| Image: Normal Stream PAGE 1 HARVARD MEI D # 0 1992 Brigham and Women's Hospital. All Right 0 1992 Brigham and Women's Hospital. All Right BEGIN HERE. PLEASE USE NO. 2 PENCIL ONLY. 4. Social Security Number 5. Height 6. Weight 7 Jan Day 1 0 < | |
|--|--|
| BEGIN HERE. PLEASE USE NO. 2 PENCIL ONLY. 1. Date of Birth 2. Sex 4. Social Security Number 5. Height 6. Weight 7 Jan Day 1 2 2 | White/ Non-Hispanic Hispanic African American/Bla Asian or Pacific Island American Indian or Alaskan Nativ Other or |
| 1. Date of Birth 2. Sex 4. Social Security Number 5. Height 6. Weight 7 Image: Security Number Image: Security Number 5. Height 6. Weight 7 Image: Security Number Image: Security Number 5. Height 6. Weight 7 Image: Security Number Image: Security Number 5. Height 6. Weight 7 Image: Security Number Image: Security Number 1 < | White/ Non-Hispanic Hispanic African American/Bla Asian or Pacific Island American Indian or Alaskan Nativ Other or |
| 1. Date of Birth 2. Sex 4. Social Security Number 5. Height 6. Weight 7 | White/ Non-Hispanic Hispanic African American/Bla Asian or Pacific Island American Indian or Alaskan Nativ Other or |
| Jan DAY YEAR Feb Mar 0 0 0 Apr 1 | White/ Non-Hispanic Hispanic African American/Bla Asian or Pacific Island American Indian or Alaskan Nativ Other or |
| Jan DAY YEAR Feb Mar 0 | White/ Non-Hispanic Hispanic African American/Bla Asian or Pacific Island American Indian or Alaskan Nativ Other or |
| Feb 1 Male Mar 0 0 0 Apr 1 1 1 May 2 2 2 Jun 3 3 3 Jul 4 4 4 4 4 Aug 5 < | Non-Hispanic Hispanic African American/Bla Asian or Pacific Island American Indian or Alaskan Natir |
| Mar 0 | Hispanic African American/Bla Asian or Pacific Island American Indian or Alaskan Nativ Other or |
| Apr 1 | African American/Bla Asian or Pacific Island American Indian or Alaskan Nation Other or |
| May 2 | Asian or Pacific Island American Indian or Alaskan Nativ Other or |
| Jul 4 | Pacific Island American Indian or Alaskan Nativ |
| Aug 5 | American Indian or Alaskan Nativ |
| Sep 6 | Indian or Alaskan Nativ |
| Oct 7 | Alaskan Nativ |
| Nov 8 9 | "nor" |
| Dec 9 | "ner" |
| 8. What is your professional qualification? 9. What is the highest level of education you have completed? L.P.N. or L.V.N. training 2-year Associate's degree-R.N. | |
| MD/MD equivalent DDS/DMD DDS/DMD DDS/DMD U.P.N. or L.V.N. training 2-year Associate's degree–R.N. | |
| 9. What is the highest level of education you have completed? O L.P.N. or L.V.N. training O 2-year Associate's degreeR.N. O Diploma program (3-yearR.N.) | |
| L.P.N. or L.V.N. training 2-year Associate's degreeR.N. Diploma program (3-year-R.N.) | DVM |
| | |
| Bachelor's degree or B.S. in nursing Master's degree Octoral degree (including MD) | |
| | |
| No, Not Yes (Includes those who have reached menopause but now have periods induced by h premenopausal sure a) At what age did your natural periods cease? b) For what reason did they cease? | AGE |
| Surgery If due to surgery, were your ovaries removed? | 0 |
| IF NO or NOT SURE: | $\tilde{0}$ |
| Do you intend to become pregnant 🥥 Radiation or Chemotherapy | 22 |
| at any time in the future? Natural 🜩 If natural menopause (not due to the above), have you had subsequ | さん なだす みがめ ススイービー・ビー |
| No Yes Not sure surgery to remove ovaries or uterus? (Mark all that apply.) | (4) |
| Have you had a tubal ligation? | 55 |
| No Yes Both ovaries removed Uterus removed | 6 6 7 7 |
| | 88 |
| 2. At what age did your menstrual periods begin? | 12 9 9 |
| | |
| \bigcirc 9 or younger \bigcirc 10 \bigcirc 11 \bigcirc 12 \bigcirc 13 \bigcirc 14 \bigcirc 15 \bigcirc 16 \bigcirc 17 or older | |
| | |
| 3. Have you <i>EVER</i> been pregnant? | ne fer fer Gelie für delte neren eine |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? | |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? No Yes IF YES a) How many pregnancies lasting six months or more have you had? No Yes IF YES a) How many pregnancies lasting six months or more have you had? | |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? None 1 2 3 4 5 6 or more b) How old were you at the end of your first pregnancy lasting six months or more? | |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? None 1 2 3 4 5 6 or more b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 15-19 20-24 25-29 | |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? None 1 2 3 4 5 6 or more b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 15-19 20-24 25-29 | ave you had? |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? None 1 2 3 4 5 6 or more b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 15-19 20-24 25-29 30-34 35-39 40 or more years | iave you had? |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? None 1 2 3 4 5 6 or more b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 15-19 20-24 25-29 30-34 35-39 40 or more years c) How many pregnancies lasting less than six months (including miscarriages and abortions) I | ave you had? |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? None 1 2 3 4 5 6 or more b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 15-19 20-24 25-29 30-34 35-39 40 or more years c) How many pregnancies lasting less than six months (including miscarriages and abortions) I None 1 2 3 4 5 6 or more Regardless of your decision | o participate |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? No Yes IF YES a) How many pregnancies lasting six months or more have you had? No Yes IF YES a) How many pregnancies lasting six months or more have you had? No Yes IF YES a) How many pregnancies lasting six months or more b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 30-34 35-39 40 or more years c) How many pregnancies lasting less than six months (including miscarriages and abortions) I None 1 2 3 4 5 6 or more None 1 2 3 4 5 6 or more None 1 2 3 4 5 6 or more 8 Regardless of your decision to in the trial, we would be grave proved the outling form | o participate |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? No Yes IF YES a) How many pregnancies lasting six months or more have you had? No Yes IF YES a) How many pregnancies lasting six months or more have you had? No Yes IF YES a) How many pregnancies lasting six months or more b) How old were you at the end of your first pregnancy lasting six months or more? b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 15-19 20-24 25-29 30-34 35-39 40 or more years c) How many pregnancies lasting less than six months (including miscarriages and abortions) I None 1 2 3 4 5 6 or more None 1 2 3 4 5 6 or more None 1 2 3 4 5 6 or more None 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | o participate teful if you |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? None 1 2 3 4 5 6 or more b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 15-19 20-24 25-29 30-34 35-39 40 or more years 0 or more years 6 or more c) How many pregnancies lasting less than six months (including miscarriages and abortions) I None 1 2 3 4 5 6 or more 1 | o participate teful if you |
| 3. Have you EVER been pregnant? No Yes IF YES a) How many pregnancies lasting six months or more have you had? None 1 2 3 4 5 6 or more b) How old were you at the end of your first pregnancy lasting six months or more? Not applicable Less than 15 years 15-19 20-24 25-29 30-34 35-39 40 or more years 0 or more years 6 or more c) How many pregnancies lasting less than six months (including miscarriages and abortions) I None 1 2 3 4 5 6 or more 1 | o participate teful if you |

| MEN'S HEALTH STUDY PAGE 2 | | <u> </u> | IAN | VAIN | | | | SCH | |
|--|---|-------------------------------|---|--|---|---|--|---|------------------|
| 4. Have you EVER used oral contraceptives for two months or more | Photo Information and an address information and an address | er Pastrik, divisi "Mastrika | Contract Sectors | Narkan Card and a | a molany na mar | an an ar ar ar | a samena an en | Jularity | , etc .) |
| ○ No ○ Not sure ○ Yes IF YES: What is the total num ○ Less than 1/2 year | | | | Shuk mer Yolf " | ontrace | | n Sin Sin Sin Sin Sin Sin Sin Sin Sin Si | | |
| | , 1/2-2 yean | | т уса | | <u></u> | | years | | |
| 5. Have you EVER used postmenopausal hormones (e.g., estroge | n)? | | | | | | | | |
| Never Past only Currently IF used in PAST or CURRENTLY: | | | | | | | | | |
| a) For how many TOTAL YEARS? Less than 1 year () 1 year | 2 years | ~~ 3_/\ \ | oare | | -7 yeai | . 7 | 8 or | more | /0 are |
| b) Type of hormone used MOST RECENTLY? () Conjugated estroge | | Children Children Children | | MORE FROM BLOD | CONCOLDED AND | | ti Generali. | No due di Ali an | 이야지 않는 것이 같아. |
| Non-conjugated estrogens <u>ALONE</u> (e.g., Estrace, Estinyl, Ogen | | | | 15 - 15 - 17 - 14 | | | | - p. ege | n ancaiche |
| Patch estrogen ALONE Patch estrogen AND progester | Directory and the state of the | nin die 900 nite 4.0 | THE SHE SHE SHE SHE | | | MARKENGER. | | | |
| 🔿 Vaginal estrogen 👘 🗇 Other 🛛 👘 🖓 🕹 | SPECIFY: | | | | | | | | |
| c) MOST RECENT dose of oral conjugated estrogen (e.g., Premarin): | | | | | | | DESA | Voteoria | 0.12.0.7.7 |
| | .625 mg/day (| ၂.9 က(| g/day o | or more |) 1.01 (101) | | | | |
| d) MOST RECENT dose of progesterone (e.g., Provera): | E O malday | 0 mm/d | | - N/~~ | - f han | 10 | | | |
| | | l0 mg/d .ess tha | | N State State | 10) Chasteria | na de la competencia de la compete encia de la competencia de la | day | 0.91.59 | |
| | intinuous — - i | .055 116 | 111 Z VV | еска р | | | <u>665</u> 6 | antan ang bagan Ang ang ang bagan Ang ang ang ang ang ang ang ang ang ang a | |
| ວີ. As a participant in the trial, you will not be able to use <i>NON-S</i> 7 | UDY aspirin, m | nedicat | ions d | ontai | ning a | spirin | , nons | teroid | al |
| anti-inflammatory agents, or individual supplements of beta-ca | - | | | | - | - | | | |
| of the following on a regular basis, i.e., MORE THAN ONE <u>DA</u> | <u>Y</u> PER WEEK, | ON A | VERA | GE ? (| Please | ansv | ver N | 0 or Y | ' ES 0 |
| each line.) | 252 Roberts Deterministration | The Section of the sec | ladatista. | e, tegagi ta | | s | | | |
| a) Aspirin (do not include acetaminophen such as Tylenol) | | | | ιQΝ | | Yes | | | |
| b) Medications containing aspirin (e.g., Alka-Seltzer, Sine-Off, Doan's Pi | | | | <u>من</u> | WELCH LAND |) Yes) Yes | | | |
| c) Nonsteroidal anti-inflammatory agents (e.g., Motrin, Advil, Naprosyr d) Individual supplements of beta-carotene (not including multivitaming) | an area on a maintaine San Sur Gradum SurChu. | , meaip | arnay | | Station - Andrew Station - Market Station - Ma |) Yes | | | |
| e) Individual supplements of vitamin E (not including multivitamins) | | 66656 | 6666 | NON | e antra tratta d | Yes | | | |
| f) Individual supplements of vitamin A (not including multivitamins) | | | 010434340 | ۱Ö | der sie der die die | Yes | | | |
| | | | | "bad"" | ~~ | 2 | | | |
| In addition, do you <i>CURRENTLY</i> take either of the following <i>M</i> | ORE THAN OF | VE <u>DA</u> | <u>Y</u> PE | R WE | ЕК, О | N AV | ERAC | GE? | |
| g) Individual supplements of vitamin C (not including multivitamins) | | 8663 | | QN | e - Colorino das | Yes | | | |
| h) Acetaminophen (e.g., Tylenol, Datril) | | | | "We's" | |) Yes | | | |
| 7. As a participant in the Women's Health Study, would you be willin containing aspirin, and nonsteroidal anti-inflammatory agents? | ng to forego the | use or | | 5100 | y aspi | rin, m | ealcat | ions | |
| | | | | | | | | | |
| A Have you experienced adverse effects to aspirin which you believe | e are serious end | ough to | prev | ent yo | u from | takin | g a lo | w dos | e |
| regularly as part of this study? | | • | • | - | | | - | | |
| | | | | | ***** | | | | |
| • Have you EVER taken multivitamins on a regular basis? (Includ | concerns and and a concernsion of an and and and and and and | Constant a serie assessment. | | CONTRACTOR AND A DESCRIPTION | | | ana ar cris | Elemente e | |
| Never Past only | | | 978.CBC20.06 | | | > ~~ | | | |
| Currently 0-1 years 2-4 years Are you CURRENTLY taking any anticoagulants (e.g., Coumadir | and the second data and the second house a sub- | 4 years | <u>10</u> 20 | 5-19 ye | ars | 20 01 | more | years | <u>Stati</u> |
| #* Are you connenter taking any anticoagularits (e.g., courriaur | | | | | | | | | |
| | | | | or ton | ical st | eroid | s only | if use | d |
| ○ No ○ Yes Are you CURRENTLY taking any corticosteroids (e.g., Prednison | - | of inh | alers | OI LOP | | | - | | |
| Nut Sur | - | e of inh | alers | | | | | | |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes | ne)? (Include use | e of inh | alers | <u> </u> | | | | | |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high or set of the set of th | ne)? (Include use cholesterol? | | | | | n dan aya 201 ta | ia.etu izi | á bi a Car | at ta ta Ca |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high on the physician of the physician as having high on the physician of the phys | ne)? (Include use cholesterol? | | | | | | | | |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No | ne)? (Include use cholesterol? ch cholesterol-lov | vering | nedic | ation? | | | | | |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high on the second se | ne)? (Include use cholesterol? h cholesterol-lov blood pressure | vering (| medic: tensic | ation? on)? | | | | | |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No Yes | ne)? (Include use cholesterol? h cholesterol-lov blood pressure | vering (| medic: tensic | ation? on)? | | | | | |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high on the physician of the physician as having high of the physician of the phys | ne)? (Include use cholesterol? th cholesterol-lov blood pressure th medication for | vering r (hyper high bl | medic: tensic | ation? m)? ressur | e? | | | | |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high to No Yes IF YES: Are you currently being treated with No Yes Have you EVER been diagnosed by a physician as having high to No Yes Have you EVER been diagnosed by a physician as having high to No Yes Have you EVER been diagnosed by a physician as having high to No Yes Have you EVER been diagnosed by a physician as having high to No Yes Please record your average consumption of the following | he)? (Include use cholesterol? th cholesterol-lov blood pressure th medication for Never or Less Than | vering (hypering high b) | nedic: tensic lood p Per | ation? on)? ressur 2-4 Per | e? 5-6 Per | 1 Per | 2-3 Per | 4-5 Per | 6+ Per |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high (| ne)? (Include use cholesterol? th cholesterol-lov blood pressure th medication for Never or | vering (hypering high b) | nedic: tensic lood p Per | ation? on)? ressur 2-4 Per | e? | | 2-3 Per Day | 4-5 Per Day | 6+ Per Day |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No Yes Yes IF YES: Are you currently being treated with No Yes Yes Please record your average consumption of the following beverages over the LAST YEAR: Beer (1 glass, bottle, can) | he)? (Include use cholesterol? th cholesterol-lov blood pressure th medication for Never or Less Than | vering (hypering high b) | nedica tensic lood p Per Week | ation? on)? ressur 2-4 Per | e? 5-6 Per | Per Day D | Per | Per | Per |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high of No Yes Have you EVER been diagnosed by a physician as having high of No Yes Have you EVER been diagnosed by a physician as having high of No Yes Have you EVER been diagnosed by a physician as having high of No Yes Have you EVER been diagnosed by a physician as having high of No Yes Have you EVER been diagnosed by a physician as having high of Yes Have you EVER been diagnosed by a physician as having high of Yes Please record your average consumption of the following beverages over the LAST YEAR: Beer (1 glass, bottle, can) Red wine (include sherry, port) (4 oz. glass) | he)? (Include use cholesterol? th cholesterol-low blood pressure th medication for Less Than One/Month | vering (hypering high b) | nedic: tensic lood p Per Week Week | ation? on)? ressur 2-4 Per | e? 5-6 Per | Per Day D | Per Day | Per | Per |
| Are you CURRENTLY taking any corticosteroids (e.g., Prednison more than 10 times/day) No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No Yes Have you EVER been diagnosed by a physician as having high of No Yes IF YES: Are you currently being treated with No Yes Yes IF YES: Are you currently being treated with No Yes Yes No Yes Yes Yes Beer (1 glass, bottle, can) | te)? (Include use cholesterol? th cholesterol-low blood pressure th medication for Less Than One/Month | vering (hypering high b) | nedica tensic lood p Per Week | ation? on)? ressur 2-4 Per | e? 5-6 Per | Per Day D | Per Day | Per | Per |

| 8. Have you EVER had any of the following? I N or Y for EACH line. If Y , provide YR c | | | | 26 | <i>L</i> / , | Did any of these relatives RELATIVE |
|--|---------------------|---|-------------|---|--------------|--|
| | NO | YES | | YEAR | | UNKOWN ANY ANY OR NONE MOTHER SISTER FATHER BROTHE |
| Myocardial infarction (heart attack) | N | Y | * | а | a) | Diabetes? |
| Stroke or TIA (transient ischemic attack) | $\langle N \rangle$ | y | - 1 - C | Ъ | b) | Colon or rectal cancer? |
| Angina pectoris | N | Y | * | c | C) | Ovarian cancer? |
| IF YES, angiogram? No Yes confirmed by: stress test? No Yes | | | | 1 | | Did any of these relatives ever have AGE AT FIRST DIAGNOSIS Myocardial |
| Coronary angioplasty (PTCA) | (N) | Y | nijo- | d | a) | Myocardial NO or BEFORE AGE 40 AGE 50 AGE 1 Infarction? UNKNOWN YES AGE 40 TO 49 TO 59 60+ A |
| Coronary bypass surgery (CABG) | (N) | $(\mathbf{\hat{Y}})$ | | | 1 | Mother |
| Carotid artery surgery (endarterectomy) | | ÌŇ | | | 2 | Father |
| Peripheral artery surgery | (N) | (Y) | · | g | ь) | Breast Cancer? |
| Intermittent claudication | (N) | V. | | | з, | Mother |
| Melanoma | (N) | $(\mathbf{\hat{Y}})$ | en ja | ; [, | 4 | Any sister 0 0 0 0 0 0 |
| Non-melanoma skin cancer | (N) | Y | • | | 5 | Maternal grandmother () () + () () () () () () () () () () () () () |
| F YES, type: basal cell unknown | | | | - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 | 6 | Paternal grandmother () () + () () () () () |
| squamous cell | 다고는 1918년 문 | | | | 29 | In the PAST YEAR , have you had migraine headaches |
| | | | | | | ■ No Yes IFYES: |
| Fibrocystic or other benign breast disease | N | $\overline{\mathbf{N}}$ | * | k | | a) What is the approximate frequency of your migraines? |
| IF YES, breast biopsy? No Yes | "No." | | | 1 | | Daily Weekly Monthly |
| confirmed by: aspiration? No Yes | | | | 2 | | Every other month C Less than 6 times per year |
| Breast cancer | (N) | (Ŷ) | | | | b) Do your migraines have any of the following characteristics? (Mark all that apply.) |
| Other cancer (non-skin, non-breast) | (N) | $(\hat{\mathbf{Y}})$ | | <u></u> . m | | Aura or any other indication O Nausea and/or vomitin |
| IF YES, SITE: | | Same | - | | | a migraine is coming () Light sensitivity |
| | | | | e | | Unilateral location of pain Sensitivity to sound |
| Active or chronic liver disease or cirrhosis | (N) | (y) | | | 節 | Pulsating quality Tingling or numbress |
| Chronic kidney failure | <u>0000</u> (N) | (Y) | | o l | | Inhibit daily activities |
| | ÎM | | | | | |
| | | XIIII | | | | |
| Bleeding hemorrhoids | (N) | $(\hat{\mathbf{y}})$ | | <u>р</u> | | O Duration of 4–72 hours O Dizziness or vertigo |
| Any other gastrointestinal bleeding | (N) | 4004 | milita- | q | | Aggravation by routine O Unilateral weakness in |
| Ulcer | (N) | $\left \begin{array}{c} 0 \\ 0 \end{array} \right $ | | <u> </u> | ♥ | physical activity face, arms or legs |
| Coagulation disorder | - 86/23 | | | | ¥ | |
| (e.g., Von Willebrand's disease) | (N) | (Ŷ) | | s | 30. | Have you smoked 100 cigarettes or more in your lifetime |
| Gout | N | $\langle \widetilde{\mathbf{y}} \rangle$ | | 5250 | | No Yes, currently Yes, smoked in |
| Migraine headaches | (N) | $(\hat{\mathbf{Y}})$ | | u i | | w smoke w past but quit |
| Diabetes mellitus, diagnosed prior to age 30 | - Section - | Y | | v S | | IF YES, CURRENTLY what IF YES, BUT QUIT: |
| Diabetes mellitus, diagnosed at 30 or older | (N) | (Y) | PR. PIL, PL | W | | specific brand and type? (e.g., When did you quit? |
| Colon polyp (benign) | (N) | Ŷ | | × | | Mariboro Lights 100's) |
| Multiple sclerosis | <u>(N</u>) | (Ŷ) | or ste | Ŷ | | SPECIFY: year ago |
| Amyotrophic lateral sclerosis (ALS) | (N) | Ŷ | | z - | | 1 or more |
| Systemic lupus erythematosus (SLE) | (N) | (Y) | 2007 1 00 | 82 | | years ago |
| Rheumatoid arthritis (Dr. diagnosed) | N | (Y) | | 66 | | a) How many <u>total</u> years have you smoked? |
| F YES, Rheumatoid factor: | | | | | | () Less than 5 years () 5-9 () 10-19 () 20-29 |
| Negative/unknown Positive | | | | | | 30-39 40-49 50 or more years |
| Other arthritis | (N) | $\langle \tilde{\mathbf{Y}} \rangle$ | - | CC. | | b) At each age: what was the average number of cigarettes you |
| Joint pain or joint swelling | (N) | $\langle \mathbf{v} \rangle$ | | del | | smoked PER DAY during the time that you smoked? |
| Hip replacement | (N) | (Y) | | ee | | None 1-4 5-14 15-24 25-35 36-44 45+ |
| Knee replacement | (N) | Ŷ | | n | | |
| Osteoporosis | (N) | (Ŷ) | 10.14 | gg | | |
| Scleroderma | (N) | Y, | | hh | | |
| Dermatomyositis or polymyositis | (N) | Ŷ | 1999 | <u>n</u> | | 30-39 0 0 0 0 0 0 0 |
| Sjögren's syndrome | (N) | $\left \begin{array}{c} \\ \end{array} \right \right $ | | <u></u> | | 40-49 0 0 0 0 0 0 0 0 0 |
| Any other connective tissue disorder | (mart) | <u>, norman kan kan kan kan kan kan kan kan kan k</u> | | | | E 50-59 0 0 0 0 0 0 0 0 |
| (including mixed) | (N) | (Ŷ) | | | | |
| Other major illness | | $\overline{\mathbf{N}}$ | | | Ŵ | |
| IF YES, SPECIFY MAJOR ILLNESS: | | | | | 31. | Are you living with a spouse or significant other who |
| | വിന്ന് | €£~1.0 | Jan Jah | ng tan dari ké Dissertan. | | CURRENTLY smokes cigarettes? |

