43639

2018

WOMEN'S HEALTH STUDY

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PLEASE USE A BALL-POINT PEN WHEN COMPLETING THIS QUESTIONNAIRE. IT IMPROVES THE QUALITY OF OUR DATA.

1. Date of birth: ☐☐ / ☐☐ / ☐☐ **We use DATE OF BIRTH to verify the identity of the person providing information.**

Is the DOB above correct? ○ Yes ○ No → **IF NO, what is your correct date of birth?** _____

2. WITHIN THE PAST YEAR, have you been NEWLY DIAGNOSED with any of the following illnesses or had any of the following procedures? Please answer NO or YES on each line. IF YES, indicate the date (month/year) of the diagnosis or the procedure.

DIAGNOSIS OR PROCEDURE	NO or YES →	IF YES, PROVIDE MO/YR IN BOXES BELOW
a. Acute coronary syndrome/unstable angina	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? ○ No ○ Yes stress test? ○ No ○ Yes	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
c. Myocardial infarction (heart attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA or PCI) or stent	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
e. Coronary bypass surgery (CABG)	○ No ○ Yes →	MO/YR of procedure: ☐☐ / ☐☐
f. Congestive heart failure	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
g. Atrial fibrillation	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
h. Intermittent claudication	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
i. Peripheral artery disease (not varicose veins)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Pulmonary embolism (PE)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
k. Deep vein thrombosis (DVT)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. Stroke	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	○ No ○ Yes →	MO/YR of surgery: ☐☐ / ☐☐
o. Melanoma	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
p. Non-melanoma skin cancer What type? ○ basal cell ○ squamous cell ○ unknown type	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Breast cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Lung cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
s. Colon cancer	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
t. Other cancer (not including any of the above cancers) SITE: _____	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
u. Colon polyp	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
v. Diabetes mellitus (NEWLY diagnosed)	○ No ○ Yes →	MO/YR of diagnosis: ☐☐ / ☐☐

2. (continued) NEWLY DIAGNOSED IN THE LAST YEAR? → IF YES, PROVIDE DATE (MO/YR) IN BOXES BELOW

w. Migraine headaches (NEWLY diagnosed)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
x. Other headaches (NEWLY diagnosed)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
y. Parkinson's disease	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
z. Elevated cholesterol (NEW dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
aa. Hypertension (NEW dx by a clinician)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
bb. Osteoarthritis (NEWLY diagnosed)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
cc. Osteoporosis (NEWLY diagnosed)	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
dd. Fracture due to osteoporosis	O No	O Yes →	MO/YR of occurence:	☐☐ / ☐☐
ee. Joint replacement	O No	O Yes →	MO/YR of surgery:	☐☐ / ☐☐
ff. Fibrocystic or other benign breast disease	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
If YES, confirmed by: breast biopsy? O No O Yes	aspiration? O No O Yes			

3. What is your CURRENT TOTAL CHOLESTEROL (mg/dl) if checked within the past year?

O <140 mg/dl O 140-159 O 160-179 O 180-199 O 200-219 O 220-239 O 240-249
O 250-259 O 260-269 O 270-279 O 280-299 O 300-329 O 330+ O unknown/not checked in past year

4. What is your CURRENT weight? ☐☐☐ pounds

5. What is your CURRENT blood pressure (mmHg)? ☐☐☐ systolic (upper #) / ☐☐☐ diastolic (lower #) O Don't know my blood pressure

Questions 6-12 BELOW are taken from the SF-12 Health Survey (Medical Outcomes Trust) QualityMetric Incorporated and the RAND 36-Item Health Survey 1.0.

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

7. The following items are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities?	**Yes, limited a lot**	**Yes, limited a little**	**No, not limited at all**
a. **Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	O	O	O
b. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	O	O	O
c. Lifting or carrying groceries	O	O	O
d. Climbing **several** flights of stairs	O	O	O
e. Climbing **one** flight of stairs	O	O	O
f. Bending, kneeling, or stooping	O	O	O
g. Walking **more than a mile**	O	O	O
h. Walking **several blocks**	O	O	O
i. Walking **one block**	O	O	O
j. Bathing or dressing yourself	O	O	O

8. 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?

	Yes	No
a. Cut down the amount of time you spent on work or other activities	○	○
b. **Accomplished less** than you would like	○	○
c. Were limited in the **kind** of work or other activities	○	○
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	○	○

9. 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)?

