WOMEN'S HEALTH STUDY
RISK FACTOR FORM

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1. What is your date of birth? □□ / □□ / □□ (month / day / year)

2. In the space to the right, please provide your current weight and height.
   WEIGHT: □□□ pounds
   HEIGHT: □ feet □□ inches

3. 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)

4. 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

5. 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

6. SINCE THE STUDY BEGAN, have you had any of the following procedures or exams?
If YES, for the MOST RECENT procedure/exam, please indicate why it was done (whether because of SYMPTOMS or as a matter of ROUTINE SCREENING) and when it was done (how many years ago).

PROCEDURE/EXAM DONE SINCE THE STUDY BEGAN?	No	Yes	Most recent, why done? Result of symptoms	Most recent, why done? Routine screening	Most recent, how many years ago? <1 yr	1-2 years	3-5 years	>5 years	Don't recall
a. Stool occult blood test	O	O	O	O	O	O	O	O	O
b. Sigmoidoscopy	O	O	O	O	O	O	O	O	O
c. Colonoscopy	O	O	O	O	O	O	O	O	O
d. Pap smear	O	O	O	O	O	O	O	O	O
e. Mammogram	O	O	O	O	O	O	O	O	O
f. A physical exam	O	O	O	O	O	O	O	O	O
g. Fasting blood sugar	O	O	O	O	O	O	O	O	O
h. Blood pressure check	O	O	O	O	O	O	O	O	O
i. Blood cholesterol check	O	O	O	O	O	O	O	O	O
j. An eye examination	O	O	O	O	O	O	O	O	O

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7. Have your menstrual periods ceased PERMANENTLY?

- O Yes: No menstrual periods →
- O Yes: Had menopause, but periods now induced by hormones →
- O No: Premenopausal
- O Not sure

IF YES, please answer the questions below:

a. At what age did your periods cease? ☐☐ age

b. For what reason did your periods cease?
- O Surgery
- O Radiation or chemotherapy
- O Natural

c. IF SURGERY, were your ovaries and/or uterus removed? (Mark ALL that apply)
- O Uterus removed
- O One ovary removed
- O Both ovaries removed

d. IF NATURAL menopause (non-surgical), have you had subsequent surgery to remove ovaries/uterus? (Mark ALL that apply)
- O No, did not have surgery
- O Uterus removed
- O One ovary removed
- O Both ovaries removed

8. IN THE LAST YEAR have you used over-the-counter or herbal remedies for hormone replacement or menopausal symptoms?

O No O Yes

IF YES, please mark the frequency of all the types you have used more than once/week.

	MONTHS used in the last year			
a. Soy pill	O 1-3 mos.	O 4-6	O 7-9	O 10-12
b. Soy powder	O 1-3 mos.	O 4-6	O 7-9	O 10-12
c. Black cohosh	O 1-3 mos.	O 4-6	O 7-9	O 10-12
d. Red clover	O 1-3 mos.	O 4-6	O 7-9	O 10-12
e. Natural progesterone cream	O 1-3 mos.	O 4-6	O 7-9	O 10-12
f. Other_____	O 1-3 mos.	O 4-6	O 7-9	O 10-12

9. IN THE PAST YEAR, have you used female hormones (other than oral contraceptives)?

O No O Yes, currently O Yes, discontinued

IF YES (either currently or discontinued), please answer the questions below. IF NO, please skip to question #10.

a. In the PAST YEAR, for how many months have you used female hormones?

O 1-2 mo. O 3-4 mo. O 5-6 mo. O 7-8 mo. O 9-10 mo. O 11-12 mo.

b. Mark the one type you have used the longest:

Estrogen: O Oral Premarin O Oral Prempro O Oral Premphase O Oral Estrace/Ogen
O Vaginal estrogen O Patch estrogen O Other estrogen, specify _____

Progesterone: O Oral O Vaginal O Other, specify _____

c. If you used conjugated estrogens (e.g., Premarin, Prempro or Premphase) what dose did you usually take?

O 0.3 mg or less O 0.625 mg O 0.9 mg O 1.25 mg O >1.25 mg
O Dose unknown O Did not take conjugated estrogen

d. If you used medroxy progesterone (e.g., Provera, Cycrin, Prempro or Premphase) what dose did you usually take?

O <5 mg O 5-9 mg O 10 mg O >10 mg O Unknown O Not used

e. If you used oral or patch estrogen, what was your pattern of use? (days per month)

O Not used O <1 O 1-8 O 9-18 O 19-26 O 27+ days per month

f. If you used progesterone, what was your pattern of use? (days per month)

O Not used O <1 O 1-8 O 9-18 O 19-26 O 27+ days per month

10. Did any of these relatives ever have . . .

RELATIVE

	None	Don't know	Mother	Any sister	Father	Any brother
a. Diabetes?	O	O	O	O	O	O
b. Hypertension?	O	O	O	O	O	O
c. Colon or rectal cancer?	O	O	O	O	O	O
d. Ovarian cancer?	O	O	O	O		

11. Did any of these relatives ever have . . .

a. Myocardial infarction?	**No**	**Don't know**	**Yes**		**If YES, please provide age when first diagnosed:**	
Mother	O	O	O	→	Age when first diagnosed: [ ][ ]	O Don't know age
Father	O	O	O	→	Age when first diagnosed: [ ][ ]	O Don't know age
b. Breast cancer?	**No**	**Don't know**	**Yes**		**If YES, please provide age when first diagnosed:**	
Mother	O	O	O	→	Age when first diagnosed: [ ][ ]	O Don't know age
Any sister	O	O	O	→	Age when first diagnosed: [ ][ ]	O Don't know age
Maternal grandmother	O	O	O	→	Age when first diagnosed: [ ][ ]	O Don't know age
Paternal grandmother	O	O	O	→	Age when first diagnosed: [ ][ ]	O Don't know age