| VOMEN'S HEALTH STUDY | GE 4 HARVARD MEDICAL SCHOOL |
|---|---|
| ID # | |
| 32. On average, how many hours PER WEEK are you in a roo | ante ante attaca della della |
| <u>○ None ○ 1-4 hrs. ○ 5-8 hrs. ○ 9-12 hrs. ○ 13-24 hrs. ○</u> | 25-36 hrs. 37-48 hrs. 49-60 hrs. 61+ hrs. |
| 33. Have you EVER had any of these procedures or injections | ? (Please mark (\mathbb{N}) or (\mathbb{Y}) for each and provide year |
| of FIRST procedure) | YEAR |
| a) Breast implant (N) (Y) when was YEAR (| of FIRST breast implant? |
| | of FIRST silicone injection? |
| | of FIRST collagen injection? |
| | of FIRST paraffin injection? |
| | we sent you a convenient collection kit? This would require |
| | essing would be necessary. A postage-paid mailer would be |
| provided to return the specimen. Unwillingness to provide | e such a sample will <u>not</u> affect your eligibility for the main study. |
| ◯ No | |
| OPTIONAL: The following assists us in maintaining follow-up. | |
| 35. Please provide us with your phone number(s) so we may a | contact HOME: WORK: |
| you if we are unable to reach you through the mail: | |
| OPTIONAL: The following information assists us in classifying | |
| 36. Which of these income groups represents your total house | |
| ○ Under \$10,000 ○ \$10,000-19,999 ○ \$20,000-29 | |
| \$40,000-49,999 \$50,000-99,999 Ove | er \$100,000 |
| THANK YOU FOR COMPLETING THE | Women's Health Study |
| THANK YOU FOR COMPLETING THIS F | Job Commonwearth Avenue Last |
| WHETHER OR NOT YOU AGREE TO PARTICIPATE, please of form below and return it along with the guestionnaire in the rep | |
| orm below and return it along with the questionnaire in the rep | ly envelope to: 1-800-633-6911 |
| CONSEN | NT FORM |
| urpose | Benefits |
| e would like permission to enroll you as a participant in the Women's Health Study. The purpose of this study is to assess the benefits and risks of taking supplements of | If low-dose aspirin, beta-carotene or vitamin E reduce the risks of cardiovascular disease or cancer, those women assigned to the active agents may benefit from- |
| ta-carotene and vitamin E, as well as low-dose aspirin, to lower the risks of devel- | participation. |
| ing cardiovascular disease and cancer. | Alternative Procedures |
| ur participation would involve: | The alternative to participation in this study is to not participate. Participation is vol- untary and you may discontinue participation at any time. |
| aking daily study pills from calendar packs we will mail to you. You will be asked to | Confidential Information Confidential information contained in your study record may not be furnished to any- |
| ake on even-numbered days a pill that is either 600 IU of vitamin E or placebo and a pill that is either 100 mg aspirin or placebo. On odd-numbered days, you will be | one unaffiliated with the Brigham and Women's Hospital without your written con- |
| asked to take a pill containing 50 mg beta-carotene or placebo. You will be assigned | sent, except as required by law or regulation. Compensation Clause |
| to your study treatment group at random. You will not know or be able to choose your treatment group; | In the rare event that you should experience any adverse effects which seem to be |
| completing a brief health questionnaire every six months. The form will ask about | associated with taking your study pills, please contact us and your pill taking may be |
| rour recent health experience and ask for permission to review medical records for elevant illnesses that you report. | discontinued. Brigham and Women's Hospital does not provide you with any compensation as the result of such effects. |
| e study will continue for approximately five years. When it ends, we will inform | Withdrawal from Study |
| u of the results of the study and tell you what your treatment group assignment has | You are free to withdraw your consent and discontinue participation in this project at any time. |
| JRING THE COURSE OF THE TRIAL, YOU MUST AGREE NOT TO TAKE | Inquiries Regarding Study Procedures |
| PART FROM THE STUDY PILLS WE WILL PROVIDE) ASPIRIN, OR ASPIRIN- | If you have any questions about the trial, you may contact us by letter or telephone. You may also request reference material on the possible role of beta-carotene, vitamin E |
| NTAINING COMPOUNDS, AS WELL AS NON-STEROIDAL ANTI-INFLAM- ATORY DRUGS THAT HAVE ASPIRIN-LIKE EFFECTS, SUCH AS MOTRIN, | and aspirin in the prevention of cardiovascular disease and cancer. In the event that at |
| VIL, AND NAPROSYN. YOU MUST ALSO AGREE NOT TO TAKE INDIVID- | any time during the course of this project, you feel you have not been adequately informed as to the risks, benefits, alternative procedures, or your rights as a research |
| AL BETA-CAROTENE, VITAMIN A, AND VITAMIN E SUPPLEMENTS. at any time you have questions or concerns regarding these procedures, you may | subject, or feel under duress to continue against your wishes, the Executive Secretary |
| ntact Dr. Julie Buring at (617) 278-0800. | of the Human Subjects Research Committee at Brigham and Women's Hospital or a representative is available to speak with you during normal working hours (8:00 a.m. |
| sks and Discomforts | to 4:30 p.m. E.T.) at (617) 732-7200. A signed copy of this consent form will be made available to you upon request. |
| though no toxic effects have been documented for either beta-carotene or vitamin E the dosages we will use in the trial, in larger doses beta-carotene can cause loose | |
| ools and yellowing of the skin, both of which disappear when the pills are stopped. | ○ No, I do not wish ○ Yes, I agree to participate |
| ere have been anecdotal reports of skin rash and fatigue associated with higher ses of vitamin E, which also cease upon discontinuing the supplement. | to participate (Please sign below) |
| | In signing this consent form, I agree to participate in the Women's |
| a minority of individuals, aspirin can cause symptoms of stomach upset. It also creases the tendency to bleed, particularly in the gastrointestinal tract, although | Health Study to evaluate the possible (but unproven) benefits of beta- |
| enerally at much higher doses than that used in this study. If you should experience | carotene, vitamin E, and aspirin in healthy women, under the conditions outlined above. I understand that I am free to withdraw my consent at |
| strointestinal symptoms, you may request an enteric-coated preparation. | any time, and that if I have questions at any time, they will be answered. |
| | |
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| Not coun | ting multi-vitamir | ıs, do you CURF | RENTLY take a | iny of the follov | ving su | uppler | nents | : | | | | | |
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| 4 . (Continued) Please fill | in your AVERAGE use, DURING THE | | | VER | | | PAS | БТ ҮЕ | | В | L = |
| PAST YEAR, of each s | specified food. | EVER, OR SS THAN | 13 PER | 1 PER | 2-4 PER | 5-6 PER | 1 PER | 2-3 PER | 4-5 PER | 6+ PER | M . |
| | FRUITS | CE/MONTH | MONTH | WEEK | WEEK | WEEK | DAY | DAY | DAY | DAY | P - |
| Please try to average | Raisins (1 oz. or small pack) or grapes | | Q | Ŵ | Q. | \bigcirc | D | 0 | <u> </u> | | a |
| your seasonal use of | Prunes (7 prunes or 1/2 cup) | 0 | \bigcirc | W | \bigcirc | \square | D | \square | \square | LQ | - |
| foods over the entire | Bananas (1) | 0 | <u>O</u> | Ŵ | \bigcirc | O | 0 | <u>O</u> | <u>lõ</u> | $ \underline{O} $ | <u> </u> |
| year. For example, if a | Cantaloupe (1/4 melon) | $\downarrow \bigcirc$ | \Box | W | \Box | \square | D | \Box | \square | | d 🚥 |
| food such as cantaloupe | Avocado (1/2 fruit or 1/2 cup) | 0 | O | W | 0 | O | (D) | Q | Q. | | e 💻 |
| is eaten 4 times a week | Fresh apples or pears (1) | \Box | \bigcirc | Ŵ | \bigcirc | $\left \right $ | D | \bigcirc | \bigcirc | | (†) – |
| during the approximate | Apple juice or cider (small glass) | 0 | O | Ŵ | 0 | 0 | D | 0 | 0 | 0 | 9 - |
| 3 months (12 weeks) | Oranges (1) | $\downarrow \bigcirc$ | 0 | Ŵ | 0 | $\left \right $ | D | $ \bigcirc$ | 0 | | h) 🗖 |
| that it is in season, then | Orange juice (small glass) | 0 | 0 | (W) | 0 | \odot | 0 | 0 | $ \bigcirc $ | | <u>i –</u> |
| the AVERAGE use | Grapefruit (1/2) | \Box | \Box | W | $\left\lfloor O \right\rfloor$ | $\left \right $ | D | \Box | \Box | | j 🗖 |
| would be once per | Grapefruit juice (small glass) | 0 | 0 | Ŵ | 0 | 0 | (D) | 0 | 0 | 0 | k 🗆 🗖 |
| week. | Other fruit juices (small glass) | \bigcirc | \bigcirc | Ŵ | \bigcirc | \bigcirc | D | \bigcirc | O | | <u> </u> |
| | Strawberries, fresh, frozen or canned (1/2 cup) | 0 | 0 | _ (W)_ | $ \odot $ | 0 | D | $ \circ $ | O | O | m) 🗖 |
| | Blueberries, fresh, frozen or canned (1/2 cup) | 0 | 0 | W | $ $ \bigcirc | \bigcirc | | | $ \bigcirc$ | O | (n) 💻 |
| 1 1 1 | Peaches, apricots or plums (1 fresh, or 1/2 cup canned) | | 0 | W | $\left \right\rangle$ | 0 | D | | 0 | 0 | <u>ہ</u> |
| 2 2 2 | | | | | | | | | | | |
| (4) (4) (4) | M | EVER, OR SS THAN | 1-3 PER | 1 PER | 2-4 PER | 5-6 PER | 1 PER | 23 PER | 4-5 PER | 6+ PER | |
| (B) (B) (B) | | CE/MONTH | MONTH | WEEK | WEEK | WEEK | DAY | DAY | DAY | DAY | P = |
| (P) (P) (P) | Tomatoes (1) | $\left[\right] $ | 0 | Ŵ | 0 | \mathbf{O} | O | 0. | 0 | 0 | a 🗖 |
| | Tomato juice, V8 (small glass) | \Box | $\left[\right] $ | W | $\left \right\rangle$ | \bigcirc | D | $\left \right\rangle$ | 0 | 0 | b 🔳 |
| | Tomato sauce (1/2 cup) e.g., spaghetti sauce | 0 | O | Ŵ | Ō. | O | D | Ó | Ó | Ô I | c = |
| $\textcircled{1} \qquad \textcircled{1}$ | Red chili sauce (1 Tbs) | \circ | \Box | Ŵ | $\Box \bigcirc$ | \bigcirc | D | 0 | 0 | $\left[\right]$ | d 🗖 |
| 2 2 2 | Tofu or soybeans (3–4 oz.) | 0 | \odot | Ŵ | 0 | 0 | D | O | O | 0 | e 🗖 |
| (4) (4) (4) | String beans (1/2 cup) | 10 | \Box | Ŵ | \Box | \Box | D | \Box | \Box | \bigcirc | f |
| B B B | Broccoli (1/2 cup) | 0 | O | W | O. | O. | D | LO. | 0 | 0 | g` 🗖 |
| (P) (P) (P) | Cabbage or coleslaw (1/2 cup) | 10 | \Box | W | \Box | \Box | D | $\overline{0}$ | $\left \right\rangle$ | $\left[\right]$ | h 🗖 |
| | | | | | | | | - | | / | ~ |
| | | | | | | | | | | | 】 |
| $\textcircled{1} \qquad \textcircled{1} \qquad \textcircled{1}$ | Cauliflower (1/2 cup) | 0 | 0 | Ŵ | O. | 0 | D | O. | 0 | | <u>i</u> = |
| 2 2 2 | Brussels sprouts (1/2 cup) | 10 | ΙÔ | Ŵ | \overline{O} | \overline{O} | D | 10 | \Box | $\overline{\mathbf{O}}$ | ĵ = |
| (4) (4) (4) | Carrots, raw (1/2 carrot or 2-4 sticks) | Ō | Ō | (W) | ĨÕ | Ō | D | ΙÕ | Ō | | k 🔳 |
| (8) (8) (8) | Carrots, cooked (1/2 cup) or carrot juice (2-3 oz.) | ĬŎ | ĨÕ | Ŵ | ĨÕ | Ō | D | ĨÕ | $\overline{\mathbf{O}}$ | | <u> </u> |
| (P) (P) (P) | Beets-not greens (1/2 cup) | ΤŎ | Ō | (W) | Ő | Õ | (D) | ĬŎ | Ō | TÕ 1 | m 🗖 |
| | Corn (1 ear or 1/2 cup frozen or canned) | Ŏ | ĨÕ | Ŵ | Ō | Õ | D | ΙÕ | Õ | Õ | n 🗖 |
| | Peas or lima beans (1/2 cup fresh, frozen, canned) | ŤŎ | Ŏ | Ŵ | Ŏ | Ŏ | D | Ŏ | ĨŎ | ŏ | • |
| | Mixed vegetables (1/2 cup) | ŤŎ | ĨÕ | Ŵ | ĨÕ | $\overline{\bigcirc}$ | D | ΤŎ | Õ | | p |
| | Beans or lentils, baked or dried (1/2 cup) | ĬŎ | ŏ | Ŵ | Ŏ | ŏ | Ď | Tŏ | ŏ | | (q) 🗖 |
| | Dark orange (winter) squash (1/2 cup) | ĬŎ | ĬŎ | Ŵ | Õ | $\overline{\cap}$ | D | Tõ | Tõ | | (r) = |
| | Eggplant, zucchini or other summer squash (1/2 cup) | Τŏ | ŏ | Ŵ | ŏ | Ŏ | (D) | ΤŎ | ŏ | | s - |
| | Yams or sweet potatoes (1/2 cup) | ŤŎ | Tõ | W | Ŏ | Õ | D | ĬŎ | Ŏ | | t = |
| | Spinach, cooked (1/2 cup) | ĬŎ | ŏ | Ŵ | ŏ | ŏ | Ó | ŏ | ĬŎ | | (u) 🗖 |
| | Spinach, raw as in salad (serving) | ĬŎ | Ő | Ŵ | Ő | Ň | D | ĬŎ | ĬŎ | | v 🗖 |
| | Kale, mustard, or chard greens (1/2 cup) | ĬŎ | ŏ | Ŵ | ŏ | Ĭň | Ō | tŏ | ŏ | | w |
| | Iceberg or head lettuce (serving) | 10 | 10 | Ŵ | 10 | $\overline{\cap}$ | D | ŏ | ΙÕ | | x |
| | Romaine or leaf lettuce (serving) | tŏ | ŏ | w | ŏ | ŏ | 0 | ŏ | 10 | | y = |
| | Celery (4" stick) | Tõ | Tõ | Ŵ | ŏ | 10 | D | 10 | ĬŎ | | z = |
| | Green peppers (3 slices or 1/4 pepper) | Τŏ | ŏ | Ŵ | Ĭŏ | Ř | D | tŏ | ŏ | | a |
| | Onions as a garnish, or in salad (1 slice) | 1 Å | 10 | Ŵ | ň | $\overline{\cap}$ | D | | | | b = |
| | Onions as a vegetable, rings or soup (1 onion) | | 1X | Ŵ | K | K | (D) | 1X | K | | c = |
| | and a set of the set o | | | U. U. | | | | | | <u> </u> | ¥ |
| | | EVER, OR | 1-3 | 1 | 2-4 | 5-6 | 1 | 2-3 | 4-5 | 6+ | |
| | | SS THAN E/MONTH | PER | PER WEEK | PER | PER WEEK | PER DAY | PER | 4-5 PER DAY | PER | P |
| | | | | WEEK | VVEEA | VVEER | DAT | | | | |
| | Eggs (1) Chicken with skin (4–6 oz.) | | - | Ŵ | $\left \begin{array}{c} \circ \\ \circ \end{array} \right $ | | | | | $\left \begin{array}{c} 0 \\ 0 \end{array} \right $ | |
| | | 10 | | | $\vdash \bowtie$ | $\left \begin{array}{c} 0 \\ 0 \end{array} \right $ | D | $\left \begin{array}{c} 0 \\ 0 \end{array} \right $ | $\left \begin{array}{c} 0 \\ 0 \end{array} \right $ | | b c |
| PLEASE | Chicken without skin (4–6 oz.) | | $\left \begin{array}{c} 0 \\ 0 \end{array} \right $ | W) | | 0 | | 0 | 10 | 3.44 | |
| TURN TO | Turkey, including ground (4–6 oz. or 2 turkey dogs) | | $ \circ\rangle$ | Ŵ | HX- | HX- | D | 10 | LQ | | <u>d</u> |
| PAGE 3 | Hot dogs (1) | 10 | $\left \begin{array}{c} \circ \\ \circ \end{array} \right $ | W | \bigcirc | \bigcirc | 0 | | Q | | e - |
| | Bacon (2 slices) | 10 | 10 | W | $\bot \bigcirc$ | \square | D | 10 | $\downarrow \bigcirc$ | | <u>1</u> |
| 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | | | a |) (2) (d | d) (0) (| t (g) | n; (1) (| 1) (k) (| l) (m) (n) | • ا |

| . (Continued |) Please fill i | n your AVERAGE use, DURING THE | | Α | VER | | | | | | STU |
|------------------------------|-----------------------|---|-------------------------|--|-------------|-------------------------|------------------------|-------------|-------------------------|-------------------------|--|
| | | pecified food. | NEVER, OR LESS THAN | 13 PER | 1 PER | 2-4 PER | 5-6 PER | 1 PER | 23 PER | 4-5 PER | 6+ PER |
| | | EGGS, MEAT, ETC. (continued) | ONCE/MONTH | MONTH | WEEK | WEEK | WEEK | DAY | DAY | DAY | DAY |
| X | | Processed meats, e.g., sausage, salami, bologna etc. (piece or slice) | i, O | $ \circ $ | Ŵ | 0 | 0 | D | 0 | 0 | 0 |
| | | Hamburger (1 patty) | 0 | 0 | Ŵ | \bigcirc | 0 | D | \bigcirc | 0 | 0 |
| | | Beef, pork, or lamb as a sandwich or mixed dish e.g., stew, casserole, lasagna, etc. | , 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Pork as a main dish, e.g., ham or chops (4–6 oz.) | | \Box | W | $\overline{\mathbf{O}}$ | $\left \right\rangle$ | D | $\overline{\mathbf{O}}$ | $\overline{\mathbf{O}}$ | \circ |
| | | Beef or lamb as a main dish, e.g., steak, roast (4-6 oz |) Õ | Ō | Ŵ | Ō | Ō | D | Ō. | Ō | Ō |
| | | Canned tuna fish (3–4 oz.) | 0 | 0 | Ŵ | 0 | \bigcirc | D | 0 | 0 | 0 |
| | | Dark meat fish, e.g., mackerel, salmon, sardines bluefish, swordfish (3–5 oz.) | , 0 | 0 | Ŵ | 0 | 0 | D | 0 | 0 | 0 |
| | | Other fish (3–5 oz.) | | \Box | W | \mathbf{O} | \circ | D | $\overline{\mathbf{O}}$ | 0 | \bigcirc |
| | | Shrimp, lobster, scallops as a main dish | Ó | Ŭ. | Ŵ | Ō. | Õ | D | Ō. | Ō | Ó |
| | | | NEVER, OR | 1-3 | 1 | 2-4 | 5-6 | 1 | 23 | 4-5 | 6+ |
|) (j) | (Î) | BREADS, CEREALS, STARCHES | LESS THAN ONCE/MONTH | PER | PER | PER WEEK | PER WEEK | PER | PER | PER DAY | PER DAY |
| 2 | 2 | Cold breakfast cereal (1 cup) | | -0 | (W) | | O | (D) | | | |
|) (4) | 4 | Cooked oatmeal/cooked oat bran (1 cup) | Ň | 1 | Ŵ | Ň | ŏ | D | ŏ | ň | ň |
|) (8) | 8 | Other cooked breakfast cereal (1 cup) | ŏ | ŏ | Ŵ | ŏ | ŏ | (D) | ŏ | ŏ | ŏ |
|) (P) | (P) | White bread (slice), including pita bread | Ō | $\overline{\mathbf{O}}$ | Ŵ | Õ | Ō | D | Õ | 0 | $\overline{\mathbf{O}}$ |
| | | Dark bread (slice), including wheat pita bread | 0 | O | W | O | Ō | () | Ō | Ō | Ō. |
| | | English muffins, bagels, or rolls (1) | 0 | 0 | Ŵ | 0 | \bigcirc | D | 0 | \bigcirc | \bigcirc |
|) ① | T | Muffins or biscuits (1) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
|) (2) | 2 | Brown rice (1 cup) | 0 | \bigcirc | W | \bigcirc | \bigcirc | D | 0 | \bigcirc | \bigcirc |
|) (4) | (4) | White rice (1 cup) | O I | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| 8 | 6 | Pasta, e.g., spaghetti, noodles, etc. (1 cup) | 0 | O | W | \bigcirc | \bigcirc | D | \bigcirc | \bigcirc | $ \bigcirc$ |
|) (P) | P | Tortillas (1) | | | Ŵ | 0 | 0 | D | 0 | 0 | 0 |
|) (1) | 1 | Other grains, e.g., bulgur, kasha, couscous, etc. (1 cu | 0 | | (W) | $\overline{\Delta}$ | 0 | (D) | | \sim | |
| 2 | 2 | Pancakes or waffles (serving) | | K | Ŵ | K | ŏ | (D) | ŏ | - X | K |
|) (4) | (4) | French fried potatoes (4 oz.) | ŏ | Ĭŏ | Ŵ | 10 | ŏ | D | ŏ | ŏ | 1ŏ |
|) (8) | 8 | Potatoes, baked, boiled (1) or mashed (1 cup) | ŤŎ | Ĭŏ | Ŵ | ŏ | ŏ | (D) | ŏ | ŏ | Ň |
|) (P) | P | Potato chips or corn chips (small bag or 1 oz.) | Ō | Ŏ | Ŵ | Ŏ | Ŏ | D | Ŏ | Ŏ | Ŏ |
| | | Crackers, Triscuits, Wheat Thins (5) | 10 | $\overline{0}$ | Ŵ | Ō | Ō | D | Ō | $\overline{\mathbf{O}}$ | Õ |
| | | Pizza (2 slices) | 0 | | Ŵ | 0 | 0 | D | 0 | \odot | 0 |
| | | | NEVER, OR | 1-3 | 1 | 2-4 | 5-6 PER | 1 | 2-3 | 4-5 | 64 |
| | | BEVERAGES | LESS THAN ONCE/MONTH | PER MONTH | PER WEEK | PER WEEK | PER WEEK | PER DAY | PER DAY | PER DAY | PER DAY |
| RBONATED | LOW- | Low-calorie cola, e.g., Diet Coke with caffeine | 0 | 0 | Ŵ | 0 | 0 | D | 0 | 0 | 0 |
| EVERAGES | CALORIE | Low-calorie caffeine-free cola | -10 | $\downarrow \bigcirc$ | W | 0 | \bigcirc | D | \bigcirc | $\lfloor \bigcirc$ | Q |
| nsider the ving size as 1 | (sugar free) TYPES | Other low-calorie carbonated beverage, e.g., Fre Diet 7-Up, diet ginger ale | sca, 🔘 | 0 | W | 0 | 0 | Ø | 0 | $ \circ $ | $ \circ \rangle$ |
| s, bottle or | | Coke, Pepsi, or other cola with sugar | | | Ŵ | | | D | \square | | |
| for these | TYPES | Caffeine Free Coke, Pepsi, or other cola with sugar | | 10 | Ŵ | 10 | ŏ | (D) | ŏ | K | HX |
| onated erages. | | Other carbonated beverage with sugar, e.g., 7-U | | $\left \begin{array}{c} \\ \\ \\ \end{array} \right $ | Ŵ | ŏ | ŏ | D | 10 | | R |
| | OTHER VERAGES | Hawaiian Punch, lemonade, or other non-carbonated fruit drinks (1 glass, bottle, can) | 0 | ŏ | Ŵ | ŏ | ŏ | O | ŏ | ŏ | ŏ |
| DE | VENAGES | Regular beer (1 glass, bottle, can) | | $\left \right\rangle$ | Ŵ | \cap | 0 | D | $\left \right\rangle$ | \cap | \cap |
| | | Light beer, e.g., Bud Light (1 glass, bottle, can) | Ĭŏ | ŏ | Ŵ | ŏ | ŏ | D | ŏ | ŏ | ŏ |
| | | Red wine (4 oz. glass) | ŏ | Ŏ | Ŵ | Õ | ŏ | (D) | Ŏ | Õ | Ő |
| | | White wine (4 oz. glass) | Ō | Õ | W | Ō | Ō | D | Ō | Ō | Ō |
| | | Liquer e a whickey ain etc /1 drink er chet) | 10 | 0 | W | 0 | 0 | D | 0 | \bigcirc | \Box |
| | | Liquor, e.g., whiskey, gin, etc. (1 drink or shot) | | provide a second se | 10205 | $1 \wedge$ | 0 | D | 0 | $ \cap$ | $ 0 \rangle$ |
| | | Plain water, bottled or tap (1 cup or glass) | 0 | 0 | Ŵ | 0 | | 4 | | | And the second |
| | | Plain water, bottled or tap (1 cup or glass) Tea (1 cup), not herbal tea | | 0 | Ŵ | 0 | 0 | D | Ō | Ŏ | 0 |
| | | Plain water, bottled or tap (1 cup or glass) Tea (1 cup), not herbal tea Decaffeinated coffee (1 cup) | | 0 | W W | 00 | 00 | D | 0 | Ŏ | 0 |
| al method o | f) Decaffeina | Plain water, bottled or tap (1 cup or glass) Tea (1 cup), not herbal tea Decaffeinated coffee (1 cup) Coffee with caffeine (1 cup) | inly espress | 000 | W W W | 000 | 000 | 0 0 0 | 000 | Ŏ O O | O O On't use |

