablet)
  - Days/week: 1 2–3 4–5 6+ days
  - Total tabs/wk: 1–2 3–5 6–14 15+ tablets
- Ibuprofen (e.g., Advil, Motrin, Naprosyn)
  - Days/week: 1 2–3 4–5 6+ days
  - Total tabs/wk: 1–2 3–5 6–14 15+ tablets
- Celebrex (COX-2 inhibitor)
  - Days/week: 1 2–3 4–5 6+ days
- Other anti-inflammatory analgesics, 2+ times/week
  (e.g., Aleve, Clinoril, IndoCin, Relafen)
- Thiazide diuretic
  (e.g., Lasix, Potassium)
- Calcium blocker (e.g., Calan, Procardia, Cardizem, Norvasc)
- Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)
- ACE Inhibitors (e.g., Capoten, Vasotec, Zestril)
- Angiotensin receptor blocker (e.g., Diovan, Cozaar, Avapro)
- Other anti-hypertensive (e.g., clonidine, doxazosin)
- Coumadin (Warfarin)
  - Days/week: 1 2–3 4–5 6+ days
- Prilosec, Nexium, Prevacid (Iansoprazole)
  - Days/week: 1 2–3 4–5 6+ days
- Aspirin or aspirin-containing products
  (e.g., Pepcid, Tagamet, Zantac, Axid)
- digoxin
  (e.g., Stanozolol)
- Other cholesterol-lowering drug
  (e.g., niacin, Lopid, Gemfibrozil, Tricor, fenofibrate, Questran (cholestyramine), Colesid, Zetia)
- Steroids taken orally (e.g., Prednisone, Decadron, Medrol)
- “Statin” cholesterol-lowering drugs:
  - Mevacor (lovastatin)
  - Zocor (simvastatin)
  - Crestor
- Other anti-hypertensive (e.g., clonidine, doxazosin)
- Xarelto
  - Days/week: 1 2–3 4–5 6+ days
  - Total tabs/wk: 1–2 3–5 6–14 15+ tablets
- Other other cholesterol-lowering drug
(e.g., niacin, Lipid (gemfibrozil), Tricor (fenofibrate), Questran (cholestyramine), Colesid, Zetia)
- Other anti-inflammatory analgesics, 2+ times/week
(e.g., Aleve, Clinoril, IndoCin, Relafen)
- Tricyclics (e.g., amitryptiline, nortriptiyline, imipramine)
- SNRIs/Other antidepressants (Wellbutrin, Effexor, Remeron, Cymbalta, venlafaxine, bupropion)
- Other hypoglycemic agents (e.g., Synthroid, Levothroid)
- Triptans (e.g., Imigran, Maxalt, Zomig, Amerge, Replax)
- Biphosphonates (e.g., Fosamax, Boniva, Actonel)
- Evista (raloxifene)
  - Days/week: 1 2–3 4–5 6+ days
  - Total tabs/wk: 1–2 3–5 6–14 15+ tablets
- Other anti-inflammatory analgesics
(e.g., ibuprofen, naproxen, ketoprofen, ibuprofen)
- Anticholinergics (e.g., Detrol, Ditropan, Vesicare)
- SSRIs (Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox, fluoxetine, citalopram)
- Tricyclics (e.g., amitryptiline, nortriptiyline, imipramine)
- SNRIs/Other antidepressants (Wellbutrin, Effexor, Remeron, Cymbalta, venlafaxine, bupropion)
- Other medications (no need to specify)

24. Have you EVER used Metformin (aka Glucophage)?

- Yes => a. When did you FIRST take it?
  - Before 1996
  - 1997–2000
  - 2001–2004
  - 2005–2008
  - 2009–2012
  - After 2012
- No

b. In all, how many years have you used Metformin?
  - Less than 1 year
  - 1–2
  - 3–5
  - 6–8
  - 9–12
  - 13–15
  - 15+ years

25. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

26. Have any of your biological siblings, offspring, or your parents ever had any of the following diseases?

<table>
<thead>
<tr>
<th>Disease</th>
<th>Relative's Age at First Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ovarian cancer</td>
<td>Y</td>
</tr>
<tr>
<td>Breast cancer</td>
<td>Y</td>
</tr>
<tr>
<td>Melanoma</td>
<td>Y</td>
</tr>
<tr>
<td>Colon or Rectal cancer</td>
<td>Y</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Y</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>Y</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>Y</td>
</tr>
<tr>
<td>Asthma</td>
<td>Y</td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td>Y</td>
</tr>
<tr>
<td>Ulcerative colitis</td>
<td>Y</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Y</td>
</tr>
<tr>
<td>Stroke</td>
<td>Y</td>
</tr>
<tr>
<td>Myocardial infarction (heart attack)</td>
<td>Y</td>
</tr>
</tbody>
</table>

27. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a transfusion?

