51586

WOMEN'S HEALTH STUDY

7 /

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.**
The first line is provided as an EXAMPLE of someone reporting a "hip replacement" performed in February 2010.

DIAGNOSIS OR PROCEDURE	NO or YES	IF YES, PROVIDE DATE (MO/YR) IN BOXES BELOW
EXAMPLE: Hip replacement	○ No ● Yes →	MO/YR of procedure: 0 2 / 1 0
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 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 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. Kidney disease (other than kidney stones)		O No	O Yes →	MO/YR of diagnosis:	/
z. Chronic kidney failure		O No	O Yes →	MO/YR of diagnosis:	/
aa. Macular degeneration	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	/
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	/
bb. Cataract (Newly diagnosed)	**RIGHT eye**	O No	O Yes →	MO/YR of diagnosis:	/
	LEFT eye	O No	O Yes →	MO/YR of diagnosis:	/
cc. Cataract extraction	**RIGHT eye**	O No	O Yes →	MO/YR of procedure:	/
	LEFT eye	O No	O Yes →	MO/YR of procedure:	/
dd. Glaucoma		O No	O Yes →	MO/YR of diagnosis:	/
ee. Dry eye syndrome		O No	O Yes →	MO/YR of diagnosis:	/
ff. Parkinson's disease		O No	O Yes →	MO/YR of diagnosis:	/
gg. Elevated cholesterol (NEW dx by a clinician)		O No	O Yes →	MO/YR of diagnosis:	/
hh. Hypertension (NEW dx by a clinician)		O No	O Yes →	MO/YR of diagnosis:	/
ii. Osteoarthritis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	/
jj. Osteoporosis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	/
kk. Fracture due to osteoporosis		O No	O Yes →	MO/YR of occurence:	/
ll. Joint replacement		O No	O Yes →	MO/YR of surgery:	/
mm. Psoriasis (NEWLY diagnosed)		O No	O Yes →	MO/YR of diagnosis:	/
nn. 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 blood pressure (mmHg)? →

O Don't know my blood pressure

systolic (upper #) / diastolic (lower #)

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. What is your CURRENT weight? pounds

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

8. 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: _____	○	○	○	○	○	○	○	○

9. 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

10. What is your usual walking pace outdoors?

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

11. IN THE PAST 3 YEARS, have you used female hormones? ○ No: Skip to the next question ○ Yes: Complete the box below ↓

a. IF YES, in the PAST 3 YEARS, for how many months have you used female hormones?
○ 1-4 mos. ○ 5-8 mos. ○ 9-12 mos. ○ 13-16 mos. ○ 17-20 mos. ○ 21-24 mos. ○ 24+ mos.

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

c. Mark the type(s) of hormones you have used the longest in the PAST 3 YEARS:

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

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

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

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

e. What was your pattern of progesterone use (days per month)? ○ Not used ○ <1 ○ 1-8 ○ 9-18 ○ 19-26 ○ 27+ days /mo.

12. 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

13. 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.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-999 mg O 1000+ mg O unknown					
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
f. Multivitamins	O	O	O	O	O
g. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
h. SINGLE supplements of calcium (include elemental calcium in Tums)	O	O	O	O	O
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown					
i. SINGLE supplements of vitamin D (in calcium supplements or separately)	O	O	O	O	O
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown					

14. In the LAST 12 MONTHS did you have unpleasant leg sensations (crawling, paraesthesias, or pain) combined with motor restlessness and an urge to move? O No O Yes

IF YES: Do these symptoms occur only at rest and does moving improve them? O No O Yes

Are these symptoms worse in the evening/night compared to the morning? O No O Yes

How often do these symptoms occur? O Daily O 3-6/week O 1-2/week O 1-3/month O < 1/month O Rarely/never

Have you EVER been specifically diagnosed with "restless legs syndrome" by a physician? O No O Yes

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

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening
a. Fasting blood sugar	O	O	O
b. Colonoscopy	O	O	O
c. Sigmoidoscopy	O	O	O
d. Mammogram	O	O	O
e. Eye exam	O	O	O
f. Bone density exam (DEXA)	O	O	O

16. Have you EVER had a breast biopsy? O No O Yes

IF YES: How many? O 1 O more than 1

Any with atypical hyperplasia? O No O Yes

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

O Excellent O Very good O Good O Fair O Poor

PLEASE COMPLETE THE CONTACT INFORMATION . THANKS.

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: _____

IS THIS CONTACT:

O Relative O Friend O Neighbor O Other