| wo | MEN'S HEALTH STUDY | PAGE 4 | | | HA | RVA | RD | MEI | DICA | L SO | сно | |
|-----|---|---|--|-------------------------|---------------------|--|--|---------------|------------------|---------------------------------|--|-----------------|
| 4. | (Continued) Please fill in your AVERAGE use, DU PAST YEAR , of each specified food. | | | | | | | | | | | |
| | • | IESS | /ER, OR S THAN | 1-3 PER | PER | 2-4 PER | 5-6 PER | 1 PER | 23 PER | 4-5 PER | 6+ PER | |
| | SWEETS, BAKED GOO | | MONTH | MONTH | | WEEK | WEEK | DAY | DAY | DAY | DAY |)(P) — |
| | Chocolate (bar or packet) eg., Hershe | | $ \otimes$ | | W | 0 | Q | 0 | Q | \bigcirc | Θ | |
| | Candy bars, e.g., Snickers, Milky Way, | Reeses | Hŏ. | Ho - | W | Q | | D | 0 | 0 | $\left \begin{array}{c} 0 \\ 0 \end{array} \right $ | (d) (d) |
| | Candy without chocolate (1 oz.) Cookies, home baked (1) | | X | K | (W) (W) | 0 | $\left \begin{array}{c} 0 \\ 0 \end{array} \right $ | (D) (D) | $\overline{0}$ | \bigcirc | | c (d) |
| | Cookies, nome baked (1) Cookies, ready made (1) | | ŏ | K | W | 0 | ŏ | 0 | ŏ | 10 | lo- | (e) |
| | Brownies (1) | | ŏ | ĬŎ | W | ŏ | ŏ | D | Ŏ | $\overline{\mathbf{O}}$ | 10 | Ť |
| | Doughnuts (1) | | ŏ | ŏ | Ŵ | ŏ | ŏ | (D) | ŏ | ŏ | ŏ | (g) |
| | Cake, home baked (slice) | | ŏ | Õ | Ŵ | Ŏ | ŏ | D | Ŏ | Ŏ | ŏ | (h) |
| | Cake, ready made (slice) | | Õ | Õ | Ŵ | Õ | Ō | (D) | Ŏ | Õ | Ŏ | 1 |
| | Pie, homemade (slice) | | $\left \right\rangle$ | 0 | W | \bigcirc | \bigcirc | D. | 0 | \bigcirc | 0 | |
| | Pie, ready made (slice) | | \bigcirc | 0 | (W) | 0 | 0 | (D) | 0 | 0 | 0 | (k) 🗖 |
| | Sweet roll, coffee cake or other pastry | , home baked (serving) | \bigcirc | \bigcirc | W | \bigcirc | $ \bigcirc$ | D | 0 | \bigcirc | 0 | |
| | Sweet roll, coffee cake or other pastry | | 0 | 0 | W | 0 | 0 | (D) | 0 | 0 | 0 | <u>(m)</u> |
| | Jams, jellies, preserves, syrup, or hon | ey (1 Tbs) | \bigcirc | LQ_ | W | Q | 0 | D | Q | LÕ. | \bigcirc | (n) |
| | Peanut butter (1 Tbs) | | $ \circ $ | $ \circ$ | W | \odot | <u>o</u> | D | 0 | $ \overset{\circ}{\bigcirc} $ | O O | <u> </u> |
| | Popcorn (1 cup) | | $ \Theta $ | 10 | W | <u>Q</u> | 0. | D | 10 | LQ- | | p) |
| | Peanuts (small packet or 1 oz.) | a Managaran na Banana ang ang ang ang ang ang ang ang an | $\left \begin{array}{c} \circ \\ \circ \end{array} \right $ | 0 | W) W | 0 | 0 | 0 | \circ | No. | 0 | (q) (r) |
| | Other nuts (small packet or 1 oz.) Oat bran, added to food (1 Tbs) | | 10 | 0 | Ŵ | 0 | 0 | D | 0 | HX- | 0 | (s) |
| | Other bran, added to food (1 Tbs) | | ŏ | | Ŵ | Ŏ | Ŏ | D | 10 | K | $\overline{\bigcirc}$ | <u>)</u> |
| | Wheat germ (1 Tbs) | | 1ŏ | ŏ | (W) | ŏ | ŏ | D | ŏ | K | ŏ | (u) |
| | Chowder or cream soup (1 cup) | | ŏ | Ĭŏ | Ŵ | ŏ | ŏ | D | ŏ | No. | $\overline{\bigcirc}$ | (v) |
| | Olive oil salad dressings (1 Tbs) | Contract in the second s | ŏ | ŏ | Ŵ | ŏ | ŏ | Ô | ŏ | ŏ | ŏ | (w) |
| | Other oil and vinegar dressing, e.g., Ita | alian (1 Tbs) | Ŏ | Õ | Ŵ | ŏ | Ŏ | D | Õ | Õ | Õ | (x) |
| | Mayonnaise or other creamy salad dre | | Ŏ | Ŏ | Ŵ | Ŏ | Ŏ | D | Ŏ | Ŏ | Ŏ | (y) |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | Salt added at table (1 shake) | | 0 | 0 | W | 0 | \bigcirc | D | \bigcirc | \bigcirc | 0 | (z) = |
| | Garlic (1 clove or 4 shakes) | and she was a strength of strength of strength of the | O. | O | Ŵ | O | 0 | D | $ \bigcirc$ | $ \bigcirc$ | \bigcirc | (a) |
| 5 | Liver: beef, calf or pork (4 oz.) ONever OL | ess than 1/mo. 💫 🔿 1 | 1 | | 2–3 ma | |) 1/w | | | | | <u> </u> |
| | | | /mo. /mo. | ~~~ | 3 mo | * | | | more | | | _(a) = (b) = |
| | | becify brand and type (e.g., Kellog | | | | <u>. </u> | ~ | | | | 7 8 9 | |
| | usually eat? | | | | | | | | | | 7 8 9 | |
| | O Don't eat cold breakfast cereal | | | | | C | | | | | 7 8 9 | |
| | | |) 3 ts) 10 t | |)4ts)11t | |) 5 ts) 12 t | o (|) 6 ts) 13 t | р (|)7 tsp | |
| | When you have beef or lamb as a main dish, how | | | | 1 | | <u></u> | <u> </u> | <u></u> | | more | (8) |
| | - | 1edium well 🛛 🔿 Wel | | | n't kno | w/not | t eater | า | | | | _ |
| 9. | How often do you eat meat that was charred dur Never Less than 1/mo. 1/mo. 2 | ing cooking? (e.g., dur –3 mo. ① 1/week | ing ba | | ueing | | | | | | | (9) |
| 10. | How much of the visible fat on your beef, pork or Remove all visible fat Remove most | · lamb do you remove) Remove small part o | | | ng? Remov | /e nor | | | ı't eat | meat | | (10) |
| 11. | What kind of fat do you usually use for frying and | | xclud | le "Pa | | pe sp | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | | | mout | | (11) |
| 12. | What kind of fat do you usually use for baking at | home? | | | | | | | | | | (12) |
| 13. | Real butter | (Exclude "Pam"-type | spray |) |) Laro | <u>) t</u> | <u>) Don</u> | <u>'t use</u> | | | | (13) |
| 14. | Never Less than once a week 1–3 tim How often do you eat fried food away from home | | | | 1000 9.300 Q | | Daily | | 000000 | | | (14) |
| | ○ Never ○ Less than once a week ○ 1–3 tim | nes per week 04-6 | | | | | Daily | | | | | |
| | What type of cooking oil do you usually use at home (e.g., Mazola Corn Oil)? | pecify brand and type | | | | Ы | | | | | 789 789 | i i |
| 16. | How does your current diet compare to your usu | al diet over the past fiv loderately changed | | a rs? Greatly | y char | nged | | | | | | 16 |
| | Thank You! Please return this form in the | ne enclosed | Nomer | n's Hea | lth Stu | - dy • 90 | 0 Comr | nonwe | ealth A | ve. Eas | t | |
| • | postage-paid envelope to: | and a product of the second | soston | , MA O | 2215-1 | 204 | | | | | | |

| DU/ you 0 0 1 1 1 2 Are Y N 2 Are Y N 1 Core | IN'S HEALTH STUDY RING THE PAST MONTH, on how many L MISS taking your study pills? 0 days missed 1-5 days missed 6-10 11-15 days missed 16-29 days missed 6-10 0 umissed days, was it due to: 0 0 0 ost/misplaced calendar packs Vaca Side effects Difficulty remembering C you willing to continue taking the study pill Vaca You willing to continue taking the study pill C You willing to continue taking the study pill C You willing to continue taking the study pill C You willing to continue taking the study pill C You willing to continue taking the study pill C You willing to continue taking the study pill C You willing to continue taking the study pill C You willing to continue taking the study pill C You will the pill C You been diagnosed as having any of the fill C You been diagnosed | days r) Tool ottion Dther r | nissed a c none b easons 2 //// 2 //// 2 //// 3 | HARVARD M | YOUR STUDY f the following N0 et | , |
|--|--|--|---|--|---|---|
| you 0 If yo L 2. Are Y N N S. SIN have Plea Myc Stro Ang If Core Core Core Peri Mel Non | MISS taking your study pills? days missed 1-5 days missed 6-10 11-15 days missed 16-29 days missed u missed days, was it due to: ost/misplaced calendar packs Vaca Side effects Difficulty remembering 0 you willing to continue taking the study pill (res No SPECIFY REASON: CE YOU STARTED TAKING YOUR STUR e you been diagnosed as having any of the f ase indicate N or Y on each line. bocardial infarction (heart attack) boke or TIA (transient ischemic attack) pina pectoris F YES, angiogram? No Yes confirmed by: stress test? No Yes | days r) Tool ition)ther r is? DY P ollow N0 (N) (N) | nissed a c none b easons 2 //// 2 //// 2 //// 3 | PILLS, have you experienced any of Please indicate N or Y on each line. Symptoms suggestive of gastric upse Symptoms suggestive of peptic ulcer Nausea Constipation Diarrhea Skin discoloration Blood in urine (hematuria) Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | f the following N0 et (N) r (N) (N) (N) (N) (N) (N) (N) (N) | YES Y |
| If yo L L Y Y N S. SIN have Plea Myc Stro Corre Core Core Core Core Core Corre Corre Core Core Core Core Core C | 11-15 days missed 16-29 days missed 11-15 days missed 16-29 days missed ou missed days, was it due to: |) Tool ation Other r s? DY P follow N0 | easons 2 ILLS, 3 ing? YES V a | Symptoms suggestive of gastric upse Symptoms suggestive of peptic ulcer Nausea Constipation Diarrhea Skin discoloration Blood in urine (hematuria) Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | et (N) r (Z) (Z) (Z) (Z) (Z) (Z) (Z) (Z) (Z) (Z) | |
| If yo L L Are Y N S S S N N Have Plea Stro Stro Core Core Core Core Core Core Core Co | ou missed days, was it due to: .ost/misplaced calendar packs Vaca Side effects Difficulty remembering C you willing to continue taking the study pill C Yes SPECIFY REASON: C ICE YOU STARTED TAKING YOUR STUD C e you been diagnosed as having any of the fase indicate N or Y on each line. C ocardial infarction (heart attack) C bke or TIA (transient ischemic attack) C gina pectoris Tress test? No FYES, angiogram? No sonfirmed by: stress test? No Yes | ition Other r Is? DY P collow NO | easons 2 ILLS, 3 ing? YES (Y) a | Symptoms suggestive of peptic ulcer Nausea Constipation Diarrhea Skin discoloration Blood in urine (hematuria) Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | | Y Y <t< th=""></t<> |
| Ang Stro Core Core Core Core Core Core Core Co | ost/misplaced calendar packs Vaca Side effects Difficulty remembering C you willing to continue taking the study pill C Yes SPECIFY REASON: C <i>ICE YOU STARTED TAKING YOUR STUL</i> C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STULE</i> C <i>ICE YOU STA</i></i></i></i></i></i> | Dy P ollow N0 | 2 <i>ILLS,</i> 3. ring? YES (Y) a | Symptoms suggestive of peptic ulcer Nausea Constipation Diarrhea Skin discoloration Blood in urine (hematuria) Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | | Y Y <t< td=""></t<> |
| Ang Stro Core Core Core Core Core Core Core Co | ost/misplaced calendar packs Vaca Side effects Difficulty remembering C you willing to continue taking the study pill C Yes SPECIFY REASON: C <i>ICE YOU STARTED TAKING YOUR STUL</i> C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STUL C <i>ICE YOU STARTED TAKING YOUR STULE</i> C <i>ICE YOU STA</i></i></i></i></i></i> | Dy P ollow N0 | 2 <i>ILLS,</i> 3. ring? YES (Y) a | Nausea Constipation Diarrhea Skin discoloration Blood in urine (hematuria) Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | S S S S S S S S S S S S S S S S S S S | Y Y <t< td=""></t<> |
| Are Y N N Are SIN Plea Myc Stro Ang Core Core Core Core Core Core Core Core | Side effects Difficulty remembering C you willing to continue taking the study pill Yes No SPECIFY REASON: CE YOU STARTED TAKING YOUR STUR e you been diagnosed as having any of the f ase indicate N or Y on each line. Docardial infarction (heart attack) boke or TIA (transient ischemic attack) boke or TIA (transient ischemic attack) gina pectoris F YES, angiogram? No Yes confirmed by: stress test? No Yes | Is? DY P ollow N0 N | 2 <i>ILLS,</i> 3. ring? YES (Y) a | Diarrhea Skin discoloration Blood in urine (hematuria) Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | | Y |
| Are Y N N S S S Nyc S S Tro Plea S Tro Coro Coro Coro Coro Coro Coro Coro | you willing to continue taking the study pill (es No SPECIFY REASON: CE YOU STARTED TAKING YOUR STUE e you been diagnosed as having any of the f ase indicate N or Y on each line. cocardial infarction (heart attack) boke or TIA (transient ischemic attack) boke or TIA (transient ischemic attack) gina pectoris F YES, angiogram? No Yes confirmed by: stress test? No Yes | DY P ollow N0 (N) (N) | ring? YES (Y) a | Diarrhea Skin discoloration Blood in urine (hematuria) Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | | Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y |
| Stro Ang Corre Core Corre Core Corre Corre Corre | Fes SPECIFY REASON: ICE YOU STARTED TAKING YOUR STUR e you been diagnosed as having any of the fase indicate N or Y on each line. ocardial infarction (heart attack) oke or TIA (transient ischemic attack) gina pectoris FYES, angiogram? No Yes confirmed by: stress test? No Yes | DY P ollow N0 (N) (N) | ring? YES (Y) a | Blood in urine (hematuria) Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | | Y Y< |
| Ang Corre Corre Carce Peri Mel | Fes SPECIFY REASON: ICE YOU STARTED TAKING YOUR STUR e you been diagnosed as having any of the fase indicate N or Y on each line. ocardial infarction (heart attack) oke or TIA (transient ischemic attack) gina pectoris FYES, angiogram? No Yes confirmed by: stress test? No Yes | DY P ollow N0 (N) (N) | ring? YES (Y) a | Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | 2 2 2 2 2 | Y Y Y Y |
| SIN have Plea Myc Stro Stro Caro Coro Caro Caro Peri Mel | No ICE YOU STARTED TAKING YOUR STUR e you been diagnosed as having any of the fase indicate N or Y on each line. bocardial infarction (heart attack) boke or TIA (transient ischemic attack) gina pectoris F YES, angiogram? sconfirmed by: stress test? No Yes | ollow NO N | ring? YES (Y) a | Easy bruising Nose bleed (epistaxis) Other bleeding Skin rash | (R) (R) (R) (R) (R) (R) | (Y) (Y) (Y) |
| have Plea Myc Stro Ang Core Core Core Core Care Peri Mel Non | e you been diagnosed as having any of the f ase indicate N or Y on each line. Docardial infarction (heart attack) oke or TIA (transient ischemic attack) gina pectoris F YES, angiogram? No Yes confirmed by: stress test? No Yes | ollow NO N | ring? YES (Y) a | Other bleeding Skin rash | (N) (N) | Ŷ |
| have Plea Myc Stro Ang Core Core Core Core Care Peri Mel Non | e you been diagnosed as having any of the f ase indicate N or Y on each line. Docardial infarction (heart attack) oke or TIA (transient ischemic attack) gina pectoris F YES, angiogram? No Yes confirmed by: stress test? No Yes | ollow NO N | ring? YES (Y) a | Skin rash | (N) | ~~~ |
| Plea Myc Stro Ang IF Core Core Core Core Care Peri Mel Non | ase indicate N or Y on each line. ocardial infarction (heart attack) oke or TIA (transient ischemic attack) gina pectoris F YES, angiogram? No Yes confirmed by: stress test? No Yes | N0 (N) (N) | YES (Y) a | | | 10 |
| Myc Stro Ang Ir Corc Corc Corc Carc Peri Mel Non | ocardial infarction (heart attack) oke or TIA (transient ischemic attack) gina pectoris F YES, angiogram? No Yes confirmed by: stress test? No Yes | (N) (N) | (Ŷ) a | Fatigue | - N | 10000 |
| Stro Ang Coro Coro Coro Caro Peri Mel Non | oke or TIA (transient ischemic attack) gina pectoris F YES, angiogram? No Yes confirmed by: stress test? No Yes | N | | | | $\overline{\mathbf{Y}}$ |
| Ang Cord Cord Card Peri Mel Non | gina pectoris FYES, angiogram? No Yes confirmed by: stress test? No Yes | | | | `ww* | 200 |
| Correction Correction Correction Carce Peri Mel Non | FYES, angiogram? No Yes confirmed by: stress test? No Yes | (N) | (Ŷ) b | Have you <i>EVER</i> had any of the follo | wing? N0 | YES |
| Correction Correction Correction Carce Peri Mel Non | FYES, angiogram? No Yes confirmed by: stress test? No Yes | <u></u> | с (Y) с | Atrial fibrillation | (N) | (Y) |
| Corro Corro Carro Peri Mel Non | confirmed by: stress test? No Yes | | 1 | Deep vein thrombosis | (N) | Ŷ |
| Cord Card Peri Mel Non | onary angioplasty (PTCA) | | 2 | Pulmonary embolism | (N) | Y |
| Cord Card Peri Mel Non | | . (N) | (Ŷ) d | Osteoporosis | (N) | $\widetilde{\mathbf{Y}}$ |
| Carc Peri Mel Non | onary bypass surgery (CABG) | (N) | Y e | Fracture of hip or forearm after age | 40 N | Ŷ |
| Peri Mel Non | otid artery surgery (endarterectomy) | (N) | Ŷ 1 | Periodontal disease | (N) | Ŷ |
| Mel Non | ipheral artery surgery | N 2 | Ŷg | Gallstones | (N) | Y |
| | anoma | (N) | Y h | Gallbladder or gallstones removal | (N) | $\widehat{\mathbf{Y}}$ |
| | n-melanoma skin cancer | (N) | Ŷi | When was your <i>LAST</i> eye exam? | | |
| | F YES, type: basal cell unknown | ٦ | 1 | ○ Within past year ○ 1-2 years ago | 🔿 3-5 years a | ao |
| | squamous cell | | | | er had an eye ex | am |
| ///// ••••• Eiba | | | | | | |
| | rocystic or other benign breast disease | | | United and the second s | | |
| | FYES, breast biopsy No Yes | | ŶI | Have you EVER had macular degend In your RIGHT eye? No Yes | Not sure | seu: |
| | confirmed by: aspiration No Yes | | | In your LEFT eye? No Yes | \bigcirc Not sure | |
| | | | | Have you EVER had a cataract diag | | |
| Brea | ast cancer | N N | Y k | In your RIGHT eye? No Yes | ⊖ Not sure | |
| | er cancer (non-skin, non-breast) | N | (\mathbf{Y}) I | In your LEFT eye? No Yes | Not sure | |
| | F YES, SITE: | | \sim | Regarding YOUR infancy: | | |
| | 1 120, 0112. | | 2 | a) Were you breast fed? | | |
| Acti | ve or chronic liver disease or cirrhosis | N) | (Y) m. | ○ No ○ Yes ▶ Number of | months? | 26365 |
| | onic kidney failure | (N) | (Y) n | Not sure | | less |
| | eding hemorrhoids | Ň | (Ŷ) 0 | () 4-8 mon | | |
| | v other gastrointestinal bleeding | (N) | (Y) p | b) What was your birthweight in pounds | | |
| Ulce | | N | (Y) q | \bigcirc Unknown \bigcirc ≤ 5 lbs. 8 ozs. | | |
| | gulation disorder | (N) | $(\widehat{\mathbf{Y}})$ r | 5 lbs. 9 ozs6 lbs. 15 ozs. 7 | lbs8 lbs. 8 075 | |
| | ., Von Willebrand's disease) | \sim | | |) 10+ lbs. | |
| Gou | | (N) | (Y) s | c) Were you: | | |
| | temic lupus erythematosus | (N) | (Y) 1 | Full term 2 or more weeks prem | nature 🔿 Don' | ′t kno |
| | pertension (physician diagnosed) chique | Magal | Image: Weight of the second | d) Were you a twin, triplet or other mult | -507 | |
| | vated cholesterol (physician diagnosed) | N) | (Y) V | No Yes | PIO NILLI | |
| <u> </u> | er major illness | (N) | (Y) W | | | |
| | F YES, SPECIFY MAJOR ILLNESS: | | 1 NO2000 | In the PAST YEAR , how many cold | s have you had | 17 |
| | | | | |) More than 10 c | |
| - | | | e | For a <u>typical cold</u> in the pas | M8 ² | uo |
| λre | you CURRENTLY taking anti-coagulants | | LA | a) For how many days were sympt | 10.078.M.A.G., 1.5.R.M.E. 1. 7. 7. 7. | cent? |
| | ., Coumadin, Heparin)? | | | \bigcirc 1-3 days \bigcirc 4-7 days \bigcirc N | | |
| (e.g. () N | - | | | b) For how many days were you us | | . to include o |
| | ······ | | | None () 1-3 days () 4-7 d | (ACA) ACAS (2012) 2012 34 10 1200 Y 100 Y 100 | , 100 |
| . Are | you CURRENTLY taking any corticosteroid | • | E | More than a week | uγo | 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 |
| | you CONNEWTLY taking any controsteroids | | 5 | CINIOLO HIAH & WEEK | Zanazar (daidai) | 28 8 6 9 |