	Yes	No
a. **Accomplished less** than you would like	○	○
b. Didn't do work or other activities as **carefully** as usual	○	○

10. During the PAST 4 WEEKS, how much did 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

11. 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:

	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
a. Have you felt calm and peaceful?	○	○	○	○	○	○
b. Did you have a lot of energy?	○	○	○	○	○	○
c. Have you felt downhearted and blue?	○	○	○	○	○	○

12. 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

13. DURING THE PAST YEAR, what was your approximate AVERAGE TIME PER WEEK spent at each of the following recreational activities?

	AVERAGE TIME PER WEEK							
	zero	1-19 min.	20-59 min.	1 hour	1.5 hours	2-3 hours	4-6 hours	7+ hours
a. Walking or hiking (include walking to work)	○	○	○	○	○	○	○	○
b. Jogging (slower than 10 minute miles)	○	○	○	○	○	○	○	○
c. Running (10 minute miles or faster)	○	○	○	○	○	○	○	○
d. Bicycling (include stationary bike)	○	○	○	○	○	○	○	○
e. Aerobic exercise / aerobic dance / exercise machines	○	○	○	○	○	○	○	○
f. Lower intensity exercise / yoga / stretching / toning	○	○	○	○	○	○	○	○
g. Tennis, squash, or raquetball	○	○	○	○	○	○	○	○
h. Lap swimming	○	○	○	○	○	○	○	○
i. Weight lifting / strength training	○	○	○	○	○	○	○	○
j. Other: Please specify activity: _____	○	○	○	○	○	○	○	○

14. ON AVERAGE, how many FLIGHTS of stairs (not individual steps) do you climb DAILY?

○ None ○ 1-2 flights ○ 3-4 flights ○ 5-9 flights ○ 10-14 flights ○ 15 or more flights

15. What is your usual walking pace outdoors?

O Don't walk regularly O Easy, casual (less than 2 mph) O Normal, average (2-2.9mph)
O Brisk pace (3-3.9 mph) O Very brisk/striding (4 mph or faster)

16. DURING THE PAST YEAR, what was your approximate AVERAGE TIME IN HOURS PER WEEK spent at each of the following sedentary activities?

	AVERAGE HOURS PER WEEK								
	zero	1 hour	2-5 hours	6-10 hours	11-20 hours	21-40 hours	41-60 hours	61-90 hours	90+ hours
a. Sitting at work or away from home or while driving (hrs/week)	O	O	O	O	O	O	O	O	O
b. Sitting at home while watching TV/VCR/DVD or using the computer (hrs/week)	O	O	O	O	O	O	O	O	O
c. Other sitting at home (e.g. reading, meal times, at desk) (hrs/week)	O	O	O	O	O	O	O	O	O

17. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel blocker, angiotensin receptor or beta-blocker, ACE inhibitor)	O Yes	O No
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O Yes	O No
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O Yes	O No

18. Do you think you might have gum disease? O Yes O No O Don't know

19. Overall, how would you rate the health of your teeth and gums?

O Excellent O Very good O Good O Fair O Poor O Don't know

20. Have you EVER had treatment for gum disease such as scaling and root planing, sometimes called "deep cleaning?"

O Yes O No O Don't know

21. Have you EVER been told by a dental professional that you lost bone around your teeth? O Yes O No O Don't know

22. Aside from brushing your teeth with a toothbrush, in the LAST 7 DAYS, on how many DAYS did you use dental floss or any other device to clean between your teeth? O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7

23. In the PAST 12 MONTHS, have you visited a dentist or dental hygienist? O Yes O No O Don't know

24. How often do you usually visit the dental office for routine check-ups or cleanings?

O More than once per year O Once per year O Less than once per year O Don't know

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

YOUR HOME PHONE: ( ) - -

YOUR CELL PHONE: ( ) - -

YOUR WORK PHONE: ( ) - -

Name, address and phone of someone at a different address than you whom we may contact if we are unable to reach you:

NAME: _____

STREET: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NO: _____

THIS CONTACT IS: O Relative O Friend O Neighbor O Other

YOUR E-MAIL ADDRESS: **This is the e-mail address we have on file:**

If it has changed, please provide your updated e-mail address below:

_____