12. Please provide the following information about your biological parents:

	Year of birth		**Is parent alive or dead?**			**If applicable, year of death**	
Father	[ ][ ][ ][ ]	O Don't know	O Alive	O Dead	O Unknown	[ ][ ][ ][ ]	O Don't know
Mother	[ ][ ][ ][ ]	O Don't know	O Alive	O Dead	O Unknown	[ ][ ][ ][ ]	O Don't know

13. Have you EVER smoked cigarettes? O No O Yes → IF YES, how many TOTAL YEARS have you smoked? [ ][ ] yrs.

During the time that you smoked, what is the **average** number of cigarettes that you smoked per day? (1 pack = 20 cigarettes) [ ][ ] cigs/day

Do you CURRENTLY smoke cigarettes? O No O Yes ↓

If you are a CURRENT smoker, please answer the questions below. If NOT A CURRENT SMOKER, go to the next page.

a. ON AVERAGE, how many cigarettes / day do you currently smoke? (1 pack = 20 cigarettes) [ ][ ] cigarettes per day (on average)

b. How soon after you wake up do you smoke your first cigarette?
O Within 5 mins. O 6-30 mins. O 31-60 mins. O After 60 mins.

c Do you find it difficult to refrain from smoking in places where it is forbidden, e.g., in church, at the library, in cinema, etc.? O No O Yes

d. Which cigarette would you hate most to give up? O The first one in the morning O All others

e. Do you smoke more frequently during the first hours after waking than during the rest of the day? O No O Yes

f. Do you smoke if you are so ill that you are in bed most of the day? O No O Yes

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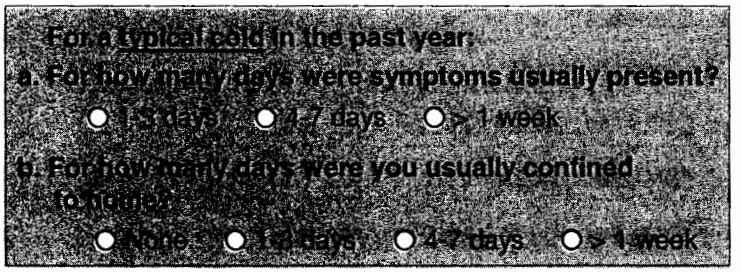
4. Have you used any of the following treatments, for any purpose DURING THE PAST TWO YEARS?

a. Acupuncture	O No	O Yes
b. Chiropractic	O No	O Yes
c. Homeopathy	O No	O Yes
d. Herbal therapies	O No	O Yes
e. High-dose vitamins (not a daily vitamin or MD-prescribed)	O No	O Yes
f. Soy pills (taken for any reason)	O No	O Yes
g. Your own prayer or spiritual practice	O No	O Yes
h. Spiritual healing by others	O No	O Yes
i. Special diet programs that you pay for (e.g., Weight Watchers)	O No	O Yes
j. Lifestyle diet (e.g., low-fat, vegetarian)	O No	O Yes
k. Relaxation techniques (e.g., meditation)	O No	O Yes
l. Imagery techniques	O No	O Yes
m. Massage	O No	O Yes
n. Energy healing (e.g., magnets, machines, laying on of hands)	O No	O Yes
o. Folk remedies	O No	O Yes
p. Self-help group	O No	O Yes
q. Biofeedback	O No	O Yes
r. Hypnosis	O No	O Yes
s. Naturopathy	O No	O Yes
t. Yoga	O No	O Yes
u. Osteopathy	O No	O Yes
v. Chelation therapy	O No	O Yes
w. Other: _____	O No	O Yes

15. IN THE PAST YEAR, how many colds have you had?

O None O 1-2 O 3-5 O 6-10 O >10 colds



16. What are your most recent cholesterol levels (both total cholesterol level and HDL cholesterol level)?

TOTAL cholesterol: ☐☐☐ mg/100 ml O Don't know

HDL cholesterol: ☐☐☐ mg/100 ml O Don't know

17. Are you CURRENTLY being treated with:

a. Cholesterol-lowering medications? O No O Yes

b. Oral medications for diabetes? O No O Yes

c. Insulin injections? O No O Yes

18. How often are your eyes dry (not wet enough)? Would you say:

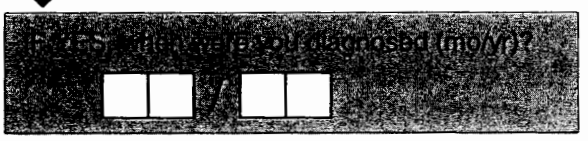
O Constantly O Often O Sometimes O Never

19. How often are your eyes irritated? Would you say:

O Constantly O Often O Sometimes O Never

20. IN THE PAST 5 YEARS, have you been diagnosed (by a clinician) as having dry eye syndrome?

O No O Yes



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

O Excellent O Very good O Good O Fair O Poor

22. For each of the study agents (white pill, amber capsule), please indicate below whether you believe you were assigned to the active agent or the placebo.

a. White pill:	O Active agent	O Placebo
b. Amber capsule:	O Active agent	O Placebo

Office use only: O RA review