| | | | | | RDI | | | | |
|--|--|---------------------------------------|--------------------------------------|--------------------------------------|---------------------------------|--------------------------|---------------------------------|------------------|---|
| DURING THE PAST MONTH, on approxima | | | | | DAY | S IN T | HE PAS | ST MON | NTH |
| of the following (do <u>not</u> count your study pills |): Please respond on ea | ch line: | | | 0 | 1-3 | 4-10 | 11-20 | 21+ |
| Acetaminophen (e.g., Tylenol, Datril) | | | | n ha gyrad | <u>Q</u> : | <u>. O _</u> | | O_{1} | <u>'O.</u> |
| Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin) | | · | | | \underline{Q} | \bigcirc | \bigcirc | \bigcirc | <u></u> |
| Medications containing aspirin (e.g., Alka-Seltzer, | | | | | \bigcirc | -0: | <u>.04</u> | | <u> () </u> |
| Nonsteroidal, anti-inflammatory agents (e.g., Mo | otrin, Advil, Nuprin, Napro | osyn, Feldene, Me | ediprin) | | \bigcirc | \bigcirc | \bigcirc | \bigcirc | 0 |
| Multivitamins | | | | | \bigcirc | | <u>101</u> | <u></u> | <u> </u> |
| Individual supplements of beta-carotene (not incl | | | | | \bigcirc | \bigcirc | \bigcirc | \bigcirc | \bigcirc |
| Individual supplements of vitamin E (not includin | | <u> 전 1 명령</u> 은 동품은 | udes des | | \bigcirc | <u></u> | | \odot | -0 |
| Individual supplements of vitamin A (not includir | ng multivitamins) | | | NI-24070- | \bigcirc | <u> </u> | \Box | 0 | <u> </u> |
| Other vitamin preparations containing Specify vitamin A, C, E, or beta-carotene | EXACT BRAND and TYPE: | | | i e | 01 1 | yO Alexa | | | * O4 |
| DURING THE PAST YEAR , what was your a | waraga tima nar | | | | | R WEE | | | |
| week spent at each of the following recreatio | | 7010 | | | One | 1.5 | 2-3 | 4-6 | 7+ Hr. |
| | | Zero | i sangi i | Min. | Hr. | Hr. | Hr. | Hr. | nı. |
| Walking or hiking outdoors (include walking | | | | | $\frac{1}{1}$ | $\frac{100}{6}$ | | | $\frac{1}{2}$ |
| Jogging (slower than 10 minute miles) | | | | | \bigcirc | $\frac{\nabla}{\nabla}$ | | | |
| Running (10 minute miles or faster) Bicycling (include stationary machine) | <u>erter i setter en setter en setter i s</u> | <u>en esta en set</u> | | 21 | $\frac{O}{O}$ | \sim | | | <u>000</u> |
| , , , | | | | $\frac{1}{2}$ | 1930 | | | | $\frac{\vee}{2}$ |
| Aerobic exercise/aerobic dance/exercise mac | | <u>estatic y</u> h | | | 2 | $\frac{2}{2}$ | \sim | <u>- 102 - 1</u> | $\frac{\bigcirc}{\frown}$ |
| Lower intensity exercise/yoga/stretching/toni | ing Management | | | | $\frac{0}{2}$ | $\frac{1}{2}$ | | \sim | $\frac{\bigcirc}{\sim}$ |
| Tennis, squash, or racquetball | <u> 등록 성명</u> 동의 것을 물질했다. 일종의 | | | | \bigcirc | <u>=();</u> | - CO - C | | |
| Lap swimming | | | $\Box \Box \Box$ | \bigcirc | \cup | \bigcirc | \cup | \cup | Q |
| What is your usual walking pace outdoors? | | | | | | | | | |
| O Don't walk regularly Easy, casual (less t | • | al, average (2-2.9 | mph) | | | | | | |
| | riding (4 mph or faster) | | | | | | | | |
| • On average, how many <i>flights</i> of stairs (not in | | | | | | | | | |
| ○ None ○ 1-2 flights ○ 3-4 flights ○ 5-9 | ə flights 🛛 10-14 flights | 15 or more | flights | | | | | | |
| b) Diastolic (mmHg): <a><65 65-74 75- • What is your CURRENT serum cholesterol lev | | · · · · · · · · · · · · · · · · · · · | - () Un | knowr | n/not | check | ed with | nin 2 ye | ears |
| <140 mg/dl ◯ 140-159 ◯ 160-179 ◯ | 180-199 | 220-239 wn/not checked v | 4004 | 0-249 | C | 250- | 259 | | |
| 270-279 280-299 300-329 | | | | years | | | | <u> </u> | 60-269 |
| ○ 270-279 ○ 280-299 ○ 300-329 | | | | years | | | | <u></u> 21 | 60-269 |
| 270-279 280-299 300-329 |) Yes | | | years | | | | <u></u> 20 | 60-269 |
| 270-279 280-299 300-329 Have you <i>EVER</i> had a mammogram? No Have you <i>EVER</i> used fertility drugs (e.g., Clon In the <i>PAST YEAR</i> , have you noticed any cha | o Yes nid)? No Yes | · | | years | | | | <u></u> 21 | 60-269 |
| 270-279 280-299 300-329 Have you EVER had a mammogram? No Have you EVER used fertility drugs (e.g., Clon In the PAST YEAR, have you noticed any cha No change Memory improved For identification and validation purposes, ple | Yes nid)? No Yes ange in your memory? Memory worse wase provide us again with YEAR b) Your Social | th: | | | | | | <u></u> 20 | 60-269 |
| 270-279 280-299 300-329 Have you EVER had a mammogram? No Have you EVER used fertility drugs (e.g., Clon In the PAST YEAR, have you noticed any cha No change Memory improved For identification and validation purposes, ple a) Your birthdate: MONTH | Yes nid)? No Yes ange in your memory? Memory worse wase provide us again with YEAR b) Your Social Security Nur | th: | | | | | | <u> </u> | 60-269 |
| 270-279 280-299 300-329 Have you EVER had a mammogram? No Have you EVER used fertility drugs (e.g., Clon In the PAST YEAR, have you noticed any cha No change Memory improved For identification and validation purposes, ple MONTH DAY a) Your birthdate: Image Please indicate the name, address and phone number of someone at a DIFFERENT PERMANENT ADDRESS whom we might contact AD | o Yes nid)? No Yes ange in your memory? Memory worse ease provide us again with the security Nur Security Nur NAME: | th: | | | | | | | 60-269 |
| 270-279 280-299 300-329 Have you EVER had a mammogram? No Have you EVER used fertility drugs (e.g., Clon In the PAST YEAR, have you noticed any cha No change Memory improved For identification and validation purposes, ple a) Your birthdate: MONTH DAY Max Please indicate the name, address and phone number of someone at a DIFFERENT PERMANENT ADDRESS whom we might contact | > Yes nid)? No Yes ange in your memory? Memory worse Memory worse vase provide us again wight YEAR b) Your Social Security Nur NAME: | th: | PHO | | |) EM-155 | | C 20 | |
| 270-279 280-299 300-329 Have you EVER had a mammogram? No Have you EVER used fertility drugs (e.g., Clon In the PAST YEAR, have you noticed any cha No change Memory improved For identification and validation purposes, ple MONTH DAY a) Your birthdate: Please indicate the name, address and phone number of someone at a DIFFERENT PERMANENT ADDRESS whom we might contact | Yes nid)? No Yes Ange in your memory? Memory worse Wasse provide us again with the security Nur YEAR b) Your Social Security Nur NAME: DRESS: ATE/ZIP: | th: | PHO! Mark R | NE NO eflex® b | y NCS | | 599:32 | Printed i | |
| 270-279 280-299 300-329 Have you EVER had a mammogram? No Have you EVER used fertility drugs (e.g., Clon In the PAST YEAR, have you noticed any chan No change Memory improved For identification and validation purposes, ple a) Your birthdate: MONTH DIFFERENT PERMANENT ADDRESS whom we might contact if we are unable to contact you: | Yes nid)? No Yes Ange in your memory? Memory worse Wasse provide us again with the security Nur YEAR b) Your Social Security Nur NAME: DRESS: ATE/ZIP: | th: nber: | _ PHO Mark R | NE NO eflex® b | y NCS Omen | 's Hea | 599:32 th Stu | Printed i | |
| 270-279 280-299 300-329 - Have you EVER had a mammogram? No - Have you EVER used fertility drugs (e.g., Clon - Have you EVER used fertility drugs (e.g., Clon - In the PAST YEAR, have you noticed any chan - No change Memory improved - For identification and validation purposes, ple - A) Your birthdate: - Please indicate the name, address and phone number of someone at a DIFFERENT PERMANENT ADDRESS whom we might contact if we are unable to contact you: 1 1 1 1 | o Yes nid)? No Yes ange in your memory? Memory worse asse provide us again with the second sec | th: nber: | _ PHO Mark R | NE NO reflex® b Wc 90 | y NCS omen) Con | 's Hea hmon | 599:32 Sth Stuwealth | Printed i | |
| 270-279 280-299 300-329 - Have you EVER had a mammogram? No - Have you EVER used fertility drugs (e.g., Clon - Have you EVER used fertility drugs (e.g., Clon - In the PAST YEAR, have you noticed any cha - No change Memory improved - For identification and validation purposes, ple - AD response indicate the name, address and phone number of someone at a DIFFERENT PERMANENT ADDRESS whom we might contact if we are unable to contact you: 1 1 1 1 1 1 1 1 | o Yes nid)? No Yes ange in your memory? Memory worse wase provide us again with the security Nur Year b) Your Social Year b) Your Social Security Nur NAME: | th: nber: | _ PHO Mark R | NE NO eflex® b Wc 900 Bo | y NCS omen) Con ston, | 's Hea nmont MA 0. | 599:32 Sth Stuwealth 2215 | Printed i | |
| 270-279 280-299 300-329 Have you EVER had a mammogram? No Have you EVER used fertility drugs (e.g., Clon In the PAST YEAR, have you noticed any cha No change Memory improved No change Memory improved Solution Memory improved No change Memory improved No change Memory improved No change Memory improved No change Memory improved Please indicate the name, address and phone number of someone at a DIFFERENT PERMANENT ADDRESS whom we might contact if we are unable to contact you: 1 1 1 1 1 1 1 1 1 2 2 2 2 2 1 1 1 1 1 1 | > Yes nid)? No Yes ange in your memory? Memory worse vase provide us again wight year b) Your Social year b) Your Social Security Nur NAME: DRESS: ATE/ZIP: 1 1 2 2 4 4 | th: hber: | PHO Mark R U. URN IN THE | NE NO eflex® b Wc 900 Bo | y NCS omen) Con ston, | 's Hea hmon | 599:32 Sth Stuwealth 2215 | Printed i | |

| INSTRUCTIONS: Use a #2 pe marks; and keep handwriting | though y ncil; plea | ou may se com | y be encour pletely dar | | n comp | lying wi | th the p | rotocol | |
|---|--|---|--|---|--|--|---|--|-------|
| FOR EACH of the THREE stud red capsule; amber capsule), below the percentage of pills over the PAST SIX MONTHS. | please in you hav | dicate | - | 3. <i>SINCE WE LA</i> months ago), (Darken in <i>NC</i> provide the m complete the | have yo ^y or <i>YES</i> onth an | u had ar to each d year o | ny of the item. H f diagne | e follow F <i>YES</i> , p osis and | lease |
| For each agent, indicate the percentage of pills <i>TAKEN</i> over the past six months. | WHITE PILL | RED CAPS | AMBER CAPS | a. Myocardial infa | irction | NO O | YES | S M(|)/YR |
| Took 100%, or missed none | | 0 | | b. Stroke or TIA | | 0 | - O | sundir | / |
| Took 93 - 99%, or missed only a few | 0.4 | 0 | 0 W | c. Angina pectori d. Coronary angio | | | <u> </u> | and a second | / |
| Took 75 - 92%, or missed between 2 - 6 weeks | | | | e. Coronary bypa (CABG) | | | | | / |
| Took 67 - 74%, or missed between 6 - 8 weeks | | | | f. Pulmonary em g. Deep vein thro | | | <u> </u> | | |
| Took 50 - 66%, or missed between 2 - 3 months | | | | h. Colon polyps i. Melanoma | | Ö Norios | 0 | | |
| Took 33 - 49%, or missed between 3 - 4 months | | <u> </u> | | j. Non-melanom k. Breast cancer | a skin car | State of the second | <u> </u> | i William (| |
| Took less than 33%, or missed more than 4 months | | | | I. Other cancer: s | ite | $-\frac{1}{2}$ | Ő | 82898)- | / 1 |
| IF YOU MISSED TAKING YOUR | | | | n. Peptic ulcer n. Bleeding hemo | rrhoide | | the second se | | / |
| PILLS, WHAT WAS THE MAIN REASON? | <u>.</u> | | | o. Any other gast | THE REPORT OF A DESCRIPTION OF A DESCRIP | ् | | | |
| a. Symptoms suggestive of gastr b. Symptoms suggestive of pepti | | 000 | | a. I may be less likely to get heart disease/ cancer in the future. | Most Important | Very Important | Somewhat Important | Slightly Important | Impor |
| c. Nausea d. Constipation e. Diarrhea | | | | b. A family member or friend had heart disease/cancer. | 0 | Ō | 0 | 0 | C |
| e. Diarmea f. Skin discoloration g. Blood in urine (hematuria) | | | <u> </u> | c. Taking the daily study pills may make me feel | 6 | 6 | 6 | | C |
| | | 0 | () (n | healthier. | | | | | |
| | | <u>80%</u> 6 | | d. I want to contribute to understanding ways to prevent | \sim | | | | |
| i. Nose bleed (epistaxis) j. Skin rash | | | 0.0 | | \subseteq | | | Sugar S | 1 |
| | | <u></u> | | disease. e. Other: specify | | | | 0.00 | 1840 |
| i. Nose bleed (epistaxis) j. Skin rash k. Fatigue I. Headache | | <u>Š</u> | | disease. | 0 | | | | |
| i. Nose bleed (epistaxis) j. Skin rash k. Fatigue I. Headache CONSENT FORM If you responded YES to any of t information we request will be u confidence. | he items i sed solely | n <i>QUES</i> | <i>TION #3,</i> ple dical statistic | disease. e. Other: specify ase <i>COMPLETE</i> and <i>SIC</i> al purposes and maint | GN the co ained in 1 | onsent fo the strict | rm belov est profe | v. The ssional | |
| i. Nose bleed (epistaxis) j. Skin rash k. Fatigue I. Headache CONSENT FORM If you responded YES to any of t information we request will be u confidence. I hereby grant permission to Dr. Avenue East, Boston, MA 02215 | he items i sed solely Julie Bur i, to reviev | n <i>QUES</i> for meaning, Ass w a cop | CTION #3, ple dical statistic sociate Profe y of the reco | disease. e. Other: specify ase <i>COMPLETE</i> and <i>SIC</i> al purposes and maint essor, Harvard Medical ords of my hospitalizati | GIV the co ained in t School, on or tre | onsent fo the strict 900 Con eatment f | rm belov est profe nmonwe or: | v. The ssional alth | |
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Mark Reflex® by NCS EM-152720:321 Printed in U.S.A.

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| WOMEN'S HEALTH ST | UDY | | FORM | 12 PAGE 1 HARVARD MEDICAL SCHOOL |
|---|---|--|--------------------------|---|
| | | | | elope provided. It is important that we receive a <i>RESPONSE</i> untering no difficulty in complying with the protocol. |
| INSTRUCTIONS: Use a #2 p marks; and keep handwriti | | | | arken the response circle; erase cleanly; make no stray (es. |
| 1. FOR EACH of the THREE st red capsule; amber capsule below the percentage of pi over the PAST SIX MONTH |), please i lls you hav S. WHITE PILL | ndicate ve <i>TAKI</i> RED CAPS | EN AMBER CAPS | 4. What is your CURRENT level of blood pressure? a) Systolic (mmHg): <110 110–119 120–129 130–139 140–149 150–159 160–169 170–179 180+ Unknown b) Diastolic (mmHg): <65 65–74 75–84 85–89 |
| Took 100%, or missed none | O | 0 | O | 90-94 95-104 105+ Unknown c) IN THE PAST YEAR, have you been diagnosed by a physician as |
| Took 93–99%, or missed only a few | Ó | 0 | O | b) the second s |
| Took 75–92%, or missed between 2–6 weeks | 0 | 0 | 0 | No () Yes d) Are you CURRENTLY being treated with medication for high |
| Took 67–74%, or missed between 6–8 weeks | õ | 0 | | blood pressure? |
| Took 50–66%, or missed between 2–3 months | Ŏ | 0 | | 5. What is your <i>CURRENT</i> blood cholesterol level? |
| Took 33–49%, or missed between 3–4 months | ō | 0 | 0 | a) () <140 mg/dl () 140–159 () 160–179 () 180–199 () 200–219 () 220–239 |
| Took less than 33%, or missed more than 4 months | 0 | 0 | O | ○ 240-249 ○ 250-259 ○ 260-269 ○ 270-279 ○ 280-299 ○ 300-329 |
| 2. IN THE PAST YEAR, have y experienced any of the following the followi | DU | NO | YES | having high cholesterol? No Yes Are you <i>CURRENTLY</i> being treated with cholesterol-lowering |
| a. Symptoms suggestive of ga | stric uneat | | | medication? |
| d. Symptoms suggestive of ga b. Symptoms suggestive of pe c. Nausea d. Constipation e. Diarrhea | In all and the second | | | 6. Do you <i>CURRENTLY</i> smoke cigarettes? |
| f. Skin discolorationg. Blood in urine (hematuria)h. Easy bruisingi. Nose bleed (epistaxis) | | 000 | Q. | IF YES: On average, number of cigarettes you smoke EACH DAY? 1-4 cigs. 5-14 cigs. 25-35 cigs. 36-44 cigs. 45+ cigs. |
| j. Skin rash k. Fatigue I. Drowsiness m. Headache | | 0 0 0 0 | | I In the PAST YEAR, how many colds have you had? |
| 3. IN THE PAST YEAR, have you had: | NU | YES, for mptoms | YES, for screening | a) For how many days were symptoms usually present? |
| a. A physical exam b. Blood pressure check c. Blood cholesterol check d. Rectal exam e. Stool occult blood test | | | | b) For how many days were you usually confined to home? None 1–3 days 4–7 days More than a week |
| f. Colonoscopy or | reelation (California | comercentition of the second | | 8. Have you EVER been <u>diagnosed by a physician</u> as |

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sigmoidoscopy

h. Breast exam by doctor

IF YES, in how many months?

Breast self-exam

07-11 months

g. Pelvic exam

i. Mammogram

() 1 month

ŏ

Õ

O

2-3 months

① 12 months (1) (2) (3) (4) (5) (6) (7) (8) (9) (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (0)

Õ

 \bigcirc

 \cap

 \bigcirc

◯ 4–6 months

having any of the following? If yes, provide YEAR of FIRST diagnosis. YR of DX NO YES

| a. Parkinson's disease | (Y) 🕷 | | |
|---------------------------------|-----------|---|-----------|
| b. Asthma | (Y) # | | (b) (C) 🚥 |
| c. Other chronic lung disease | | | |
| (e.g., emphysema, chronic | | | |
| bronchitis, bronchiectasis) 🔊 🔊 | Y | 8 | (c) () 💻 |
| | | | |

| OMEN'S HEALTH STUDY 9. IN THE PAST YEAR, have you h | nad | any of | the fo | llowing | PAGE 2 HARVARI | m. If <i>Y</i> | ES, ple | |
|---|----------------------------------|---|--|---|--|-------------------|-------------------|---|
| - | ursingsinger: iP | - | and co | - | e the consent form at the bottom of | | r. minasionnionis | DX |
| | NO | YES | MŐ/YF | | | NO | YES | MO/YR |
| | N | (Y) | | (a) | Peptic ulcer | N | Ý | |
| Stroke | N | Ŷ | | b)() | Gout | N | | |
| | N | | | - C | Diabetes mellitus | <u>N</u> | | and the second se |
| Angina pectoris IF YES, confirmed by: | |) 🕐 🏓 | * | d | Colon polyp | <u>(N)</u> | (Y) | |
| and the state of the second | | | | | Osteoporosis | <u>(N)</u> | (Y) | |
| angiogram? () No () Yes stress test? () No () Yes | 田田 | | | | Fractures IF YES, hip (N) (Y) | | | |
| Coronary angioplasty (PTCA) | (N) | 10 | 1 | (e) | foot (Nt (Y) | | | |
| Coronary bypass surgery (CABG) | N | (Y) | | 10 | arm (N) Y | | | |
| | N | (Y) = | and the second s | | wrist (N) Y | | | |
| Peripheral artery surgery | N | (Y) | | h | other N Y Specify: | | | |
| Intermittent claudication | N | \odot | 22 | U. | | | | |
| Pulmonary embolism (PE) | N | Ŷ | | | Macular degeneration RIGHT eye | <u> </u> | | 111 |
| Deep vein thrombosis (DVT) | (N) | 0 | <u> </u> | k | Macular degeneration LEFT eye | <u>N</u> | | |
| Melanoma | N N | | <u> </u> | -9.0 | Cataract RIGHT eye | <u> </u> | | 5. C |
| Non-melanoma skin cancer | \mathbb{P} | (Y) 🍽 | | | Cataract LEFT eye | N | (Y) | |
| IF YES, basal cell unknown type: squamous cell | | | | | Multiple sclerosis | <u>(N)</u> | | |
| type: 🕜 squarnous cell | | | | X235 | Amyotrophic lateral sclerosis (ALS) Systemic lupus erythematosus (SLE) | <u>(N)</u> | | |
| Fibrocystic or other benign breast disease | (N) | (Y) | <u>⊳006600</u> ∗ / | _ n_(_) | Rheumatoid arthritis (Dr. diagnosed) | <u>(N)</u> | (Y) | |
| IF YES, confirmed by: breast biopsy? No Yes aspiration? No Yes | | | L | | IF YES, Rheumatoid factor: Negative/unknown OPositi | ve | | |
| | ~ | | a 1 | _ | | | | |
| Breast cancer | <u>(N)</u> (N) | (Y) => (Y) => | | • | Other arthritis | <u>(N)</u> (N) | (Y) (Y) | |
| Lung cancer Colon cancer | | (\mathbf{w}) | | P | Joint pain or joint swelling Hip replacement | <u> </u> | | the second se |
| Other cancer | (N) | $\mathbf{\hat{v}}$ | Contraction of the second second | T | Knee replacement | (N) | (Y) | |
| | |] ~ [| | 1.00 m 2.04 | Scleroderma | N | (Y) 🕸 | |
| IF YES, SITE: | | | | | Dermatomyositis or polymyositis | N | (Y) 📫 | |
| | | | | | Sjögren's syndrome | (N) | (Y) 100 | |
| | | | | | Any other connective tissue disorder | N | Ý | > / |
| Active or chronic liver disease | | | | | (including mixed) | | | |
| or cirrhosis | N | (\mathbf{r}) | 1 | s | Other major illness | <u>(N)</u> | (Y) 🕪 | · [/ |
| Chronic kidney failure | N | (Y) | | ् | IF YES, SPECIFY MAJOR ILLNESS: | | | |
| Migraine headaches | N | (Y) 🐢 | | u | | 0 | | |
| Bleeding hemorrhoids | N | (Y) | | v | | | | |
| | | <u> </u> | | | | | | |
| Coagulation disorder | N | (Y) 🗭 | - / | (x | | | POR CAL | |
| Coagulation disorder CONSENT FORM IF YES TO AN PLEASE CO If you responded YES to any of the items a solely for medical statistical purposes and | N N N T bove main | TEM AB NUE O please ntained in | OVE, P ON BAC COMPL n the str | LEASE (CK PAG ETE and ictest co | COMPLETE THIS CONSENT FORM. OTH SE. SIGN the consent from below. The information fidence. rd Medical School, 900 Commonwealth Aven | on we re | quest wi | ll be use |
| to review a copy of the records of my hosp | ig, As italiz | ssociate ation or | treatme | or, Harva ent for: | ra Medical School, 900 Commonwealth Aven | ue East, | Boston, | IVIA UZZIS |
| DIAGNOSIS: | | | DA | TES OF | HOSPITALIZATION/TREATMENT: | | | |
| Name of hospital/physician: | | | | | | | | |
| Address of hospital/physician: | | | | | | - | | |
| City: | | | | | State: Zi | p: | | |
| YOUR FULL NAME AT TIME OF DIAG | NOS | IS: | | | | | | |
| | | | | | | | | |
| YOUR SIGNATURE: | | | | | | | | |