- Yes => a. What was the site of the bleeding?
  - Colon/rectum
  - Duodenum
  - Stomach
  - Esophagus
  - Duodenum
  - Other
- No

28. In the last year, how often have you had heartburn or acid-reflux?

- None in the past year
- Less than once a month
- About once a month
- About once/week
- Several times/week
- Daily

29. In the past 2 years, have you had migraine headaches?

- Yes =>
  - Did you sometimes have an aura?
    - No
    - Yes
  - On average, how many days per month do you get migraine headaches?
    - 1–7 days
    - 8–14 days
    - 15–29 days/month
- No

30. Do you have unpleasant sensations (like crawling, paraesthesia, or pain) in your legs combined with an urge or need to move your legs?

- No
  - Once/month or less
  - 2–4 times/month
  - 5–14/month
  - 1–7 days
  - 8–14 days
  - 15–29 days/month
  - 1 day
  - Daily

a. Do these symptoms occur only at rest?
- No
- Yes
b. Does moving improve them?
- No
- Yes
c. Are these feelings/symptoms worse in the evening/night than in the morning?
- No
- Yes

31. In the past two years, has there been a time lasting 2 weeks or longer:

a. When most of the day you felt sad, empty or depressed?
- Yes
- No
b. When most of the day you were very discouraged about how things were going in your life?
- Yes
- No
c. When you lost interest in most things you usually enjoy like work, hobbies, and personal relationships?
- Yes
- No
d. When most days you felt much more anxious and worried than other people with the same problems as you?
- Yes
- No

32. How many full marathons have you ever run?

- Never
- <1 year
- 1–2
- 3–5
- 6–8
- 9–12
- 13–15
- 15+ years

33. Have you ever used talcum, baby or deodorizing powder AT LEAST WEEKLY in the genital/rectal area or on sanitary napkins, tampons or underwear?

- Never
- Less than 1 year
- 1 to <10 years
- 10 to <20 years
- 20 to <30 years
- 30+ years
34. How frequently do you have a bowel movement?
- More than twice a day
- Twice a day
- Daily
- Every other day
- Every 3–4 days
- Every 5 days or less

35. In the past 3 months, how often did you have hard or lumpy stools?
- Never or rarely
- Occasionally
- About 1 time/month
- About 2 times/month
- About 5 times/month
- About once/week
- Several times/week

36. In the past 3 months, how often did you have loose, mushy or watery stools?
- Never or rarely
- Occasionally
- About 1 time/month
- About 2 times/month
- About 5 times/month
- About once/week
- Several times/week

37. How often do you use a laxative (such as softeners, bulking agents, fiber supplements or suppositories)?
- Never
- < Once/month
- 1–3 times/month
- Once/month
- 2–3 times/week
- 4–5 times/week
- Daily
- > 2 times/day

38. How often in the past year have you experienced any amount of accidental bowel leakage? Answer a) and b)
   a) Liquid stool:
   - Never
   - < 1/month
   - 1–3/month
   - About once/month
   - Several times/month
   - Nearly daily
   - Daily
   - > 2 times/month
   b) Solid stool:
   - Never
   - < 1/month
   - 1–3/month
   - About once/month
   - Several times/month
   - Nearly daily
   - Daily
   - > 2 times/month

39. During the last 12 months, how often have you leaked or lost control of your urine?
   - Never
   - Less than once/month
   - 1–3 times/month
   - About once/week
   - Almost every day

   i) When you lose your urine, how much usually leaks?
   a) A few drops
   b) Enough to wet your underwear
   c) Enough to wet your outerclothing
   d) Enough to wet the floor

   ii) When you lose urine, what is the usual cause?
   a) Coughing, sneezing, laughing, or doing physical activity
   b) A sudden and urgent need to go to the bathroom
   c) Both a) and b) equally
   d) In other circumstances

40. Have you talked to your healthcare provider about leaking urine or accidental bowel leakage? (Mark all that apply.)
- No
- Yes, about leaking urine
- Yes, about bowel leakage

41. How much do you think your leaking urine or accidental bowel leakage affects your life?
- Not at all
- A little bit
- Quite a bit
- Extremely

42. Have you ever had the following treatments for urinary incontinence? Answer a) and b)
   a) Kegel exercises or physical therapy to strengthen pelvic muscles?
   - No
   - Yes

   b) Surgery?
   - No
   - Yes

   When?
   - Before 2001
   - 2001–2002
   - 2003–2004
   - 2005–2006
   - 2007–2009
   - 2010–2012

43. What is your usual walking pace outdoors?
- Unable to walk
- Very brisk/striding (4 mph or faster)
- Extremely brisk (4 mph or faster)
- Brady pace (0–1 mph)
- Easy, casual (less than 2 mph)

