18916

2013-2014

WOMEN'S HEALTH STUDY

9 /

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

1. **Birth date:** ☐☐ / ☐☐ / ☐☐ → **Last 6 digits of SSN: (optional)** X X X - ☐☐ - ☐☐☐☐

2. **WITHIN THE PAST 2 YEARS, 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	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
b. Angina pectoris If YES, confirmed by: angiogram/cardiac cath? O No O Yes stress test? O No O Yes	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
c. Myocardial infarction (heart attack)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
d. Coronary angioplasty (PTCA or PCI) or stent	O No O Yes →	MO/YR of procedure: ☐☐ / ☐☐
e. Coronary bypass surgery (CABG)	O No O Yes →	MO/YR of procedure: ☐☐ / ☐☐
f. Congestive heart failure	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
g. Atrial fibrillation	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
h. Intermittent claudication	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
i. Peripheral artery disease (not varicose veins)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
j. Pulmonary embolism (PE)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
k. Deep vein thrombosis (DVT)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
l. Stroke	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
m. TIA (transient ischemic attack)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
n. Carotid artery surgery (endarterectomy)	O No O Yes →	MO/YR of surgery: ☐☐ / ☐☐
o. Melanoma	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
p. Non-melanoma skin cancer What type? O basal cell O squamous cell O unknown type	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
q. Breast cancer	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
r. Lung cancer	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
s. Colon cancer	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
t. Other cancer (not including any of the above cancers) SITE: _____	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
u. Colon polyp	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐
v. Diabetes mellitus (NEWLY diagnosed)	O No O Yes →	MO/YR of diagnosis: ☐☐ / ☐☐

2. (continued) NEWLY DIAGNOSED IN LAST 2 YEARS? → 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. Macular degeneration	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
z. Cataract (Newly diagnosed)	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
aa. Cataract extraction	**RIGHT eye**	O No	O Yes →	MO/YR of procedure:	☐☐ / ☐☐
	LEFT eye	O No	O Yes →	MO/YR of procedure:	☐☐ / ☐☐
bb. Glaucoma		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
cc. Dry eye syndrome		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
dd. Parkinson's disease		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ee. Elevated cholesterol (NEW dx by a clinician)		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ff. Hypertension (NEW dx by a clinician)		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
gg. Osteoarthritis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
hh. Osteoporosis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	☐☐ / ☐☐
ii. Fracture due to osteoporosis		O No	O Yes →	MO/YR of occurence:	☐☐ / ☐☐
jj. Joint replacement		O No	O Yes →	MO/YR of surgery:	☐☐ / ☐☐
kk. 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. In general, would you say your health is: O Excellent O Very good O Good O Fair O Poor

4. What is your CURRENT TOTAL CHOLESTEROL (mg/dl) if checked within the past 2 years?

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 2 yrs

5. What is your CURRENT HDL-CHOLESTEROL (mg/dl) if checked within the past 2 years?

O <30 mg/dl O 30-39 O 40-49 O 50-59 O 60-69 O 70-79
O 80-89 O 90-99 O 100+ O unknown/not checked in 2 yrs

6. Do you CURRENTLY smoke cigarettes? O No O Yes → If YES: On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

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

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

9. 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)	O	O	O	O	O	O	O	O
b. Jogging (slower than 10 minute miles)	O	O	O	O	O	O	O	O
c. Running (10 minute miles or faster)	O	O	O	O	O	O	O	O
d. Bicycling (include stationary bike)	O	O	O	O	O	O	O	O
e. Aerobic exercise / aerobic dance / exercise machines	O	O	O	O	O	O	O	O
f. Lower intensity exercise / yoga / stretching / toning	O	O	O	O	O	O	O	O
g. Tennis, squash, or raquetball	O	O	O	O	O	O	O	O
h. Lap swimming	O	O	O	O	O	O	O	O
i. Weight lifting / strength training	O	O	O	O	O	O	O	O
j. Other: Please specify activity: _____	O	O	O	O	O	O	O	O

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

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

11. 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)

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

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

13. IN THE PAST 2 YEARS, have you used female hormones? O No: Skip to the next question O Yes: Complete the box below ↓

a. IF YES, in the PAST 2 YEARS, for how many months have you used female hormones?
O 1-4 mos. O 5-8 mos. O 9-12 mos. O 13-16 mos. O 17-20 mos. O 21-24 mos. O 24+ mos.

b. Are you CURRENTLY using them (within the last month)? O No O Yes

c. Mark the type(s) of hormones you have used the longest in the PAST 2 YEARS:

Combined: O Prempro (cream) O Prempro (gold) O Prempro (peach) O Prempro (light blue) O Premphase O Combipatch O FemHRT

Estrogen: O Oral Premarin O Patch estrogen O Vaginal estrogen O Ogen O Estrace O Estratest O Estrogen gels, creams or skin spray O Other estrogen

Progesterone/Progestin: O Provera/Cycrin/MPA O Micronized (e.g., Prometrium) O Vaginal O Other progesterone

d. If you used oral conjugated estrogens (e.g., Premarin) what dose did you usually take?
O .30 mg/day or less O .45 mg/day O .625 mg/day O .9 mg/day O 1.25 mg/day or higher
O Unsure O Did not take oral conjugated estrogen

14. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.

	DAYS USED IN THE PAST MONTH				
	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	○	○	○	○	○
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	○	○	○	○	○
On days taking, TOTAL DOSE per day: ○ <100 mg ○ 100-499 mg ○ 500-999 mg ○ 1000+ mg ○ unknown					
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	○	○	○	○	○
d. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	○	○	○	○	○
e. Multivitamins	○	○	○	○	○
f. SINGLE supplements of omega-3 fatty acids (fish oil)	○	○	○	○	○
g. SINGLE supplements of calcium (include elemental calcium in Tums)	○	○	○	○	○
What dose per day (elemental calcium)? ○ <400 mg ○ 400-900 mg ○ 901-1300 mg ○ 1301+ mg ○ unknown					
h. SINGLE supplements of vitamin D (in calcium supplements or separately)	○	○	○	○	○
What dose per day? ○ <300 IU ○ 300-500 IU ○ 600-900 IU ○ 1000 IU or more ○ unknown					

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

a. Antihypertensives (e.g., diuretic, calcium channel blockers, angiotensin receptor or b-blockers, ACE inhibitor)	○ No	○ Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	○ No	○ Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	○ No	○ Yes
d. Fosamax or other bisphosphonates for prevention/treatment of bone loss	○ No	○ Yes
If YES, for how many years have you been regularly taking this bone loss med.? ○ < 1 yr ○ 1-2 yrs ○ 3-4 yrs ○ 5+ yrs		

16. IN THE PAST YEAR, have you had any of the following?

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening
a. Colonoscopy	○	○	○
b. Sigmoidoscopy	○	○	○
c. Mammogram	○	○	○

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening
d. Fasting blood sugar	○	○	○
e. Eye exam	○	○	○
f. Bone density exam (DEXA)	○	○	○

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

HOME PHONE: ( ) - -

CELL PHONE: ( ) - -

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: ○ **Relative** ○ **Friend** ○ **Neighbor** ○ **Other**