| | TH STUDY | | RM 12 | PAG | E 3 | | VARD | VIEL | ЛСА | LSC | Ю |
|--|---|--|--|---|---|--|---|--|--|---|--|
| | ST MONTH, on ap | nrovimately by | | v dave | did you tel | ID#: | | | HF PAS | ST MON | ЛТН |
| | (do <u>not</u> count you | | | | | | 0 | 1–3 | | 11-20 | 21+ |
| Acetaminophen (e.g | | | | | | | | -02 | 60 | 0 | |
| The second s | Bufferin, Anacin, Exc | edrin) | GRUICTRAIDADACT | NGROATING (CH3) | nen en en regen en en elle si rat | andar and an and a state of the second | | | | | |
| | ning aspirin (e.g., Alka | | . Doan's | Pills, Dai | von. Fiorinal |) | <u>ista</u> | Č | 1 ÓS | Õ | |
| | nflammatory agents (| | | | | | | $\overline{\bigcirc}$ | $\left \right\rangle$ | \cap | () |
| Multivitamins | | Specify EXACT BRAND | | | | 1 (i) | te de | Ĩ | ST S | - Ó | |
| | | | , | | | | | | | | |
| | | | | | | | | | | | |
| Individual supplem | ents of vitamin C (not | including multivi | itamins) | | | and and the statement of the statement of the | | ANCHESING AND | | | |
| | ents of beta-carotene | - | | ins) | | | sex à l | Ť | - OA | Ŏ | |
| Contraction of the second se | ents of vitamin E (not | A DIG. DIGA DALAMA ANALYSING ANALYSING AN A STREET | Sectore and the sector of a statement of the sector of the | ALIC TO DESCRIPTION | <u>koka manaka mang</u> angk | <u> 1996 - 1997 - 19</u> | | | | \cap | $\overline{\bigcirc}$ |
| And and a second s | ents of vitamin A (not | | | | | | <u>serñ</u> e | Ň | 0 | ŏ | ă. |
| Other vitamin prepa | | Specify EXACT BRAND | | | | | | () | \cap | | |
| beta-carotene, vitan | | opecity <u>Louis</u> Divise | and Fri E. | | | | Sec. of | Sound | "New!" | ~~~ | Sec. P |
| (not including mult | | | | | | | | | | | |
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| | used DES (diethyls ▹ a) Counting ALL preg | | | | | | AL MONTHS | 20923 | 55566 | ustati | 663663 |
| | b) YEAR of FIRST use | | | OI OOL (| | | | | | | |
| · · | c) YEAR of LAST use | | | | | | | | | | |
| | | | | | | 50000000 | | 944 <u>9466</u> | gestaut | | 910-20 |
| Have your mensi PERMANENTLY? | trual periods cease | 54 | AG | Έ. | ▶b) For wha | t reacon did | Vour perio | de cor | se? | 9793-59 | Second |
| No: Premenopau | | 🍽 a) Age 🚥 | |] *** | | GERY: If due | | | | overie | n na sanganging Ngangganging Nganggang |
| - | al periods | natural | (0) | 0 | And the second se | or uterus ren | Burthan and a state of the | SUCCESSION REPORT | NEW TOTAL PLACE | | |
| | use but now have | periods | (1) | 0 | | oth ovaries r | 8~35~844 | | | | |
| periods indu | iced by hormones | ceased? | 2 | 2 | | ne ovary rer | | n all an air air an air air air air air an air air air air air | | Second | |
| ◯ Not sure | | | (3) | 3 | AND A CALIFFERENCE TO | terus remov | | | | | |
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| replacement hor | mones (other than ora , a) How many montl used them? | al contraceptives) ? hs have you | historius said said | (5) (6) | NATI have | JRAL: If natu you had sul | ıral (non-s osequent | surgic: surger | al) mer y to re | move | e, |
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| replacement hor No Yes, some currently | mones (other than ora a) How many month used them? () 1–2 mo. () 3–4 mo. (| al contraceptives) ? hs have you _) 7–8 mo. _) 9–10 mo. | · (5) | 5 6 7 8 | ◯ NATI have ovari ◯ N | JRAL: If natu you had sul es or uterus o | ural (non-s osequent ? (Mark A O C | surgic: surger <u>LL</u> th)ne ov | al) mer y to re at appl ary ren | move γ) noved | |
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| N | OMEN'S HEALTH STUDY | FORM 24/PAG | E 1 🔨 📕 | IARVA | RD ME | DICAL SCHOO | DL |
| 1a. | Are you CURRENTLY taking your WHS pills? | | | NO | YES | Dx MO/YR | |
| | | C. | Coronary angioplasty (PTCA) | | | | (c) |
| \frown | FOR EACH of the TWO study agents (white pill; amber capsu | d. | Coronary bypass surgery (CABG) | | . 🗆 👄 | · <u></u> | (d) |
| | indicate below the percentage of pills you have | e. | Stroke | | , 🗔 🚔 | * <u></u> | · · · · |
| | TAKEN over the PAST YEAR. | f. | TIA (transient ischemic attack) | | , 🗖 🖶 | 1 | (f) |
| | WHITE AN | BER 9. | Carotid artery surgery (endarterectomy | | | | (g) |
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| | Took 100%, or missed none | <u> </u> | Intermittent claudication | | | | |
| | Took 93-99%, or missed | | Pulmonary embolism (PE) | | | - <u> </u> | (j) |
| | | <u> </u> | Deep vein thrombosis (DVT) | | _⊢ ⇒ | en <u>en en e</u> | • • • |
| | Took 75-92%, or missed between 1-3 months | | Melanoma | | _∟. ⇒ | | () |
| | Took 67-74%, or missed | <u> </u> | Non-melanoma skin cancer | | _ ∟ ➡ | | (m) |
| | | 🗖 (🖞 – 🗛 stad | IF YES, type: Dasal cell | | | | |
| | Took 50-66%, or missed | | ☐ squamous cell ☐ unknown | | | | |
| | between 4-6 months | | | | | . <u> </u> | · (n) |
| | Took 33-49%, or missed | | Breast cancer | | | | |
| | between 6-8 months | 0. | | | | | • • • |
| | Took less than 33%, or missed | p. | Colon cancer Other cancer (non-skin) | | | <u>.</u> | (q) (q) |
| | | | IF YES, SPECIFY SITE: | لسبا | | | (Y) |
| | | | IF TES, SPECIFT SITE. | | · . | | |
| | If you missed taking your pills, what was the main reason? | r. | Peptic ulcer | - . [] | | 6. <u>1</u> | (r) |
| | | '' s. | Gout | П | | | |
| 2. | IN THE PAST YEAR, have you | | Diabetes mellitus | Ē | | | (t) |
| ۷. | experienced any of the following? | | Colon polyp | | | | (u) |
| | | D YES v. | Active or chronic liver disease | | 100 | · · · · · · · · · · · · · · · · · · · | |
| | a. Symptoms suggestive of gastric upset | | or cirrhosis | | . 🗖 🔿 | | (v) |
| | b. Symptoms suggestive of peptic ulcer |) 🔲 W. | Chronic kidney failure | | | 2 | (w) |
| \sim | c Nausea | х. | Migraine headaches | | | | (x) |
| | d. Constipation | ј 📋 У. | Bleeding hemorrhoids | | | | (y) |
| | e. Diarrhea | a service relation of the service serv | Any other gastrointestinal bleeding | | j 🗖 🔿 | | (z) |
| | f. Skin discoloration | | Coagulation disorder | | | - | (aa) |
| | g. Blood in urine (hematuria) | bb. | Fibrocystic or other benign breast disease | | | | |
| | h. Easy bruising |] | IF YES, confirmed by: | | ຸ 🛄 🚔 | | (bb) |
| | 1. Nose bleed (epistaxis) | | breast biopsy? | | | | |
| | j. Skin rash | | aspiration? | | | | |
| | k. Fatigue | | Macular degeneration RIGHT eye | П | | | (cc) |
| | I. Drowsiness | | Macular degeneration LEFT eye | | | | (dd) |
| | m. Headache | | Cataract RIGHT eye | | | | (aa) (ee) |
| 3. | IN THE PAST YEAR, were you newly diagnosed with any of the | | Cataract LEFT eye | | | | (00) (ff) |
| | Check NO or YES for each item. If YES, please provide the mo | ionoming. | Cataract extraction RIGHT eye | | | | (gg) |
| | year of diagnosis and complete the consent form at the bottom of | | Cataract extraction LEFT eye | | | | (hh) |
| | NO YES DX MO | | Multiple sclerosis | | | | (ii) |
| | a. Myocardial infarction (heart attack) | (a) jj. | Other major illness | | | | (ii) |
| | b. Angina pectoris | (a) " | IF YES, SPECIFY MAJOR ILLNESS: | | | A LA LA | |
| | IF YES, confirmed by: | (~/ | | | | * | |
| | | | | | | <u></u> | |
| | | | | | | | . ` |
| | stress test? | | | | | ÷ . | |

CONSENT FORM If you responded YES to any of the items above, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.

I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

| DIAGNOSIS: | · · · · · · · · · · · · · · · · · · · | DATES OF HOSPITALIZATION/TREATMENT: | | | | |
|---------------------------------------|---------------------------------------|---|--|--|--|--|
| ne of hospital / physician: | | | Phone #: | | | |
| Address of hospital/physician: | | | | | | |
| C | ;ity: | State: | Zip: | | | |
| YOUR FULL NAME AT TIME OF D | | and the second secon | a da se a companya da se a tanàna amin'ny faritr'i da sa ana amin'ny faritr'i da sa ana amin'ny faritr'i da sa | | | |
| YOUR SIGNATURE: | | | | | | |
| · · · · · · · · · · · · · · · · · · · | Signed | | Date | | | |

| W | /OMEN'S HEALTH STUDY FORM 24/PAGE 2 | | | | | |
|-----|--|---------------|----------|-----------|--------------------|---------|
| 4. | DURING THE PAST MONTH, on approximately how many DAYS did you take any | DA | YS IN | THE PA | ST MO | NTH |
| | of the following (do not count your study pills)? Please respond for each item: | 0 | 1-3 | 4-10 | 11-20 | 21+ |
| | Acetaminophen (e.g., Tylenol, Datril) Aspirin, (e.g., Bayer, Bufferin, Anacin, Excedrin) | | | | | |
| | Medications containing aspirin (e.g., Alka-Seltzer, Sine-Off, Doan's Pills, Fiorinal) | D | | | | |
| | Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Mediprin) Multivitamins: Specify brand name. | | | | | |
| | Specify: contains Vitamin A (including beta-carotene)? INO Ves - content IU | | | | | |
| | contains Vitamin E? □ No □ Yes → content IU Individual supplements of vitamin C (not including multivitamins) | | | | | |
| | Individual supplements of beta-carotene (not including multivitamins) | | | 0 | | -0 |
| | Individual supplements of vitamin E (not including multivitamins) | | | | | |
| | Individual supplements of vitamin A (not including multivitamins) | | 0- | ° О | | |
| | Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) Specify EXACT BRAND and TYPE: | | | | | |
| | Do you CURRENTLY smoke cigarettes? □ No □ Yes ⇒ IF YES, on average, how many cigarettes do you smoke EACH DAY? □ 1-4 cigs. □ 5-14 cigs. □ 15-24 cigs. □ 25-35 cigs. □ 36-44 cigs. | □ 4 | 5+ cig | js. | | |
| 6. | Did you EVER breast-feed? | | | | | |
| | No ☐ Yes ➡ IF YES, age you FIRST breast-fed? years old age you ENDED breast feeding? years old TOTAL MONTUP | | | | | |
| | TOTAL DURATION (in months) you breast-fed (for all pregnancies): TOTAL MONTHS | | | | h f . | |
| 7. | How often did you participate in strenuous (aerobic) physical activity or sports at least twice per week (e.g. swin basketball, cycling, running)? | iming, | aerobi | cs, tiela | поскеу, | |
| | During high school (please average): I Never I 1-3 months/yr I 4-6 months/yr I 7-9 During ages 18-22 (please average): I Never I 1-3 months/yr I 4-6 months/yr I 7-9 | | | | 12 mont 12 mont | |
| ß | a. Between the AGES OF 18 AND 30 (excluding illness and pregnancy-related changes): | | | | | |
| Ų. | What was your: Minimum weight Ibs. ➡ AND Maximum weight Ibs. | | | | | |
| | b. Between the AGES OF 18 AND 30, how many times did you lose EACH of the following amounts of weig pregnancy-related changes)? | ht on j | ourpos | e (exclu | ding illne | ess and |
| | 5-9 lbs: 🖸 0 times 🔲 1-2 times 🗍 3-4 times 🗍 5-6 times 🗐 7 + tim | es i | | Don't I | mow | |
| | 10-19 lbs: 0 times 1-2 times 3-4 times 5-6 times 7+ tim | | | Don't I | | |
| | 20-49 lbs: 0 times 1-2 times 3-4 times 5-6 times 7+ tin | 185 | L C |] Don't I | know | |
| | 50 + lbs: \Box 0 times \Box 1-2 times \Box 3-4 times \Box 5-6 times \Box 7 + times | les | [| Don't I | know | |
| | c. What is your CURRENT weight? Ibs. | | | | | |
| 9. | Have you EVER used permanent hair dyes? (Do not count dyes that rinse out with washing.) | | | | | |
| | □ No □ Yes → IF YES, ANSWER (a) and (b) below: | | 1 | _ | | |
| | a. How often at EACH AGE? Not Used Every 2-4 weeks Every 5-7 weeks Every 8-1 | 134 6TC | S | Every | 13+ we | eks |
| | Prior to age 40 Image: Control of the second s | Service State | | | | |
| | Ages 50-59 | | | | D . | |
| | Ages 60 + | | | | | |
| 0 | b. TOTAL DURATION (in years) of permanent hair dye use? TOTAL YEARS The following assists us in maintaining follow-up: | | | | | |
| ••• | a. Please provide us with your phone number(s) so we may contact you if we are unable to reach you through t | he mai | 1: | | | |
| | HOME:() WORK:() | | | | | |
| | b. Please indicate the name, address and phone number of SOMEONE AT A DIFFERENT PERMANENT ADDRE unable to contact you: | | | - | | |
| | NAME: PHONE NO.: () | | | | | |
| | ADDRESS: STATE/ZIP: | | | | | |
| 1. | For identification and validation purposes, please provide us again with: a) Your birthdate: AND → b) Your Social Security Number: | | | | | |
| | MO DAY YR | | <u> </u> |] | | |

Bomming Health Study

FORM 36/PAGE 2

| 1a. Are you CURRENTLY | taking ANY of | your WHS pills? | 🗆 No | 🗌 Yes |
|-----------------------|---------------|-----------------|------|-------|
|-----------------------|---------------|-----------------|------|-------|

b. FOR EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have TAKEN over the PAST YEAR.

| ۵ | |
|---|--|
| | |
| | |
| | |

2. IN THE PAST YEAR, have you experienced the following?

| and the second | NO | YES |
|--|----|-----|
| a. Symptoms suggestive of gastric upset | | D |
| b. Symptoms suggestive of peptic ulcer | | |
| c. Nausea de la contracta de la | E | |
| d. Constipation | | |
| e. Diarrhea | | |
| f. Skin discoloration | | |
| g. Blood in urine (hematuria) | | |
| h. Easy bruising | | |
| i. Nose bleed (epistaxis) | | |
| j. Skin rash | | |
| k. Fatigue | | |
| I. Drowsiness | | |
| m. Headache | | |

| 3. | IN THE PAST YEAR, were you newly diagnosed with any of the following? Check NO or YES for EACH item. If YES, please provide the month and |
|----|--|
| | year of diagnosis and complete the consent form at the bottom of this page. |
| | NO YES DX MO/YR |

| а | Active or chronic liver disease | 110 | 120 | DA WO/TH | |
|----|-------------------------------------|------|-------|------------|-----|
| ц. | or cirrhosis | | | | (a) |
| b. | Chronic kidney failure | | - 🗆 🔿 | | (b) |
| c. | Migraine headaches | | | | (c) |
| d. | Bleeding hemorrhoids | | | · | (d) |
| e. | Any other gastrointestinal bleeding | | `□ ⇒ | | (e) |
| f. | Coagulation disorder | | | | (f) |
| | PL | EASE | GO TO | NEXT COLUM | N |

review a copy of the records of my hospitalization or treatment for:

Signed

request will be used solely for medical statistical purposes and maintained in the strictest confidence.

| AG | IE 2 HARV | ARL | | CAL SCHOOL |
|----------|--|-----|-------------|------------|
| | | NO | YES | Dx MO/YR |
| g. | Myocardial infarction (heart attack) | | | (9 |
| h. | Angina pectoris | | | (|
| | IF YES, confirmed by: NO YES | | | |
| | angiogram/cardiac cath? | | | |
| | stress test? | - | - | |
| i. | Coronary angioplasty (PTCA) | Ц | | (|
| | IF YES, # of vessels | · · | | |
| j. | Coronary bypass surgery (CABG) | | | (|
| 1. | IF YES, # of vessels | | E 1 | |
| k. | Stroke | | | (|
| I. | TIA (transient ischemic attack) | | | (|
| m. | Carotid artery surgery (endarterectomy) | | | (n |
| n. | Peripheral artery surgery (not varicose veins) | | | (r |
| о. | Intermittent claudication | | | |
| p. | Pulmonary embolism (PE) | | | |
| q. | Deep vein thrombosis (DVT) | | | (0 |
| r. | Melanoma | | | (|
| s. | Non-melanoma skin cancer | | | |
| | IF YES, type: 🗌 basal cell | | | |
| | 🗌 squamous cell | | | |
| | 🗆 unknown | | | |
| t. | Breast cancer | | | (|
| u. | Lung cancer | | | (u |
| ٧. | Colon cancer | | | (|
| w. | Other cancer (non-skin) | | | (v |
| | IF YES, SPECIFY SITE: | | | |
| x. | Peptic ulcer | П | <u>гл</u> _ | () |
| у. | Gout | | | |
| у. z. | Diabetes mellitus | | | |
| | Colon polyp | | | (aa |
| | Fibrocystic or other benign breast disease | | | (bt |
| | IF YES, confirmed by: NO YES | | | |
| | breast biopsy? | | | |
| | aspiration? | | | |
| cc. | Macular degeneration RIGHT eye | | | (co |
| | Macular degeneration LEFT eye | | | (do |
| | Cataract RIGHT eye | | | (00 |
| | Cataract LEFT eye | | | (st |
| | Cataract extraction RIGHT eye | | | (gg |
| | Cataract extraction LEFT eve | | | (98 |
| | | | | |

| Other | major | nness |
|-------|--------|--------|
| IF YE | S. SPE | ECIFY: |

ii.

CONSENT FORM If you responded YES to any of the items above, please COMPLETE and SIGN the consent form below. The information we

I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to

_____ DATES OF HOSPITALIZATION/TREATMENT: __

_____ State: _____ Zip: ____

_____ Phone #: _____

(ii)

City: ______
YOUR FULL NAME AT TIME OF DIAGNOSIS: ___

| • • | | | | | | |
|-----|------|-----|---------|-------------|------|--|
| | | | | | | |
| v | חוור | 010 | Shi A 7 | HIDE. | | |
| | JUH | 210 | 3NA I | URE: | | |

Name of hospital/physician: ____ Address of hospital/physician:

DIAGNOSIS:

• _ . . .

Date

FORM 36/PAGE 3

HARVARD MEDICAL SCHOOL

DAYS IN THE PAST MONTH

DX

| 4. | SINCE YOU STARTED THE TRIAL (about 3 years ago), have you had any of the following? | |
|----|---|--|
| | IF YES, please provide the month and year of diagnosis. | |

| ES, please provide the month and year of diagnosis. | NO | YES | DX MO/YR |
|---|----|-------|-------------|
| a. Gallstones IF YES, Did you have symptoms? | | | |
| b. Gallbladder removal | | | |
| c. Periodontal disease (specify number of teeth lost:) | | | |
| d. Kidney disease (NOT kidney stones): specify type: | | · 🗆 🛶 | |
| e. Elevated cholesterol (diagnosed by a clinician) | | | |
| f. Hypertension (diagnosed by a clinician) | | | |
| g. Asthma | | | |
| h. Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis) | | | |

5. Are you CURRENTLY being treated with:

| | NO | YES | |
|--|----|-----|-----------------|
| a. Oral medication for diabetes? | | П | |
| b. Insulin injection? | | | |
| c. Cholesterol-lowering medication(s)? | Π | | Specify Med(s): |
| d. Anti-hypertensive medication(s)? | | | Specify Med(s): |

6. DURING THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do not include your study pills. Please respond for each item.

Γ

0 1-3 4-10 21+ 11-20 a. Acetaminophen (e.g., Tylenol, Excedrin P.M.) \square b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) c. Medications containing aspirin (e.g., Alka-Seltzer, Sine-Off, Doan's Pills, Fiorinal) d. Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Aleve) e. Multivitamins: Specify brand name: П Π Π Specify: Does multivitamin contain vitamin E? IU Contain vitamin A (including beta-carotene)? No Yes - content IU f. Individual supplements of vitamin C (not including multivitamins) \square g. Individual supplements of beta-carotene (not including multivitamins) Π h. Individual supplements of vitamin E (not including multivitamins) \square Π i. Individual supplements of vitamin A (not including multivitamins) Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) j. Specify EXACT BRAND and TYPE:

7. What is your CURRENT weight? ____ ___ pounds.

| 8. | DURING THE PAST | YEAR, what was | your approxim | ate average | time per week |
|----|------------------------|----------------|---------------|-------------|---------------|
| | spent at each of the | | | | |

| | Zero | 1-19 Min. | 20-59 Min. | Une Hr. | 172 Hr. | Z-3 Hr. | 4-6 Hr. | / + Hr. |
|--|------|--------------|---------------|------------|------------|------------|------------|------------|
| a. Walking for exercise (include walking to work, hiking, treadmill) | | | | | | | Π | |
| b. Jogging (slower than 10 minute miles) | | | | | | | | |
| c. Running (10 minute miles or faster) | a | | | | | | | |
| d. Bicycling (include stationary machine) | | | | | | | | |
| e. Aerobic exercise/aerobic dance/exercise machines | | | | | | | | |
| f. Lower intensity exercise/yoga/stretching/toning | | | | | | | | |
| g. Tennis, squash, or racquetball | | | | | | | | |
| h. Lap Swimming | | | | | | | | |
| i Other: Please specify activity | | m | | | r-1 | - - | | |

TIME PER WEEK

| WOMEN'S HEALTH STUDY | FORM 36/PAGE 4 |
|--|---|
| 9. Have your menstrual periods ceased PERMANENTLY? Yes: No menstrual periods Yes: Had menopause, but now have periods induced by hormones No: Premenopausal Not Sure | At what AGE did your periods cease? b. For what REASON did your periods cease? SURGERY: If due to surgery, were your ovaries and/or uterus removed? (Mark <u>ALL</u> that apply) Uterus removed One ovary removed Both ovaries removed Both ovaries removed RADIATION or CHEMOTHERAPY NATURAL: If natural (non-surgical) menopause, have you had subsequent surgery to remove ovaries or uterus? (Mark <u>ALL</u> that apply) |
| 10. IN THE PAST YEAR, have you used female replacement hormones (other than oral contraceptives)? | No, did not have surgery One ovary removed |
| □ No □ Yes, currently □ Yes, discontinued ↓ ↓ a. ESTROGEN: Did you use ESTROGEN in the PA | Uterus removed Both ovaries removed |
| □ 1-2 mo. □ 3- 2. What type of ESTROG □ Oral Premarin □ Vaginal Estrogen 3. If you used ORAL COM □ DID NOT USE OR/ □ .30 mg/day or less □ .625 mg/day (brown 4. If you used ORAL or P □ DID NOT USE OR/ □ DID NOT USE OR/ □ A. | n) |
| No Yes → 1. In the PAST YEAR, for 1-2 mo. 3. What type of PROGES Oral Vagin 3. If you used ORAL MEE DID NOT USE ORA < 5 mg 5 4. If you used ORAL PRO DID NOT USE ORA | DROXY PROGESTERONE (e.g., Provera, Cycrin), what dose did you usually take? AL MEDROXY PROGESTERONE -9 mg |

11. Have you EVER used PERMANENT hair dye (do NOT include dyes that rinse out)? Don't Remember No Yes IF YES: Please indicate below the color(s) and years of use for each.

| USED? | | | | IF YES, NUMBER OF YEARS USED (APPROXIMATELY) | | | | | | | |
|-----------------|-------------------|----|-----|--|---------|----------|-----------|-----------|-----------|----------|--|
| DYE COLOR | Don't Remember | No | Yes | < 1 YR | 1-5 YRS | 6-10 YRS | 11-15 YRS | 16-20 YRS | 21-25 YRS | > 25 YRS | |
| a. Blonde | | | | | | | | | | | |
| b. Red/Auburn | | | | | | | | | Ū, | | |
| c. Light Brown | D | | | | | D | D | | | | |
| d. Medium Brown | | | | | | | | | | | |
| e. Dark Brown | D | | | | | | | | | | |
| f. Black | | | | | | | | | | · [] | |
| g. Silver Gray | | | | | | | | | | | |
| h. Other Color | | | | | | | | | | | |

12. Did either of YOUR PARENTS EVER have macular degeneration of the retina?

| | Unknown | No | Yes | If Yes: what age? | | | | | |
|-----------|---------|----|-----|-------------------|----------|-------------|--|--|--|
| a. Mother | | | | before age 60 | age 60 + | age unknown | | | |
| b. Father | | | | | | | | | |