44. How many total flights of stairs (not individual steps) do you climb daily?
- None
- 2 flights or less
- 3–4
- 5–9
- 10–14
- 15 or more flights

45. DURING THE PAST YEAR, what was your average time PER WEEK spent at each of the following recreational activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>TIME PER WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking for exercise or running</td>
<td>0</td>
</tr>
<tr>
<td>Jogging</td>
<td>0</td>
</tr>
<tr>
<td>Bicycling (include stationary machine)</td>
<td>0</td>
</tr>
<tr>
<td>Tennis, squash, racquetball</td>
<td>0</td>
</tr>
<tr>
<td>Lap swimming</td>
<td>0</td>
</tr>
<tr>
<td>Other aerobic exercise (aerobic dance, ski or stair machine, etc.)</td>
<td>0</td>
</tr>
<tr>
<td>Lower intensity exercise (yoga, stretching, toning)</td>
<td>0</td>
</tr>
<tr>
<td>Other vigorous activities (e.g., lawn mowing)</td>
<td>0</td>
</tr>
<tr>
<td>Weight training or resistance exercises</td>
<td>0</td>
</tr>
<tr>
<td>Lower intensity exercise (yoga, stretching, toning)</td>
<td>0</td>
</tr>
</tbody>
</table>

46. DURING THE PAST YEAR, on average, how many HOURS PER WEEK did you spend:

<table>
<thead>
<tr>
<th>Activity</th>
<th>TIME PER WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing or walking around at work or away from home? (hrs/week)</td>
<td>0</td>
</tr>
<tr>
<td>Sitting at work or away from home or while driving? (hrs/week)</td>
<td>0</td>
</tr>
<tr>
<td>Sitting at home while watching TV/DVD/video? (hrs/week)</td>
<td>0</td>
</tr>
<tr>
<td>Other sitting at home (e.g., reading, meal times, at desk)? (hrs/week)</td>
<td>0</td>
</tr>
</tbody>
</table>

47. Is your biological mother still living?
- No
- Yes
  a) At what age did she die?
- <50
- 50–59
- 60–69
- 70–79
- 80–89
- 90+
  b) Was this due to:
- Heart disease
- Stroke
- Cancer
- Trauma/Accident/Suicide
- Other

48. Is your biological father still living?
- No
- Yes
  a) At what age did he die?
- <50
- 50–59
- 60–69
- 70–79
- 80–89
- 90+
  b) Was this due to:
- Heart disease
- Stroke
- Cancer
- Trauma/Accident/Suicide
- Other

49. Were you hospitalized over the past 12 months?
- No
- Yes
  a) What was the reason?
- Surgery - elective
- Pregnancy - delivery
- Trauma/Accident/Suicide
- Other
  b) Was this due to:
- Heart disease
- Stroke
- Cancer
- Trauma/Accident/Suicide
- Other

50. Have any of your biological children been diagnosed with attention deficit hyperactivity disorder (ADHD)?
- No
- Yes
  a) Year(s) of birth
  b) Age(s) of diagnosis
  c) Other details
51. The following question asks about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as sweets, starches, salty snacks, fatty foods, sugary drinks, and others.

**IN THE PAST 12 MONTHS...**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never (0)</th>
<th>Once per month (1)</th>
<th>2-4 times per month (2)</th>
<th>2-3 times per week (3)</th>
<th>4+ times per week (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I find myself consuming certain foods even though I am no longer hungry.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I worry about cutting down on certain foods.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel sluggish or fatigued from overeating.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I have spent time dealing with negative feelings from overeating certain foods, instead of spending time in important activities such as time with family, friends, work, or recreation.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I have had physical withdrawal symptoms such as agitation and anxiety when I cut down on certain foods. (Do NOT include caffeinated drinks: coffee, tea, cola, energy drinks, etc.)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My behavior with respect to food and eating causes me significant distress.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Issues related to food and eating decrease my ability to function effectively (daily routine, job/school, social or family activities, health difficulties).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

52. Do you have any problems with your sense of smell, such as not being able to smell things or things not smelling the way they are supposed to for at least 3 months?

- **Yes**
- **No**
- **Don't know**

53. Do you have a problem with your sense of taste, such as not being able to taste salt or sugar, or with tastes in the mouth that shouldn’t be there, like bitter, salty, sour or sweet tastes, for at least 3 months?

- **Yes**
- **No**
- **Don’t know**

54. Below is a list of some of the ways you may have felt or behaved during the past month.

**Please indicate how often you have felt this way.**

- **During the past month...**
  - **Mark one answer per line**

55. Did you EVER use oral contraceptives at any time in your life (even one dose)?

- **Yes, I used them**
- **No, I never used them**
- **Still using/current user**
- **Used other contraception**
- **Concerns about safety/side effects**
- **Personal/family history of heart disease or cancer**
- **Religious reasons**
- **Did not use contraception**
- **Other**

56. How many hours each week do you participate in any groups such as a social or work group, church-connected group, self-help group, charity, public service or community group?