THANK VOUL DI FASE CALL (800) 633-6911 IF VOULHAVE ANY OUESTIONS

| WC | MEN'S HEALTH STUDY | Yomonth | FORM 48 | B/PAC | E 2 HAR | VARD M | EDICA | L SCHOOL | - |
|-------|---|----------------------------|---------------------|---------------|---|----------|--------|-----------------------|--------------|
| 1a. A | are you CURRENTLY taking the | WHITE PILLS? | 🗆 No 🔲 Yes | NEW | LY DIAGNOSED IN PAST YEAR? | NO | YES | Dx MO/YR | |
| A | are you CURRENTLY taking the | AMBER CAPS? | 🗆 No 🗌 Yes | ١. | Asthma | | □ ⇒ | | (I) |
| | or EACH of the TWO study age | | er capsule), please | m. | Other chronic lung disease | | □ ⇒ | <u> </u> | (m) |
| | ndicate below the percentage or MKEN over the PAST YEAR. | r pills you nave | | | (e.g., emphysema, chronic bronchitis, bronchiectasis) | | | | |
| | | WHITE | AMBER | n. | Elevated cholesterol (dx by clinician) | | | | (n) |
| - | | PILL | CAPS | o. | Hypertension (dx by clinician) | | | | (0) |
| | Took 100%, or missed none | | | р. | Melanoma | | | | (p) |
| | Took 93-99%, or missed only a few | | | q. | Non-melanoma skin cancer | | | | (q) |
| | Took 75-92%, or missed | | | | IF YES, type: 🔲 basal celi | | | | (-1/ |
| - | between 1-3 months | | | | 🗔 squamous cell | | | | |
| | Took 67-74%, or missed between 3-4 months | | | | 🗆 unknown | | | | |
| | Took 50-66%, or missed | | | r. | Breast cancer | | | <u></u> | (r) |
| | between 4-6 months | | | s. | Lung cancer | | | | (s) |
| | Took 33-49%, or missed between 6-8 months | | | t. | Colon cancer | | | <u></u> | (t) |
| | Took less than 33%, or missed | | | u. | Other cancer (non-skin) | | | | (u) |
| | more than 8 months | | | | IF YES, SPECIFY SITE: | | | | |
| | Took none, or missed all | | | | | _ | | | |
| | If you missed taking your pills, w | /hat was the main re | eason? | ۷. | Colon polyp | | | | (v) |
| L | | | | w. | Fibrocystic or other benign breast disease | | | | (w) |
| | N THE PAST YEAR have you | | llowing? | | | | | | |
| ·F | Please check NO or YES for EA | <u>CH</u> item. | NO YES | | breast biopsy? | | | | |
| | a. Symptoms suggestive of gas | tric upset | | | aspiration? | | | | |
| | b. Symptoms suggestive of pep | | | x . | Diabetes mellitus | | | | (x) |
| | c. Nausea | | | у. | Gout | | | | (y) |
| | d. Constipation | | | z. | Peptic ulcer | | □ ⇒ | | (z) |
| | 1. Diarrhea | | | aa. | Gallstones | | □ ⇒ | | (aa) |
| ļ | f. Skin discoloration | | | | IF YES, how diagnosed? | | | | |
| ŀ | g. Blood in urine (hematuria) | | | | 🗋 x-ray, ultrasound | | | | |
| | h. Easy bruising | | | | other | _ | | | |
| | i. Nose bleed (epistaxis) j. Skin rash | | | bb. | Gallbladder removal | | | | (bb) |
| | k. Fatigue | | | cc. | Active or chronic liver disease or cirrhosis | | | | (cc) |
| ĺ | I. Drowsiness | | | dd. | Kidney disease (NOT kidney stones) | | □ ⇒ | | (dd) |
| | m. Headache | | | | IF YES, specify type: | | | | 、 |
| 3. I | N THE PAST YEAR, were you I | NEWLY DIAGNOS | ED with any of the | | | | | | |
| f | ollowing? Please check NO or YE | S for EACH item. If \ | ES, please provide | ee. | Chronic kidney failure | | | مهنيو ويتعاد والمراجع | (ee) |
| | he month and year of diagnosi he next page. | s and complete th NO YE | | ff. | Migraine headaches | | | | (ff) |
| | | | _ | gg. | Bleeding hemorrhoids | | | <u></u> | (gg) |
| | a. Myocardial infarction (heart a | • | _]. ➡ (a) | hh. | Any other gastrointestinal bleeding | | | | (hh) |
| Ł | Angina pectoris | | □ ➡ (b) | ii. | Coagulation disorder | | □ ⇒ | | (ii) |
| | IF YES, confirmed by: angiogram/cardiac cath? | | | jj. | Periodontal disease | | | <u> </u> | (ij) |
| | stress test? | | | | IF YES, # teeth lost: | - | | | |
| c | c. Coronary angioplasty (PTCA) | | □ → (c) | kk. | Macular degeneration RIGHT eye | | | | (kk) |
| | IF YES, # of vessels | | | II. | Macular degeneration LEFT eye . Cataract RIGHT eye | | | | (II) (mm) |
| c | d. Coronary bypass surgery (CA | | □ ➡ (d) | mm nn. | Cataract LEFT eye | | | | (mm) (nn) |
| | IF YES, # of vessels | | _ | 00. | Cataract extraction RIGHT eye | | | <u> </u> | (00) |
| 6 | e. Stroke | | □ ➡ (e) | оо. pp. | Cataract extraction LEFT eye | | | | (00) (pp) |
| ئے | TIA (transient ischemic attack | · | □ ➡ (f) □ ➡ (g) | qq. | Other major illness | | | | (qq) |
| ŀ | Carotid artery surgery (endar . Peripheral artery surgery (not | ·····,,, | □ ➡(9) □ ➡(h) | | IF YES, SPECIFY: | | | | |
| 1 | veins) | | (1) | | | | | | 1 |
| i | | | □ ➡ (i) | • | IF YES TO ANY OF THE ITEM | IS IN QU | JESTIC |)N # 3, PLE | ASE |
| j | . Pulmonary embolism (PE) | | □ ➡ (j) . | \mathbf{A} | COMPLETE THE CONSENT | FORM | АТ ТН | E TOP OF | THE |
| ł | c. Deep vein thrombosis (DVT) | | | \mathcal{J} | NEXT PAGE. OTHERWISE F | LEASE | CONT | INUE WITH | 1#4. |
| | | | | | | | | | |

FORM 48/PAGE 3

HARVARD MEDICAL SCHOOL

DAYS IN THE PAST MONTH

0 1-3 4-10 11-20 21+

CONSENT FORM If you responded YES to any of the items in question # 3, please COMPLETE and SIGN the consent form below. The information we request will be used solely for medical statistical purposes and maintained in the strictest confidence.

I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Medical School, 900 Commonwealth Avenue East, Boston, MA 02215, to review a copy of the records of my hospitalization or treatment for:

| DIAGNOSIS: | DATES OF HOSPITALIZATION/TREATMENT: | · · · · · · · · · · · · · · · · · · · |
|--------------------------------------|-------------------------------------|---------------------------------------|
| Name of hospital/physician: | Phone # : | |
| Address of hospital/physician: | | |
| City: | State: Zip: | |
| YOUR FULL NAME AT TIME OF DIAGNOSIS: | · | |
| YOUR SIGNATURE: | Date | |

 DURING THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do NOT include your study pills. Please respond for each item.

| a. Acetaminophen (e.g., Tylenol, Excedrin P.M.) | C. | | | Ð | D. |
|---|----|---|---|---|-------|
| b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) | | | | | |
| c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal) | D | D | D | D | D |
| d. Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Feldene, Aleve) | | | | | |
| e. Multivitamins: Specify brand name: | | | | | ٦ |
| f. Individual supplements of vitamin C (not including multivitamins) | | | | | |
| g. Individual supplements of beta-carotene (not including multivitamins) | | Ð | D | D | |
| h. Individual supplements of vitamin E (not including multivitamins) | | | | | ~ ` \ |
| i. Individual supplements of vitamin A (not including multivitamins) | | D | П | | 4 |
| j. Other vitamin preparations containing beta-carotene, vitamin E or vitamin A (not including multivitamins) Specify EXACT BRAND and TYPE: | | | | | |

| ase record your average consumption of the following beverages the LAST YEAR: | Never or Less Than One / Month | 1-3 Per Month | 1 Per Week | 2-4 Per Week | 5-6 Per Week | 1 Per Day | 2-3 Per Day | 4-5 Per Day | 6+ Per Day |
|---|--------------------------------------|---------------------|------------------|--------------------|--------------------|-----------------|-------------------|-------------------|------------------|
| a. Beer (1 glass, bottle, can) | | | W | | | D | | | |
| b. Red wine (include sherry, port) (4 oz. glass) | | | W | | | D | | | |
| c. White wine (4 oz. glass) | | | W | | | D | | | |
| d. Liquor (e.g., vodka, rum, gin, liqueur, brandy) (one drink or shot) | | | W | | | D | | | |

6. Do you CURRENTLY smoke cigarettes?

5.

□ No □ Yes → IF YES, on average, how many cigarettes do you smoke EACH DAY?

| 🗌 1-4 cigs. | 🗌 5-14 cigs. |
|-------------|--------------|
|-------------|--------------|

25-35 cigs.

 \Box 36-44 cigs. \Box 45 + cigs.

7. Have you EVER been diagnosed with any of the following conditions? IF YES, please provide month and year of diagnosis.

15-24 cigs.

| | · · · | NO | YES | Dx MO/YR | | | NO | YES | Dx MO/YR |
|----|-----------------------------------|-------|----------|--|--------------|---------------------------------------|-------|----------|-----------|
| | a. Congestive heart failure | | | ······ | f. | Urinary incontinence | | □ ⇒ | |
| | b. Left ventricular hypertrophy | | | <u></u> | 9 | Depression | | □ ⇒ | <u> </u> |
| | c. Ventricular tachycardia | | | | h | Fluid retention | | | |
| | d. Atrial fibrillation | | | an an an 1967 a talan an atau ana an talan | i. | Leg swelling | | - | |
| | e. Bradycardia | | □ ➡ . | | j. | Dry eye syndrome (dx by clinician) | | □ ➡ | |
| 8. | How often are your eyes dry (not | wet e | enough)? | Would you say: | Constantly | 🗌 Often 🔲 | Some | times | Never |
| 9. | How often are your eyes irritated | , | Would yo | u say: 🛛 Consta | ntly 🗌 Ofter | n 🗌 Sometimes | | Never | |
| | | | | | | Please c | ontir | nue on n | ext page> |

| | and the second | the second s | |
|--|---|--|----------------------|
| What is your CURRENT blood press | ure? / mmHg | 🔲 don't know | |
| Are you CURRENTLY being treated | with any medications SPECIFICAL | LY for hypertension? | |
| □ No □ Yes ➡ IF YES, please | specify below (PLEASE WRITE (| | |
| | | | |
| Brand Name of Drug | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | |
| a | | | |
| b | | | |
| 3 | | | |
| | | | |
| When was your TOTAL blood choles | -2 years ago 🛛 3-5 years ago | \Box more than 5 years ago/net | ver 🗌 don't remember |
| If checked within the past 5 years, w | | | |
| | | | |
| When was your HDL cholesterol leve | | | — |
| | | more than 5 years ago/new | |
| If checked within the past 5 years, w | hat is your most recent HDL chole | sterol level? mg/100 r | ml 🔲 don't know |
| Are you CURRENTLY being treated | with any cholesterol-lowering medi | cations? | |
| and the second secon | | | |
| □ No □ Yes ➡ IF YES, please | specify below (PLEASE WRITE C | LEARLY): | |
| □ No □ Yes ➡ IF YES, please Brand Name of Drug | specify below (PLEASE WRITE C <u>Dose (each pill)</u> # Pills/V | | |
| Brand Name of Drug | Dose (each pill) # Pills/V | | |
| Brand Name of Drug a b IN THE PAST TWO WEEKS, have yo inhalers, patches, etc.)? | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | |
| Brand Name of Drug a b IN THE PAST TWO WEEKS, have yo inhalers, patches, etc.)? | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | RITE CLEARLY): |
| Brand Name of Drug a b IN THE PAST TWO WEEKS, have yo inhalers, patches, etc.)? □ No □ Yes ➡ IF YES, please | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | |
| Brand Name of Drug a b IN THE PAST TWO WEEKS, have you inhalers, patches, etc.)? □ No □ Yes ➡ IF YES, please Brand Name of Drug PRESCRIPTION: | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | RITE CLEARLY): |
| Brand Name of Drug a b IN THE PAST TWO WEEKS, have yo inhalers, patches, etc.)? □ No □ Yes ➡ IF YES, please Brand Name of Drug PRESCRIPTION: a | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | RITE CLEARLY): |
| Brand Name of Drug a b N THE PAST TWO WEEKS, have you inhalers, patches, etc.)? □ No □ Yes ➡ IF YES, please Brand Name of Drug PRESCRIPTION: | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | RITE CLEARLY): |
| Brand Name of Drug a | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | RITE CLEARLY): |
| Brand Name of Drug a b IN THE PAST TWO WEEKS, have yo inhalers, patches, etc.)? □ No □ Yes ➡ IF YES, please Brand Name of Drug PRESCRIPTION: a b d | Dose (each pill) # Pills/V | Veek Date Began (mo/yr) | RITE CLEARLY): |
| Brand Name of Drug a | Dose (each pill) # Pills/V bu taken any OTHER medications specify below, including the reaso Dose (each pill # Pills/W | Veek Date Began (mo/yr) | RITE CLEARLY): |
| Brand Name of Drug a | Dose (each pill) # Pills/V bu taken any OTHER medications specify below, including the reaso Dose (each pill # Pills/W | Veek Date Began (mo/yr) | RITE CLEARLY): |
| Brand Name of Drug a | Dose (each pill) # Pills/V u taken any OTHER medications specify below, including the reaso Dose (each pill or application) # Pills/W (or application) | Veek Date Began (mo/yr) | RITE CLEARLY): |

THANK YOU! PLEASE CALL (800) 633-6911 IF YOU HAVE ANY QUESTIONS.

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□ No □ Yes 1a. Are you CURRENTLY taking the WHITE PILLS? □ No □ Yes Are you CURRENTLY taking the AMBER CAPS?

b. For EACH of the TWO study agents (white pill; amber capsule), please indicate below the percentage of pills you have TAKEN over the PAST YEAR.

| | WHITE PILL | AMBER CAPS |
|--|---------------|---------------|
| Took 100%, or missed none | | |
| Took 93-99%, or missed only a few | | |
| Took 75-92%, or missed between 1-3 months | | |
| Took 67-74%, or missed between 3-4 months | | |
| Took 50-66%, or missed between 4-6 months | | |
| Took 33-49%, or missed between 6-8 months | | |
| Took less than 33%, or missed more than 8 months | , 🗋 | |
| Took none, or missed all | | |

2. IN THE PAST YEAR, have you experienced the following? Please check NO or YES for EACH item.

| | | NO | YES |
|------|---|----|-----|
| a. | Symptoms suggestive of gastric upset | | |
| b. | Symptoms suggestive of peptic ulcer | | |
| c. | Nausea | | |
| d. | Constipation | | |
| e. | Diarrhea | | |
| f. | Skin discoloration | | |
| g. | Blood in urine (hematuria) | | |
| h. | Easy bruising | | |
| i, | Nose bleed (epistaxis) | | D |
| j. | Skin rash | | |
| k. | Fatigue | | |
| ۱. , | Drowsiness | | |
| m. | Headache | | |
| ` L. | The second | | |

3. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please check NO or YES for EACH item. If YES, please provide the month and year of diagnosis and complete the consent form on the next page. NO YES Dx MO/YR

| a. | Myocardial infarction (heart attack) | | □ : ➡ | (a) |
|----|--|--------|------------|--------|
| b. | Angina pectoris | | □ | (b) |
| | IF YES, confirmed by: NO angiogram/cardiac cath? | YES | | |
| c. | Coronary angioplasty (PTCA) | | □ ⇒ | (c) |
| | IF YES, # of vessels: | | | |
| d. | Coronary bypass surgery (CABG) | | □ ▶ | (d) |
| | IF YES, # of vessels: | | | |
| е. | Congestive heart failure | | | (e) |
| f. | Ventricular tachycardia | | □ | (f) |
| g. | Atrial fibrillation | | □ ⇒ | (g) |
| h. | Intermittent claudication | | □ | (h) |
| i. | Pulmonary embolism (PE) | | □ . | (i) |
| j. | Deep vein thrombosis (DVT) | | □ ⇒ | (j) 🔺 |
| | PLEASE GO TO THE | TOP OF | THE NEXT (| COLUMN |

| NEW | LY DIAGNOSED IN PAST YEAR? | NO | YES | Dx MO/YR | |
|------------|--|-----|------------|-----------|--------------|
| k. | Stroke | × . | | | (k) |
| I. | TIA (transient ischemic attack) | | | | (1) |
| m. | Carotid artery surgery (endarterectomy) | | | | /m |
| n. | Peripheral artery surgery (not varicose veins) | | | | |
| о. | Asthma | Π | | | (0) |
| p. | Other chronic lung disease (e.g., emphysema, chronic bronchitis, bronchiectasis) | | | | (p) |
| q. | Elevated cholesterol (dx by clinician) | | | | (q) |
| r. | Hypertension (dx by clinician) | | - | | (r) |
| s. | Melanoma | | - | | (s) |
| t. | Non-melanoma skin cancer IF YES, type: | | □ ⇒ | | (t) |
| u. | Breast cancer | | □ ⇒ | | (u) |
| ٧. | Lung cancer | | - | | (V) |
| w. | Colon cancer | | □ ⇒ | | (w) |
| x . | Other cancer (non-skin) IF YES, SPECIFY SITE: | | □► | | (x) |
| у. | Colon polyp | | | | (y) |
| z. | Fibrocystic or other benign breast disease | | □ ► | | (z |
| | IF YES, confirmed by: NO YES breast biopsy? aspiration? | | _ | | |
| aa. | Diabetes mellitus | | ∐ ⇒ | | , |
| bb. | Gout | | • | · | (הי) |
| cc. | Peptic ulcer | | ₽ | | (cc) |
| dd. | Galistones | | | | (dd) |
| | IF YES, how diagnosed? x-ray, ultrasound other | | | | |
| ee. | Gallbladder removal | | | | (ee) |
| ff. | Active or chronic liver disease or cirrhosis | | | | (ff) |
| gg. | Kidney disease (NOT kidney stones) | | □ ⇒ | | (gg) |
| | IF YES, specify type: | | | | |
| hh. | Chronic kidney failure | | □ ⇒ | | (hh) |
| ii. | Migraine headaches | | | | (ii) |
| jj. | Bleeding hemorrhoids | | □ ⇒ | . <u></u> | (ii) |
| kk. | Any other gastrointestinal bleeding | | | | (kk) |
| И. | Coagulation disorder | | □ ⇒ | | (II) |
| mm. | Periodontal disease | | | (| (mm) |
| | IF YES, # teeth lost: | | | | |
| nn. | Macular degeneration RIGHT eye | | □ ⇒ | | (nn) |
| 00. | Macular degeneration LEFT eye | | | , | (00) |
| pp. | Cataract RIGHT eye | | ∐ ⇒ | | (pp) |
| qq. | Cataract LEFT eye | | ➡ | | (qq) |
| rr. | Cataract extraction RIGHT eye | | | <u> </u> | (rr) |
| SS. | Cataract extraction LEFT eye | Ľ | | |) |
| tt. | Other major illness | | | | (tt) |
| | IF YES, SPECIFY: | | Real Parts | | |

IF "YES" IN QUESTION # 3, PLEASE COMPLETE THE **CONSENT FORM ON PAGE 2.**

HARVARD MEDICAL SCHOOL

| WOMEN'S HEALTH S | 10 | UΥ |
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|------------------|----|----|

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HARVARD MEDICAL SCHOOL

| CONSENT FORM If you responded YES to any of the items in quest information we request will be used solely for medical statistical purposes an I hereby grant permission to Dr. Julie Buring, Associate Professor, Harvard Me review a copy of the records of my hospitalization or treatment for: | nd maintair | ied in the s | trictest c | onfide | ence. | | | |
|--|--|---|--|-------------------------|----------------------|----------------------------------|--|---------|
| NOSIS: DATES OF HOSPITA | | | | | | | | |
| Name of hospital/physician: | | | P | hone | #: | | | |
| Address of hospital/physician: | | | | | | | • | |
| City: State: State: | | | | • | | | | |
| YOUR FULL NAME AT TIME OF DIAGNOSIS: YOUR SIGNATURE: | | | | | | | | |
| | | the followin | | | DAYS | | AST MON | тн |
| DURING THE PAST MONTH, on approximately how many DAYS did you to Do NOT include your study pills. Please respond for each item. | ake any or | the following | ינ. | 0 | 1-3 | 4-10 | 11-20 | 21+ |
| a. Acetaminophen (e.g., Tylenol, Excedrin P.M.) | | | | | | | | |
| b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) | <u>all allege to de la de la</u> | | | | | | | |
| c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fio | orinal) | | | | | | D | |
| d. Nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, N | laprosyn, F | eldene, Alev | e) | | | | | |
| e. Multivitamins: Specify brand name: | | | | | | | | |
| Specify: Does multivitamin contain vitamin E? | | | the second s | | | | | |
| Contain vitamin A (including beta-carotene)? | s 🗭 conten | t <u></u> | IU | | | | | |
| f. Individual supplements of vitamin C (not including multivitamins) | Contraction of the | | | | | | | |
| g. Individual supplements of beta-carotene (not including multivitamins) | | | | | | | | |
| h. Individual supplements of vitamin E (not including multivitamins) | | | | | | | | |
| i. Individual supplements of vitamin A (not including multivitamins) | | | | | | | | |
| Other vitamin preparations containing beta-carotene, vitamin E or vitamin Specify EXACT BRAND and TYPE: | | luding multiv | itamins) | | | | | |
| 5. Please indicate the number of times you have had each of the following IN THE PAST YEAR. Please provide a response on each line. | None | TIME : 1-2X | S IN PAST 3-5X | | 1 0X | >10X | | |
| a. Common cold | | | | | | | | |
| b. Acute bronchitis | | | | | | | | |
| c. Sinusitis | | | | | | | | |
| d. Pneumonia | | | | | | | | |
| e. Skin and/or soft tissue infection | | | | | | | | |
| f. Urinary infection | | | | | | | | |
| g. Any OTHER infection | | | | | | | | |
| 6. IN THE PAST YEAR, have you used antibiotics? □ No □ Yes ➡ IF YES, on approximately how many TOTAL DAYS? □ | 1-7 days | 🗆 8-14 days | 6 🗆 15- | 30 day | s 🗆 : | 31-60 day | ' rs □ > | 60 days |
| ► No: Premenopausal (Mark | REASON of GERY: If du k <u>ALL</u> that a Ute One Bot IATION or C URAL: If na | lid your peri e to surgery pply) rus removed ovary remo n ovaries rer CHEMOTHE tural (non-su | ods cease , were you ved noved RAPY irgical) me | ? Ir ovari Inopau | es and/o se, have | • you had | | |
| PLEASE CONTINUE ON THE BACK | 🗆 No, | ve ovaries or did not have rus removed | surgery | | One ova | appiy) iry remov aries rem | and the second s | |

| WOMEN'S HEALTH S | FORM 60/PAG | | | | |
|-----------------------------|-----------------------|--|--|--|--|
| ALL THE PLANT SAME SAME AND | here is a set formate | | | | |

|] No □ Yes, currently | y Yes, discontinued |
|---------------------------|---|
| ₹ a. ESTROGEN: Did you | use ESTROGEN in the PAST YEAR? |
| □ No □ Yes ➡ | 1. In the PAST YEAR, for how many months have you used ESTROGEN? |
| | 2. What type of ESTROGEN have you used the longest in the PAST YEAR? Oral Premarin Oral Estrace Patch Estrogen Vaginal Estrogen Oral Ogen Other Estrogen: please specify |
| | 3. If you used ORAL CONJUGATED ESTROGEN (e.g., Premarin), what dose did you usually take? DID NOT USE ORAL CONJUGATED ESTROGEN .30 mg/day or less (green) .9 mg/day (white) More than 1.25 mg/day .625 mg/day (brown) 1.25 mg/day (yellow) |
| | 4. If you used either ORAL CONJUGATED ESTROGEN (e.g., Premarin) or a PATCH ESTROGEN, what was you pattern of use (days per month)? DID NOT USE EITHER ORAL OR PATCH ESTROGEN < 1 day/mo. 1-8 days/mo. 9-18 days/mo. 19-26 days/mo. 27 + days/mo. |
| b. PROGESTERONE/P | ROGESTIN: Did you use PROGESTERONE/PROGESTIN (e.g., Provera, Cycrin) in the PAST YEAR? |
| □ No □ Yes ➡ | 1. In the PAST YEAR, for how many months have you used PROGESTERONE/PROGESTIN? |
| | 2. What type of PROGESTERONE/PROGESTIN have you used the longest in the PAST YEAR? Oral |
| | 3. If you used ORAL MEDROXY PROGESTERONE (e.g., Provera, Cycrin), what dose did you usually take? DID NOT USE ORAL MEDROXY PROGESTERONE < 5 mg 5-9 mg 10 mg > 10 mg Dose unknown |
| | 4. If you used ORAL PROGESTERONE, what was your pattern of use (days per month)? |

10. How often did you participate in strenuous (aerobic) physical activity or sports at least twice per week (e.g. swimming, aerobics, field hockey, basketball, cycling, running) . . .

| a. During high school? (please average) | Never | 1-3 months/yr | 4-6 months/yr | 7-9 months/yr | 10-12 months/yr |
|---|-------|---------------|---------------|-----------------|-----------------|
| b. During ages 18-22? (please average) | Never | 1-3 months/yr | 4-6 months/yr | □ 7-9 months/yr | 10-12 months/yr |

11.

| A. Please provide us with you | ur phone number(s) so we may contact you if we are unable to reach you through the mail: |
|-------------------------------|---|
| НОМЕ: () | WORK: () |
| | , address and phone number of <i>SOMEONE AT A DIFFERENT PERMANENT ADDRESS</i> whom we mig o contact you. Please indicate if: |
| | PHONE NO.: () |
| NAME: | PHONE NO.: |
| | PHONE NO.: STATE/ZIP: |
| ADDRESS: | |

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HARVARD MEDICAL SCHOOL

12. IN THE PAST TWO WEEKS, have you taken any medications (either prescription or over-the-counter, including pills, creams, inhalers, patches, etc.)? Please include medications/vitamins which you may have reported elsewhere on this form.

□ No □ Yes → IF YES, please specify below, including the reason for taking the drug (PLEASE WRITE CLEARLY):

| | Brand name of drug | Dose (each pill) or application | # Pills/week (or applications) | Date began (mo/yr) | Reason for taking |
|-----------|--------------------|------------------------------------|-----------------------------------|--------------------|-------------------|
| PRESCRIPT | FION: | | | | |
| a | | | | | |
| b | | | | | |
| c | | | | | |
| d | | | | | |

OVER THE COUNTER:

| · | | |
|---|--|--|
| | | |
| | | |
| | | |

13. ONE YEAR AGO were you taking any ADDITIONAL prescription medications that you ARE NO LONGER TAKING NOW?

□ No □ Yes → IF YES, please specify below, including the reason for taking and reason for discontinuation (PLEASE WRITE CLEARLY):

| | Brand name of drug | Reason for taking Reason for discontinuation | | |
|---|--------------------|--|--|--|
| | | | | |
| ٠ | | | | |
| J | | | | |
| c | | · | | |
| d | | | | |
| e | | | | |
| f | | | | |

14. The following items are about activities you might do during a typical day.

Does your health now limit you in these activities? If so, how much?

| Please mark one response on each line. | No, not limited at all | Yes, limited a little | Yes, limited a lot |
|---|---------------------------|--------------------------|-----------------------|
| A. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports | | | |
| b. <i>Moderate activities,</i> such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | . 🗆 | | |
| c. Lifting or carrying groceries | | | |
| d. Climbing several flights of stairs | | | |
| e. Climbing one flight of stairs | | | |
| f. Bending, kneeling, or stooping | | | |
| g. Walking more than a mile | | D | |
| h. Walking several blocks | | | |
| i. Walking one block | | | |
| j. Bathing or dressing yourself | | | |

PLEASE CONTINUE ON THE BACK.

| | WOMEN'S HEALTH S | TUDY | FORM 60/PAG | E 5 | | | |
|----|---------------------------|----------------------------|------------------------------|---------|--------------|----------|---|
| 15 | . Which best describes yo | ur current employment stat | us (including self-employmen | t)? | | | 8 |
| | Employed full-time | Employed part-time | Eull-time homemaker | Retired | Not employed | Disabled | |

16. If you have been employed within the past 2 years, the following questions relate to your current or most recent job:

| Please choose the answer which best describes the degree to which you agree or disagree with each of the following statements. | Strongly disagree | Disagree | Agree | Strongly agree |
|---|-------------------|----------|-------|-------------------|
| a. My job requires that I learn new things | | | | |
| b. My job involves a lot of repetitive work | | | | |
| c. My job requires me to be creative | | | | |
| d. My job allows me to make a lot of decisions on my own | | | | |
| e. My job requires a high level of skill | | | | |
| f. On my job, I have very little freedom to decide how I do my work | | | | |
| g. I get to do a variety of different things on my job | | | | |
| h. I have a lot of say about what happens on my job | | | | |
| i. I have an opportunity to develop my own special abilities | | | | |
| j. My job requires working very fast | | · 🗌 | | |
| k. My job requires working very hard | | | | |
| I. My job requires lots of physical effort | | | | |
| m. I am not asked to do an excessive amount of work | | D | | |
| n. I have enough time to get the job done | | | | |
| o. My job security is good | | | | |
| p. I am free from conflicting demands that others make | | | | |

17. 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*...

| Please mark one response on each line. | 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 been a very nervous person? | | | | | | |
| b. Have you felt so down in the dumps nothing could cheer you up? | | | | | | |
| c. Have you felt calm and peaceful? | | | | | | |
| d. Have you felt downhearted and blue? | | | | | | |
| e. Have you been a happy person? | | | | | | |

18. Is there anyone special you know that you feel close to; someone you feel you can share confidences and feelings with?

☐ Yes → IF YES, How often do you talk?

| Daily | Weekly | Monthly | |
|-------|--------|---------|--|
|-------|--------|---------|--|

□ Several times a year □ Once a year or less

| 19. | In | general, | compared to | o other | persons | your | age, | would | you | say | your | health | is |
|-----|----|----------|-------------|---------|---------|------|------|-------|-----|-----|------|--------|----|
|-----|----|----------|-------------|---------|---------|------|------|-------|-----|-----|------|--------|----|

| [| Excellent | Very good | Good | 🗌 Fair | 🗌 Poor |
|---|-----------|-----------|------|--------|--------|
|---|-----------|-----------|------|--------|--------|

THANK YOU!

PLEASE RETURN THE ENTIRE FORM IN THE PRE-PAID ENVELOPE TO . . .



WOMEN'S HEALTH STUDY 900 COMMONWEALTH AVENUE EAST BOSTON, MA 02215

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR TOLL-FREE NUMBER

1-800-633-6911

| | | | 72 W | AN | TH | | | | |
|-----|---|-------------------|---------------------|----------|---|-------|-----------|----------|------------|
| V | OMEN'S HEALTH STUDY | | FORM 7 | 2/PA | GE 1 HARVA | ARD M | IEDICA | L SCHOOL | • |
| 1a. | Are you CURRENTLY taking the W | VHITE PILLS? | 🗆 No 🔲 Yes | NE | WLY DIAGNOSED IN PAST YEAR? | NO | YES | Dx MO/YR | |
| | Are you CURRENTLY taking the A | MBER CAPS? | 🗌 No 🔲 Yes | q. | Elevated cholesterol (dx by clinician) | | • | | (q) |
| b. | For EACH of the TWO study agents | (white pill; ambe | er capsule), please | r. | Hypertension (dx by clinician) | | □ ⇒ | | (r) |
| | indicate below the percentage of p TAKEN over the PAST YEAR. | ills you have | | s. | Melanoma | | □ ➡ | | (s) |
| | TAREN OVER THE FAST TEAN. | WHITE | AMBER CAPS | t. | Non-melanoma skin cancer | | □ ⇒ | | (t) |
| | Took 100%, or missed none | | | | IF YES, type: 🗌 basal cell | | | | |
| | Took 93-99%, or missed | | | | Squamous cell | | | | |
| | only a few | | | | | | | | () |
| | Took 75-92%, or missed | | | u. v. | Breast cancer | | | | (u) |
| | between 1-3 months | 0 | | v. w. | Lung cancer Colon cancer | | | <u> </u> | (v) (w) |
| | Took 67-74%, or missed | | | w. x. | Other cancer (non-skin) | | | | (w) (x) |
| | between 3-4 months | | | ^. | IF YES, SPECIFY SITE: | | | <u></u> | (^) |
| | Took 50-66%, or missed between 4-6 months | | | | | | | | |
| | Took 33-49%, or missed | | | у. | Colon polyp | | | | (y) |
| | between 6-8 months | | | , Z. | Fibrocystic or other benign breast disease | | | | (z) |
| | Took less than 33%, or missed more than 8 months | | | | IF YES, confirmed by: NO YES | | | | |
| | Took none, or missed all | | | | breast biopsy? | | | | |
| | If you missed taking your pills, wha | t was the main re | eason? | aa. | Diabetes mellitus | | □ ⇒ | | (aa) |
| | | | | bb. | Gout | | □ ⇒ | | (bb) |
| | | | | cc. | Peptic ulcer | | □ ⇒ | | (cc) |
| 2. | IN THE PAST YEAR, were you NE following? Please check NO or YE | | | dd. | Gallstones | | □ ⇒ | | (dd) |
| | provide the month and year of dia | | | | IF YES, how diagnosed? | | | | |
| | form on the next page. | NO YES | S Dx MO/YR | | 🔲 x-ray, ultrasound | | | | |
| | a. Myocardial infarction (heart attac | ck) 🗆 🗆 | ➡ (a) | | other | | | | |
| | b. Angina pectoris | | | ee. | Gallbladder removal | | | | (ee) |
| | IF YES, confirmed by: | | 、 | ff. | Active or chronic liver disease | | - | <u> </u> | (ff) |
| | angiogram/cardiac cath? | | | | or cirrhosis | _ | 1 | | |
| | |] [] | | gg. | Kidney disease (NOT kidney stones) | | ∐ ⇒ | <u> </u> | (gg) |
| | c. Coronary angioplasty (PTCA) | | ➡ (c) | | IF YES, specify type: | | | | |
| | IF YES, # of vessels: | , <u> </u> | | hh. | Chronic kidney failure | | Ü 🖛 | | (hh) |
| | d. Coronary bypass surgery (CABG | ע (ג וו ⊔ | ➡ (d) | Н. | Migraine headaches | | □ ⇒ | | (ii) |
| | IF YES, # of vessels: | | | | Bleeding hemorrhoids | | | | (ii) |

| | | | | | | • • | ii. | Migraine headaches |
|----|---|----|---|---|-------|------|--------------------|-------------------------------------|
| | IF YES, # of vessels: | | | | | | jj. | Bleeding hemorrhoids |
| e. | Congestive heart failure | | | • | | (e) | kk. | Any other gastrointestinal bleeding |
| f. | Ventricular tachycardia | | | • | | (f) | | , , , |
| g. | Atrial fibrillation | | | | | (g) | II. | Coagulation disorder |
| b. | Intermittent claudication | П | m | | | (h) | mm. | Periodontal disease |
| | | | | - | | | | IF YES, # teeth lost: |
| 1. | Pulmonary embolism (PE) | | | • | | (i) | nn. | Macular degeneration RIGHT eye |
| j. | Deep vein thrombosis (DVT) | | | * | ····· | (j) | 00. | Macular degeneration LEFT eye |
| k. | Stroke | | | ► | | (k) | pp. | Cataract RIGHT eye |
| I. | TIA (transient ischemic attack) | | | • | | (I) | ••• | • |
| m. | Carotid artery surgery (endarterectomy) | | | | (| (m) | qq. | Cataract LEFT eye |
| n. | Peripheral artery surgery (not varicose | | | | | (n) | rr. | Cataract extraction RIGHT eye |
| | veins) | LJ | | - | | (11) | SS. | Cataract extraction LEFT eye |
| о. | Asthma | | | | | (0) | tt. | Other major illness |
| p. | Other chronic lung disease | | | • | | (p) | | IF YES, SPECIFY: |
| | (e.g., emphysema, chronic bronchitis, bronchiectasis) | | | | | | $\hat{\mathbf{M}}$ | IF "YES" IN QUESTIC |
| | , | | | | | | 18 | |

UESTION # 2, PLEASE COMPLETE THE CONSENT FORM ON PAGE 2.

🔲 🗭

-

🗌 🗰

🔲 🗭

🗆 🗭

-

□ ⇒ _____

□ .

(jj)

(kk)

(II)

(nn) ____

(00) ____

(pp)

(qq)

(rr)

(ss)

(tt)

_____ (mm)

PLEASE GO TO THE TOP OF THE NEXT COLUMN

.....

FORM 72/PAGE 2

HARVARD MEDICAL SCHOOL

| | | | ALIZATION/TREATMENT | • | | | | |
|--|---|---|--|---|----------------------|-------------------------|------------------------|--------|
| Name o | f hospital/physician: | | | | | | | |
| | s of hospital/physician: | | | | | | | |
| | City: | State: _ | | z | ip: | | | |
| YOUR F | FULL NAME AT TIME OF DIAGNOSIS: | | | | | | | |
| YOURS | SIGNATURE: | | | Date | | | | |
| | oigino | COPY VALID AS | ORIGINAL | | | | | |
| 3. IN T | HE PAST YEAR, have you experienced any o | f the following? Please chec | K NO or YES for EACH ite | əm. | | | | |
| | | NO YES | | | | No. of Concession, Name | | NO YES |
| | Symptoms suggestive of gastric upset | | h. Easy bruising | | | | | |
| 100000000000000000000000000000000000000 | Symptoms suggestive of peptic ulcer Nausea | | i. Nose bleed (epista) | .18) | | | | |
| 1000 | Constipation | | k. Fatigue | | | | 92000020420 | |
| е. | Diarrhea | | I. Drowsiness | | | | | |
| AT-100-00-00-00-00-00-00-00-00-00-00-00-00 | Skin discoloration | | m. Headache | | | | | |
| g . | Blood in urine (hematuria) | | | | | | | |
| | | | | | DAVEL | | | TU |
| 4. DUR Do N | ING THE PAST MONTH, on approximately ho IOT include your study pills. Please respond f | ow many DAYS did you take or each item. | any of the following? | 0 | 1-3 | 4-10 | 11-20 | 21+ |
| | a. Acetaminophen (e.g., Tylenol, Excedr | | | | | +-10 | | |
| | b. Aspirin (e.g., Bayer, Bufferin, Anacin, | e developing the provide developing the second | | | | | | |
| | c. Medications containing aspirin (e.g., A | The second s | rínal) | | | | | |
| | d. Nonsteroidal, anti-inflammatory agents | | | | | | | |
| | e: Multivitamins: Specify brand name: | | | | | | | |
| | Specify: Does multivitamin contain vita | min E? 🗌 No 🗍 Yes 🛛 | CALL AND A REAL AND A R | υ | | | | - |
| | Contain vitamin A (including be | | s ➡ content I | U | | | | |
| | f. Individual supplements of vitamin C (no | The second se | | | | | Electron of the second | |
| | g. Individual supplements of beta-caroten | | | | | | D. | |
| | h. Individual supplements of vitamin E (no | | | | | | | |
| | i. Individual supplements of vitamin A (no | | | | | D. | | |
| | Other vitamin preparations containing be multivitamins) | ta-carotene, vitamin E or vitam | n A (not including | | | | | |
| | Specify EXACT BRAND and TYPE: | | | _ | | | | |
| | | | | | | | 1 | |
| 5. Do y | ou CURRENTLY smoke cigarettes? | na na sa ang kana na | na na seu des mais segura en angles. Estas est sur en angles des constructions de la construction de la constru | | 141-1411-111-11-14-2 | | | |
| 1 N | | | and the second | □ 45 + | | | | |
| | □ 1-4 cigs. □ 5-14 cigs. | 🗌 15-24 cigs. 🗌 25-3 | 5 cigs. 🔲 36-44 cigs. | L 40 + | cigs. | | | |
| 6 Have | e you EVER been diagnosed by a physician as | having rheumatoid arthritis? | | | | | | |
| | | - | 1 | | | | | |
| | b. Rheumatoid factor | r: 🗆 negative / unknown 🛛 🕻 |] positive | | | | | |
| | | | ··· | en an | | ALCO STRUCTURE | | |
| 7. Have | e you EVER had shingles (Varicella-zoster virus) |)? □ No □ Yes ➡ IF YES | : What YEAR were you init | ially diagno | sed with | shingle | s? | |
| | | | | | | | | |
| 0 147 | t is your CURRENT weight and height? Weigh | | loiabt # | in | | | | |

| W | OMEN'S HEALTH ST | UDY | F | ORM 72/PAGE 3 | | | | | | | | |
|-----|----------------------------------|--|---------------------------------------|-------------------------|--------------|-----------------|------------|------------------|---------------|----------------|-----------|---------------|
| 9. | Using the instructions fo | und on the cover letter | r, please record | the following measu | rements | to the <u>n</u> | earest q | uarter in | ich: | | | |
| | | inches | fraction | | | incl | hes | fractio | n | | | |
| | | WAIST: | /4 | | HIP | S: | | <u></u> , | /4 | | | |
| 10. | During the PAST 6 YEA | RS (since the study be | gan), what is th | e difference betwee | n your hig | hest an | d lowest | weight | (excludi | ng illnes | s)? | |
| | 🗌 No change | 2-4 lbs | 5-9 lbs | 10-14 lbs | | 15-29 | lbs | | 30-49 II | os | | 50 + Ibs |
| | | | | | | | | | | | | |
| 11. | During the PAST 6 YEA | RS (since the study be | gan), have you | had unintentional we | eight loss | (e.g., d | ue to illr | iess, uni | usual str | ess, dep | pression) |)? |
| | 🗆 No 🛛 Yes 🗭 | IF YES: How many lbs | .? 🗌 2-4 lbs | □ 5-9 lbs | 🗆 10-14 | lbs | □ 15-2 | 9 lbs | □ 3 0 | -49 lbs | | 50 + Ibs |
| | | | | | | | | | | | | |
| 12. | During the PAST 6 YEAF | S (since the study beg | jan), what prima | ry methods have you | used to a | control y | our weig | ght? PLE | ASE CH | IECK AL | L THAT | APPLY. |
| | None None | Diet pills/over | er-the-counter | | | | rash die | t/fasting | 9 | | | |
| | Exercise | 🗌 Diet pills/pr | escription | | | | igarette | smoking | 9 | | | |
| | Calorie restriction | Commercial | diet program (e | e.g., Weight Watcher | rs) | G | astric si | urgery | | | | |
| | Low-fat diet | Commercial | diet supplemer | nt (e.g., Slim-Fast) | | | Other | | | | | |
| | | | | | | | | | | | | |
| 13. | DURING THE PAST YE | | | ge <u>time per week</u> | | | | TIME PE | R WEE | ĸ | | |
| | spent at each of the follo | owing recreational activ | vities? | | | 1-19 | 20-59 | One | 11/2 | 2-3 | 4-6 | 7 + |
| | a. Walking for exercis | e (including walking to | work, hiking, ti | eadmill) | Zero | Min. | Min. | Hr. | Hr. | Hr. | Hr. | Hr. |
| | b. Jogging (slower tha | | | | | | | | | | | |
| | c. Running (10 minute | | | | | | | tails of the sec | Contraction (| a contractions | | Seally of the |
| | | | | | | | | | | | | |
| | d. Bicycling (include s | | | | | | | | | | | |
| | | erobic dance/exercise | | | | | | | | | | |
| | | rcise/yoga/stretching/ | toning | | | | | | | | | |
| | g. Tennis, squash, or | racquetball | | | | D | D. | | | | | |
| | h. Lap swimming | | | | | | | | | | | |
| | i. Other: Please spec | ify activity: | | | | | | D | | D | П | D |
| | | | | | | | | | | | | |
| 14. | | | | | | | | | | | | |
| | OF FOLLOW-UP. | ON BELOW IS IMPOR | RIANI FOR VI | ERIFICATION PUR | POSES A | ND AS | SISTS (| JS IN M | IAINTAI | NING H | IGH RA | TES |
| | | | | | | | | | | | | |
| | | us with your phone | | | | | e to rea | ch you 1 | through | the mai | 1: | |
| | НОМЕ: (|) | | WOF | ак: <u>(</u> |) | | | | | | |
| | | e the name, address a tre unable to contact y | | | | FEREN | | ANENT | | SS who | m we m | night |
| | | | | PHONE | |) | | | | | | |
| | | | | | | | | | | | | |
| | ADDRESS: | | · · · · · · · · · · · · · · · · · · · | STATE/2 | ZIP: | · | | | | | | |
| | C. Your birthdate | | R AND ■ | D. LAST 6-digits of | Social S | ecurity | Numbe | r: X | | | .) | |
| | E. Your Maiden N (LAST NAME C | | | | | | | | | | | |

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THANK YOU!

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR TOLL-FREE NUMBER

1-800-633-6911

| | | 84 | MON | JT | HQ. | Q_{-} | | ······ | | | |
|------|---|--------------|----------|-----------|--------------|-----------------|----------|--|--------|------------|----------|
| W | OMEN'S HEALTH STUDY | | | | FORM | 184/F | PA(| GE 1 HARVAR | D MED | ICAL SO | CHOOL |
| 1a. | Are you CURRENTLY taking the | | | | No 🗌 Ye | | IEV | VLY DIAGNOSED IN PAST YEAR? | NO | YES | Dx MO/YR |
| h | Are you CURRENTLY taking the | | | | | q | | Elevated cholesterol (dx by clinician) | | | (q) |
| D. | For EACH of the TWO study ag indicate below the percentage o | • | | er ca | psule), piea | r. | | Hypertension (dx by clinician) | | | · (r) |
| | TAKEN over the PAST YEAR. | WHIT | | | AMBER | s. | | Melanoma | | | · (s) |
| | | PILL | | | CAPS | t. | | Non-melanoma skin cancer | | | · (t) |
| | Took 100%, or missed none | | | | | | | IF YES, TYPE: 🗌 basal cell | | | |
| | Took 93-99%, or missed | | | | | | | 🗆 squamous cell | | | |
| | only a few | | | | | | | 🗌 unknown | | | |
| | Took 75-92%, or missed | | | | | u | | Breast cancer | | | • (u) |
| | between 1-3 months | | | | L] | v. | | Lung cancer | | | · (v) |
| | Took 67-74%, or missed | | | | | w | | Colon cancer | | | •(w) |
| | between 3-4 months | | | | | X. | | Other cancer (non-skin) | | | · (x) |
| | Took 50-66%, or missed | | | | | | | IF YES, SPECIFY SITE: | | | |
| | between 4-6 months | | | | | | | | | | |
| | Took 33-49%, or missed | | | | | у. | | Colon polyp | | | · (y) |
| | between 6-8 months | | | | | Z. | 2 | Fibrocystic or other benign breast disease | | | · (z) |
| | Took less than 33%, or missed | | | | · · · · · · | | | IF YES, confirmed by: NO YES | | | |
| | more than 8 months | | | | | í, | 00000000 | breast blopsy? | | | |
| | Took none, or missed all | | | | | | 000000 | aspiration? | | — . | |
| | | | | | | | | Diabetes mellitus | | | •(aa) |
| | If you missed taking your pills, | what was th | e main i | reaso | n? | | - | Gout | | | (bb) |
| | | | , | | | | | Peptic ulcer | | | •(cc) |
| 2. 1 | N THE PAST YEAR, were you | NEWLY DIA | GNOSI | ED w | ith any of t | he d | × | Gallstones | | | (dd) |
| | ollowing? Please check NO or provide the month and year of dia | | | | | | ž | IF YES, how diagnosed? | | | |
| | on the next page. | agriosis anu | comple | | COnsent IO | | - 8 | □ x-ray, ultrasound | | | |
| | | ١ | 10 YE | S I | Dx MO/YR | | × | | _ | | |
| | a. Myocardial infarction (heart att | tack) | |] 🔿 | · | u) | | Gallbladder removal | | | •(ee) |
| t | o. Angina pectoris | | |] 🖚 | (| 5) | | Active or chronic liver disease or cirrhosis | | | • (ff) |
| | IF YES, confirmed by: | NO YES | | | | g | | Kidney disease (NOT kidney stones) | | | •(gg) |
| | anglogram/cardiac cath? | | | | | | | IF YES, specify type: | | | |
| | stress test? | | | | | | | | _ | | |
| C | c. Coronary angioplasty (PTCA) | | |] 📫 | (| | | Chronic kidney failure | | | •(hh) |
| | IF YES, # of vessels: | | | | | ii. | | Migraine headaches | | | • (ii) |
| (| d. Coronary bypass surgery (CAI | BG) | |] 📫 | (| d) Ü | | Bleeding hemorrhoids | | | • (ii) |
| | IF YES, # of vessels: | | | | | k | | Any other gastrointestinal bleeding | | | •(kk) |
| (| e. Congestive heart failure | | |] 🖦 | (| e) II. | | Coagulation disorder | | | · (II) |
| f | . Ventricular tachycardia | | |] 🔿 | | (f) rr | | Periodontal disease | | | •(mm) |
| ę | g. Atrial fibrillation | | |] 🄿 | (| g) | | IF YES, # of teeth lost: | _ | | |
| ł | n. Intermittent claudication | | |] *** | (| | | Macular degeneration RIGHT eye | | | •(nn) |
| i | . Pulmonary embolism (PE) | | |] 🔿 | | (i) o | | Macular degeneration LEFT eye | | | •(00) |
| j | . Deep vein thrombosis (DVT) | | |] 🔿 | | (j) p | | Cataract RIGHT eye | | | •(pp) |
| ŀ | <. Stroke | | |] 🖚 | (| k) 9 | - | Cataract LEFT eye | | | (qq) |
| I | . TIA (transient ischemic attack) |) | |] 🔿 | | (I) r r | | Cataract extraction RIGHT eye | | | • (rr) |
| I | n. Carotid artery surgery (endarte | erectomy) | |] 🔿 | (r | n) ^s | | Cataract extraction LEFT eye | | | •(ss) |
| ľ | n. Peripheral artery surgery (not | varicose | |] 📫 | (| n) tt | | Shingles (Varicella-zoster virus) | | | • (tt) |
| | veins) | | | | | | | Rheumatoid arthritis | | | •(uu) |
| | o. Asthma | | | 」 ■⇒ 1 | | o) | | IF YES, rheumatoid factor: Inegative / u | nknown | | |
| I | Other chronic lung disease (e.g., emphysema, chronic bill | | | | (| p) v | 4 | Other major illnesses | | | •(vv) |
| | bronchiectasis) | -, | | | | | أح | IF YES, SPECIFY: | | | |
| | PLEASE GO 1 | | | | | | | IF "YES" IN QUESTION #2, PLEA CONSENT FORM ON | | | INE |

| W | VOMEN'S | HEALTH | STUDY | |
|---|---------|--------|-------|--|
| | | | | |

FORM 84 / PAGE 2

HARVARD MEDICAL SCHOOL

DAYS IN THE PAST MONTH

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Г

| CONSENT FORM If you responded The information we request will be use | d YES to any of the ite ed solely for medical s | ms in question #2, pleas tatistical purposes and n | e COMPLETE and SIGN the on naintained in the strictest con | onsent form below. |
|---|---|---|---|---------------------------------------|
| I hereby grant permission to Dr. Julie I to review a copy of the records of my DIAGNOSIS: | Buring, Professor, Harv hospitalization or treat | vard Medical School, 900 ment for: | Commonwealth Avenue East | , Boston, MA 02215, |
| Name of hospital / physician: | | | | |
| Address of hospital / physician: | | | | |
| | City: | State: | Zip: | |
| YOUR FULL NAME AT TIME OF DIAGN | 10SIS: | | | |
| YOUR SIGNATURE: | | | | ····· |
| | Signed COPY | ALID AS ORIGINAL | Date | |
| 3. IN THE PAST YEAR, have you experience | d any of the following? Plea | ase check NO or YES for EAC | CH item. | · · · · · · · · · · · · · · · · · · · |
| | NO | /ES | | NO YES |
| a. Symptoms suggestive of gastric upset | | h. Easy bruisin | 9 | |
| b. Symptoms suggestive of peptic ulcer | | i. Nose bleed | (epistaxis) | |
| c. Nausea | | j. Skin rash | | |
| d. Constipation | | k. Fatigue | · | |
| e. Diarrhea | | I. Drowsiness | | |
| f. Skin discoloration | | m.Headache | | |
| g. Blood in urine (hematuria) | | | ·,, , · · · , · · · · · · · · · · · · · | |