- **None**
- **1 to 2 hours**
- **3 to 5 hours**
- **6 to 10 hours**
- **11 to 15 hours**
- **16 or more hours**

57. How often do you go to religious meetings or services?

- **More than once a week**
- **Once a week**
- **1 to 3 times per month**
- **Less than once per month**
- **Never or almost never**

58. Apart from your children, how many relatives do you have with whom you feel close?

- **None**
- **1 to 2**
- **3 to 5**
- **6 to 9**
- **10 or more**

59. How many close friends do you have?

- **None**
- **1 to 2**
- **3 to 5**
- **6 to 9**
- **10 or more**

60. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with?

- **Yes**
- **No**
- **Daily**
- **Weekly**
- **Monthly**
- **Several times/year**
- **Once/year or less**

61. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?

- **None of the time**
- **A little of the time**
- **Some of the time**
- **Most of the time**
- **All of the time**
62. How many people can you count on to provide you with emotional support?
- None
- 1
- 2
- 3+

63. Over the last 4 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Feeling nervous, anxious or on edge</th>
<th>Not being able to stop or control worrying</th>
<th>Worrying too much about different things</th>
<th>Trouble relaxing</th>
<th>Being so restless that it is hard to sit still</th>
<th>Becoming easily annoyed or irritable</th>
<th>Feeling afraid as if something awful might happen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>Several days</td>
<td>More than half the days</td>
<td>Nearly every day</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

64. Has your spouse (or sleep partner) ever told you that you appear to “act out your dreams” while sleeping (punched or flailed arms in the air, shouted or screamed), which has occurred at least three times?
- No
- Yes
- I do not have a sleep partner

65. This question asks about how well you sleep:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Rarely or Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have difficulty falling asleep?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you have trouble with waking up during the night?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often are you troubled by waking up too early and not being able to fall asleep again?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you get so sleepy during the day or evening that you have to take a nap?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you feel really rested when you wake up in the morning?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

66. How often do you snore?
- Every night
- Most nights
- A few nights a week
- Occasionally
- Almost never
- Don’t know

67. Has anyone noticed that you stop breathing during your sleep?
- No
- Yes

68. Have you ever had physician-diagnosed sleep apnea?
- No
- Yes

69. From June 2011 to June 2013, 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 months
- 10–14 months
- 15–19 months
- 20+ months

70. Which best describes your hearing?
- Excellent
- Good
- A little hearing trouble
- Moderate hearing trouble
- Deaf

71. Have you noticed a change in your hearing?
- Yes
- At what age did you first notice a change in your hearing?
  - <20
  - 20–29
  - 30–39
  - 40–44
  - 45–49
  - 50–54
  - 55–59
  - Age 60+
  - Unsure

72. In the past 12 months, have you had ringing, roaring, or buzzing in your ears?
- Never
- Once/month or less
- 2–3 times/mo
- About once/wk
- Several times/wk
- Almost every day
  
  a) On the days you hear the sound, how long does it last?
  - Less than 5 minutes
  - More than 5 minutes but less than 1 hour
  - 1 hour to 2 hours
  - 2 hours to 6 hours
  - 6 hours to a full day
  - A few seconds

  b) Does the sound affect your ability to:
  - Sleep
  - Work
  - Perform other activities
  - None of these

73. Over the past 4 weeks...

How would you rate your level (degree) of sexual desire or interest?
- Very high
- High
- Moderate
- Low
- Very low or none at all

How would you rate your level of sexual arousal (“turn on”) during sexual activity or intercourse?
- No sexual activity
- Very high
- High
- Moderate
- Low
- Very low or none at all

How often did you become lubricated (“wet”) during sexual activity or intercourse?
- No sexual activity
- Almost always or always
- Most times
- Sometimes
- A few times
- Almost never or never

When you had sexual stimulation or intercourse, how often did you reach orgasm?
- No sexual activity
- Almost always or always
- Most times
- Sometimes
- A few times
- Almost never or never

How satisfied have you been with your overall sexual life?
- Very satisfied
- Moderately satisfied
- About equally satisfied and dissatisfied
- Moderately dissatisfied
- Very dissatisfied

How often did you experience discomfort or pain during vaginal penetration?
- Did not attempt intercourse
- Almost never or never
- A few times
- Sometimes
- Most times
- Almost always or always

74. 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: ______________________________

Phone or E-mail: ________________________

Thank you! Please return form to: Nurses’ Health Study, 181 Longwood Ave, Boston, MA 02115.