4. DURING THE PAST MONTH, on approximately how many days did you take any of the following? Do NOT include your study pills. Please respond for each item.

| include your study pills. Please respond for each item. | 0 | 1-3 | 4-10 | 11-20 | 21+ |
|--|---|-----|------|-------|-----|
| a. Acetaminophen (e.g., Tylenoi, Excedrin P.M.) | | | | | |
| b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) | | | | | |
| c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal) | | | | | |
| d. Traditional nonsteroidal, anti-inflammatory agents (e.g., Motrin, Advil, Nuprin, Naprosyn, Aleve) | | | | | |
| e. New NSAIDs (Cox-2 inhibitors, e.g., Celebrex, Vioxx) | | | | | |
| f. Multivitamins: Specify brand name: Specify: Does multivitamin contain vitamin E? □ No □ Yes ➡ content IU Contain vitamin A (including beta-carotene)? □ No □ Yes ➡ content IU | | | | | |
| g. Individual supplements of vitamin C (not including multivitamins) | | | | | |
| h. Individual supplements of beta-carotene (not including multivitamins) | | | | | |
| i. Individual supplements of vitamin E (not including multivitamins) | | | | | |
| j. Individual supplements of vitamin A (not including multivitamins) | | | | | |
| k. Other vitamin preparations containing beta-carotene, vitamins E or A (not including multivitamins) Specify EXACT BRAND and TYPE: | | | | | |

5.

| Ť | E INFORMATION BELOW ASSISTS US IN MAINTAINING HIGH RATES OF FOLLOW-UP. |
|----|--|
| A. | Please provide us with your phone number(s) so we may contact you if we are unable to reach you through the mail: |
| | HOME: () WORK: () |
| B. | Please indicate the name, address and phone number of SOMEONE AT A DIFFERENT PERMANENT ADDRESS whom we might contact if we are unable to contact you. Please indicate if: friend neighbor relative |
| | NAME: PHONE NO.: () |
| | ADDRESS: STATE / ZIP: |
| C. | Your birthdate: AND C DAY YR AND C LAST 6-digits of Social Security Number: XXX(OPTIONAL) |
| E. | Your Maiden Name: (LAST NAME ONLY) |

| | MEN'S HEALTH STUDY | | | FORM | 96 / PAGE | | VARD MED | | SCH(|
|---|---|--|---|---|--|---|----------|-------------|-------------|
| | re you CURRENTLY taking the WHITE | | | □No □Yes | | Y DIAGNOSED IN PAST YEAR? | NO | YES | Dx |
| | re you CURRENTLY taking the AMBE or EACH of the TWO study agents (wi | | | 🗆 No 🔲 Yes cansule), niese | - C. EI | evated cholesterol (dx by clinician) | | 📄 🗖 | • |
| | dicate below the percentage of pills yo | 이 이 관계하는 | | oupoulo), pious | Ϋ́r. Hy | vpertension (dx by clinician) | | े 🗆 = | • |
| Т | AKEN over the PAST YEAR. | HITE | <u> </u> | AMBER | s. Me | elanoma | | ۰ 🗆 - |) <u> </u> |
| _ | | NLL | | CAPS | t, No | on-melanoma skin cancer | | | • |
| T | ook 100%, or missed none | | | | . IF | YES, TYPE: Desal cell | | | |
| | ook 93-99%, or missed | | | | | squamous cell | | | |
| Т | ook 75-92%, or missed | | | <u> </u> | | east cancer | | | • |
| | | | | | | blon cancer | | - - - | • |
| | ook 67-74%, or missed etween 3-4 months | | | | x. Ot | ther cancer (non-skin) | | | • |
| | ook 50-66%, or missed etween 4-6 months | | | Ξ. | IF | YES, SPECIFY SITE: | | | |
| Г | ook 33-49%, or missed | _ | | | | blon polyp | | | • |
| | etween 6-8 months | | | | | brocystic or other benign breast disea | *** | | * |
| 1.1 | ook less than 33%, or missed nore than 8 months | | | | | YES, confirmed by: NO YE breast blopsy? | | | |
| T | ook none, or missed all | П | | | | abetes mellitus | | | • .' ♦ 1 |
| H | you missed taking your pills, what wa | | nain rea | a esta a barrega a desa | bb. Go | 영상 소가 영상 비행을 알려야 한다. 가지 않는 것이다. | , L | | • • • • |
| | , mooos aming your pino, wildt wa | | | | | aptic ulcer | | | • |
| | | | | | | alistones | | | <u>،</u> آ |
| foll pro | THE PAST YEAR, were you NEWLY owing? Please check NO or YES fo vide the month and year of diagnosis a the next page. | r. <u>EACH</u> and con NO | H item. nplete ti YES | If YES, please ne consent form Dx MO/YR | | YES, how diagnosed? x-ray, ultrasound other | | | |
| foll pro on a. | owing? Please check NO or YES fo wide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) | r. <u>EACH</u> and con NO | H item. nplete ti YES | If YES, please ne consent form Dx MO/YR |), IF) □ 1 □ 1 000 | x-ray, ultrasound other allbladder removal | | | · |
| foll pro on a. | owing? Please check NO or YES fo wide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) Angina pectoris | r. <u>EACH</u> and con NO | H item. nplete ti YES | If YES, please ne consent form Dx MO/YR | 9 9 1 □ 1 □ 1 □ 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 | x-ray, ultrasound other allbladder removal ctive or chronic liver disease or cirrho | | _ | |
| foll pro on a. | owing? Please check NO or YES fo vide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) Angina pectoris IF YES, confirmed by: anglogram/cardiac cath? | r. <u>EACH</u> and con NO D S | H item. nplete ti YES | If YES, please ne consent form Dx MO/YR | 9 1 □ 1 0 1 ee. Ga 1 ff. Ac gg. Ki | x-ray, ultrasound other allbladder removal | sis 🗌 | - | |
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| foll pro on a. b. | owing? Please check NO or YES fo vide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) Angina pectoris IF YES, confirmed by: anglogram/cardiac cath? stress test? | r. <u>EACH</u> and con NO C S J | H nem. mplete ti YES O • | If YES, please he consent form Dx MO/YR | 9 9 IF 1 □ 1 ee. Ga 1 ff. Ac gg. Kin 1 IF 1 IF 1 IF 1 IF | x-ray, ultrasound other allbladder removal xtive or chronic liver disease or cirrho dney disease (NOT kidney stones) YES, specify type: | sis 🗌 | - | |
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| foll pro on a. b. c. d. e. f. g. h. i. j. k. | owing? Please check NO or YES fo vide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) Angina pectoris IF YES, confirmed by: NO YE angiogram/cardiac cath? stress test? Coronary angioplasty (PTCA) IF YES, # of vessels: Coronary bypass surgery (CABG) IF YES, # of vessels: Congestive heart failure Ventricular tachycardia Atrial fibrillation Intermittent claudication Pulmonary embolism (PE) Deep vein thrombosis (DVT) | r. <u>EAC</u> and con D D S S C D D D D D D D D D D D D D D D | <u>H</u> tem. mplete ti YES □ • □ • □ • □ • □ • □ • □ • □ • | If YES, please he consent form Dx MO/YR | 9 9 9 1 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 | x-ray, ultrasound other allbladder removal stive or chronic liver disease or cirrho dney disease (NOT kidney stones) YES, specify type: YES, specify type: aronic kidney failure igraine headaches eeding hemorrhoids ny other gastrointestinal bleeding bagulation disorder eriodontal disease YES, # of teeth lost: acular degeneration RIGHT eye ataract RIGHT eye ataract LEFT eye ataract extraction RIGHT eye | sis | | |
| foll prc on a. b. c. d. f. g. h. i. j. k. l. | owing? Please check NO or YES fo vide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) Angina pectoris IF YES, confirmed by: NO YE anglogram/cardiac cath? stress test? Coronary angioplasty (PTCA) IF YES, # of vessels: Congestive heart failure Ventricular tachycardia Atrial fibrillation Intermittent claudication Pulmonary embolism (PE) Deep vein thrombosis (DVT) Stroke | r. EACH | <u>H</u> tem. mplete ti YES □ • □ • □ • □ • □ • □ • □ • □ • | If YES, please he consent form Dx MO/YR (a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c | ee. Ga ff. Ac gg. Kii i, Ac gg. Kii i, Mi i, Mi jj. Bli kk. Ar ii. Mi kk. Ar ii. Mi ji, Bli kk. Ar ii. Ca ii. Ca i | x-ray, ultrasound other allbladder removal stive or chronic liver disease or cirrho dney disease (NOT kidney stones) YES, specify type: rronic kidney failure igraine headaches eeding hemorrhoids ny other gastrointestinal bleeding bagulation disorder eriodontal disease YES, # of teeth lost weak to the the lost studar degeneration LEFT eye ataract RIGHT eye ataract LEFT eye | | | |
| foll prc on a. b. c. d. e. f. g. h. i. j. k. l. m, n. | owing? Please check NO or YES fo vide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) Angina pectoris IF YES, confirmed by: NO YE angiogram/cardiac cath? Configuration attress test? Coronary angioplasty (PTCA) IF YES, # of vessels: Coronary bypass surgery (CABG) IF YES, # of vessels: Congestive heart failure Ventricular tachycardia Atrial fibrillation Intermittent claudication Pulmonary embolism (PE) Deep vein thrombosis (DVT) Stroke TIA (transient ischemic attack) | r. EAC) and con S S C C C C C C C C C C C C C C C C C | <u>H</u> tem. mplete ti YES □ • • • • • • • • • • • • • • | If YES, please ne consent form Dx MO/YR (a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c | ee. Ga ff. Ac gg. Ki ff. Ac gg. Ki if. Ac gg. Ki if. Ac if. A | x-ray, ultrasound other allbladder removal stive or chronic liver disease or cirrho dney disease (NOT kidney stones) YES, specify type: YES, specify type: aronic kidney failure igraine headaches eeding hemorrhoids ny other gastrointestinal bleeding bagulation disorder eriodontal disease YES, # of teeth lost: acular degeneration RIGHT eye ataract RIGHT eye ataract LEFT eye ataract extraction RIGHT eye | sis | | |
| foll pro on a. b. c. d. f. g. h. i. j. k. l. m. n. | owing? Please check NO or YES fo vide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) Angina pectoris IF YES, confirmed by: angiogram/cardiac cath? stress test? Coronary angioplasty (PTCA) IF YES, # of vessels: Coronary bypass surgery (CABG) IF YES, # of vessels: Congestive heart failure Ventricular tachycardia Atrial fibrillation Intermittent claudication Pulmonary embolism (PE) Deep vein thrombosis (DVT) Stroke TIA (transient ischemic attack) Carotid artery surgery (not varicose | r. EAC) and con S S C C C C C C C C C C C C C C C C C | <u>H</u> tem. mplete ti YES □ • • • • • • • • • • • • • • | If YES, please he consent form Dx MO/YR (a) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c | 9 9 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | x-ray, ultrasound other allbladder removal tive or chronic liver disease or cirrho dney disease (NOT kidney stones) YES, specify type: YES, specify type: aronic kidney failure ligraine headaches eeding hemorrhoids ny other gastrointestinal bleeding bagulation disorder arodontal disease YES, # of teeth lost: acular degeneration RIGHT eye ataract RIGHT eye ataract LEFT eye ataract extraction RIGHT eye ataract extraction LEFT eye ataract extraction LEFT eye ataract extraction LEFT eye iningles (Varicella-zoster virus) | sis | | |
| foll prc on a. b. c. d. f. g. h. i. j. k. l. m. n. o. | owing? Please check NO or YES fo vide the month and year of diagnosis a the next page. Myocardial infarction (heart attack) Angina pectoris IF YES, confirmed by: anglogram/cardiac cath? stress test? Coronary angioplasty (PTCA) IF YES, # of vessels: Coronary bypass surgery (CABG) IF YES, # of vessels: Congestive heart failure Ventricular tachycardia Atrial fibrillation Intermittent claudication Pulmonary embolism (PE) Deep vein thrombosis (DVT) Stroke TIA (transient ischemic attack) Carotid artery surgery (not varicose veins) | r. <u>EAC</u> ; and con NO S S C C C C C C C C C C C C C | H ntem. yES U U U U U U U U U U U U U | If YES, please he consent form Dx MO/YR (a) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c | 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 | x-ray, ultrasound other allbladder removal tive or chronic liver disease or cirrho dney disease (NOT kidney stones) YES, specify type: Pronic kidney failure ligraine headaches eeding hemorrhoids ny other gastrointestinal bleeding bagulation disorder arlodontal disease YES, # of teeth lost; acular degeneration RIGHT eye ataract RIGHT eye ataract EFT eye ataract extraction RIGHT eye ataract extraction LEFT eye ataract extraction LEFT eye ningles (Varicella-zoster virus) heumatoid arthritis | sis | | |

| WOMEN'S HEALTH STUDY | FORM 96 / PA | GE 2 | | | HAR | VARD | MEDICA | L SCHC | OL |
|---|--|--|---|----------------------|--|---------------------|---------------------|------------------|----------|
| NSENT FORM If you responded YES to information we request will be used solely reby grant permission to Dr. Julie Buring, P eview a copy of the records of my hospitali GNOSIS: | for medical statistical pur professor, Harvard Medica | irposes a Il School, | nd mair 900 Co | itained ir mmonwe | the stries the stries of the stries of the string of the s | ictest c enue Ea | onfiden ast, Bos | nce. ston, MA | |
| | | | | | e # : | | | | 5 |
| ne of hospital / physician: Iress of hospital / physician: | | | | | | | | | |
| City: | | 1 | 19. j. j. | State: | | | _Zip: | an da an | |
| JR FULL NAME AT TIME OF DIAGNOSIS: _ | | | | | | | | | |
| JR SIGNATURE: | | | | Date: | n ya sana | | | | |
| | COPY VALID AS O | and the second | <u>.</u> | | | | | | |
| N THE PAST YEAR, have you experienced any of the | 그 가슴 옷을 가지 않는 것을 것을 것 같아. 같이 많이 했다. | or YES fo | r EACH it | em. | | | | | |
| | NO YES | | | | | | | NO | <u>)</u> |
| a. Symptoms suggestive of gastric upset b. Symptoms suggestive of peptic ulcer | | h. Easy b i. Nose b | 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 1.1 | | | | | | |
| c. Nausea | | i. Skin ra | | | | | | | |
| d. Constipation | | k. Fatigue | , | | | | | | |
| e. Diarrhea | | I. Drowsi | ness | | | | | | |
| f. Skin discoloration | <u> </u> | m.Headad | che | | | | | | |
| g. Blood in urine (hematuria) | | | | | | | | | |
| | NEXT COLUMN | | | | | | | | |
| DURING THE PAST MONTH, on approximately how | | f the follow | /ing? | | | 1 | 1 | ST MON | ŀ. |
| to NOT include your study pills. Please respond for | each item. | | | | 0 | 1-3 | 4-10 | 11-20 | 1 |
| a. Acetaminophen (e.g., Tylenol, Excedrin | P.M.) | | | | | | | | |
| b. Aspirin (e.g., Bayer, Bufferin, Anacin, Ex | cedrin, Ecotrin) | | | | | | | | |
| c. Medications containing aspirin (e.g., Alk | a-Seltzer, Doan's Pills, Florina | l) | | | | | | | |
| d. Traditional nonsteroidal, anti-inflammato | ry agents (e.g., Motrin, Advil, I | Nuprin, Naj | prosyn, A | eve) | | | | | |
| e. New NSAIDs (Cox-2 inhibitors, e.g., Cel | ebrex, Vioxx) | | | | | | | | |
| f. Multivitamins: Specify brand name: | | | | | | | | | 1 |
| Specify: Does multivitamin contain vitar Contain vitamin A (including be | | | | | | | | | |
| | | Content_ | | _10 | | Π | | \square | |
| g. Individual supplements of vitamin C (no h. Individual supplements of beta-carotene | | | | | | | | | |
| | | | | | | | | | |
| Individual supplements of vitamin E (noi Individual supplements of vitamin A (not | | | | | | | | | |
| | | | | | | | | | |
| k. Other vitamin preparations containing b Specify <u>EXACT</u> BRAND and TYPE: | | | | lamins) | | | | | |
| openiy <u>www.</u> envire and the set | | | | AVER | AGE TIM | E PER W | /EEK | | |
| | ate average unie per week | | 1-19 Min. | 20-59 Min. | One Hr. | 1½ Hr. | 2-3 Hr. | 4-6 Hr. | |
| DURING THE PAST YEAR, what was your approxim spent at each of the following recreational activities? | | Zero | 10 C 20 C 20 C | | | | | | |
| spent at each of the following recreational activities? | A | Zero | | | | | | | |
| spent at each of the following recreational activities? a. Walking or hiking (include walking to wo | A | | | | | | | | |
| spent at each of the following recreational activities? a. Walking or hiking (include walking to wo b. Jogging (slower than 10 minute miles) | A | | | | | | | | |
| spent at each of the following recreational activities? a. Walking or hiking (include walking to wo | A | | | | | 100 T R 1 | 1.000 | | |
| a. Walking or hiking (include walking to wo b. Jogging (slower than 10 minute miles) c. Running (10 minute miles or taster) | nrk) | | | | | | | | |
| a. Walking or hiking (include walking to wo b. Jogging (slower than 10 minute miles) c. Running (10 minute miles or faster) d. Bicycling (include stationary machine) | ork) cise machines | | | | | | | | |
| a. Walking or hiking (include walking to wo b. Jogging (slower than 10 minute miles) c. Running (10 minute miles or faster) d. Bicycling (include stationary machine) e. Aerobic exercise / aerobic dance / exer | ork) cise machines | | | | | | | | |
| a. Walking or hiking (include walking to wo b. Jogging (slower than 10 minute miles) c. Running (10 minute miles or faster) d. Bicycling (include stationary machine) e. Aerobic exercise / aerobic dance / exer f. Lower intensity exercise / yoga / stretch | ork) cise machines | | | | | | | | |
| a. Walking or hiking (include walking to wo b. Jogging (slower than 10 minute miles) c. Running (10 minute miles or faster) d. Bicycling (include stationary machine) e. Aerobic exercise / aerobic dance / exert f. Lower intensity exercise / yoga / stretch g. Tennis, squash, or racquetball | ork) cise machines | | | | | | | | |

| WOMEN'S HEALTH STUDY | FORM | 196 / PAGE 3 |
|--|---|---|
| 7. What is your usual walking pace outdoors? | ☐ Don't walk regularly ☐ Brisk pace (3-3.9 mph) | Easy, casual (less than 2 mph) Normal, average (2-2.9 mph) |
| e your menstrual periods ceased MANENTLY? Yes: No menstrual periods Yes: Had menopause, but now have periods induced by hormones, No: Premenopausal Not sure |] | a. At what AGE did your periods cease? b. For what REASON did your periods cease? SURGERY: If due to surgery, were your ovaries and/or uterus removed? Mark ALL: that apply Uterus removed One ovary removed Both ovaries removed RADIATION or CHEMOTHERAPY |
| 9. Have you EVER taken SERMS such as raloxifene (Evista) or tamoxifen? No Yes, currently Yes, past | | NATURAL: If natural (non-surgical) menopause, have you had subsequent surgery to remove ovaries or uterus? (Mark ALL that apply) No, did not have surgery One ovary removed Uterus removed Both ovaries removed |
| IF YES, what is the total amount □ < 6 mo □ 6-12 mo □ 13 | | 36 mo |
| 0. Have you used female hormones (other than | oral contraceptives) in the I | PAST THREE YEARS? |
| Estr Proy d) if yo c d e) if yo e) if yo c f) Wha d f) Wha d oral | u used conjugated astrogen 0.3 mg 0.625 mg ose unknown u used <u>medroxy progesteror</u> 5 mg 5-9 mg tt was your <u>pattern</u> of hormo or patch estrogen no | Oral Prempro Oral Premphase Oral Estrace/Ogen Patch estrogen Other estrogen, specify: |
| 1. Do you CURRENTLY smoke cigarettes? □ No □ Yes → □F YES: On average, □ 1-4 cigs. □ 5-14 | | smoke EACH DAY? -35 cigs. 36-44 cigs 45 + cigs. |
| A. Please provide us with your ph HOME: () B. Please indicate the name, addic contact if we are unable to corr NAME: ADDRESS: | one number(s) so we ma ress and phone number o tact you. Please indicate | NG HIGH RATES OF FOLLOW-UP. uy contact you if we are unable to reach you through the mail: WORK: |
| C. Your birthdate: | and here in the second s | (OPTIONAL) |

| | DMEN'S HEALTH STUDY | | | | FORM 10 | | - Anna Anna Anna Anna Anna Anna Anna Ann | · | |
|---|--|--|---|---|--|--|---|----|------------|
| · · · | Are you CURRENTLY taking the W | | | | > 🗌 Yes | NE | WLY DIAGNOSED IN PAST YEAR? | NO | YES Dx I |
| | Are you CURRENTLY taking the Al For EACH_of the TWO study agent | | | | | q. | Elevated cholesterol (dx by clinician) | | ° □ |
| | indicate below the percentage of | | | | | r. | Hypertension (dx by clinician) | | `D 👄 🔜 |
| | YEAR. | | | | | s. | Melanoma | Ĺ | □ ⇒ |
| | | WHITE | | | IBER APS | t. | Non-melanoma skin cancer | | □ ⇒ _ |
| [| Took 100%, or missed none | | | | | | IF YES, TYPE: 🗌 basal cell | | |
| | Took 93-99%, or missed only a few | | | <u>,</u> [| | | squamous cell unknown | • | |
| ſ | Took 75-92%, or missed | | | r | | u. | Breast cancer | | □ ➡, |
| | between 1-3 months | | | l | | v . | Lung cancer | | □ ➡ |
| ſ | Took 67-74%, or missed | | | | | w. | Colon cancer | | □ ➡ |
| | between 3-4 months | | | · •.[| | х. | Other cancer (non-skin) | | □ ➡ |
| | Took 50-66%, or missed between 4-6 months | | | Ĭ | | | IF YES, SPECIFY SITE: | | |
| F | Took 33-49%, or missed | | | - | | у. | Colon polyp | | 🗋 📫 |
| | between 6-8 months | | | | | z . | Fibrocystic or other benign breast disease | | □ ➡ |
| | Took less than 33%, or missed more than 8 months | | | | | | breast blopsy? | | |
| T | Took none, or missed all | | | | | | aspiration? | | — . |
| | | | | | | | Diabetes mellitus | | □ ➡ |
| | If you missed taking your pills, what | at was the | main r | reason? | | | Gout | | ∟ ● |
| - 1 | | | | | | CC. | Peptic ulcer | | . 🗆 🔿 |
| fo pi | I THE PAST YEAR, were you NE ollowing? Please check NO or YE rovide the month and year of diagn n the next page. | ES for EA | <u>CH</u> ite omplet | m. If YE | ES, please | dd. | Gallstones IF YES, how diagnosed? A-ray, ultrasound other | | □ ➡ |
| fo pi oi | ollowing? Please check NO or YE rovide the month and year of diagn | ES for <u>EA</u> osis and c NC | <u>CH</u> ite omplet | m. If YE te the con S Dx I | ES, please nsent form | | IF YES, how diagnosed? | | |
| fo pr or a. | Nowing? Please check NO or YE rovide the month and year of diagn n the next page. | ES for <u>EA</u> osis and c NC | <u>CH</u> ite omplet D YE | m.lfYE tethecon SDxl]➡ | ES, please insent form MO/YR | | IF YES, how diagnosed? x-ray, ultrasound other | | |
| fo pr or a. | Illowing? Please check NO or YE rovide the month and year of diagn in the next page. Myocardial infarction (heart attack Angina pectoris | ES for <u>EA(</u> osis and c NC k) | <u>CH</u> ite omplet D YE | m.lfYE tethecon SDxl]➡ | ES, please insent form MO/YR (a) | ee. ff. | IF YES, how diagnosed? x-ray, ultrasound other Gallbladder removal | | |
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| WOMEN'S HEALTH STUDY | | | FORM | 108 / PAGE 2 | · · · · · · · · · · · · · · · · · · · | HARV | ARD MEDICA | L SCHOOL |
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| No ☐ Yes ➡ IF YES: a. ☐ Don't know b. 6. Have you EVER been diagno 7. How often are your eyes dry the second sec | Do the Are the sed (by (not we sted? W been o N, have of <u>ROUT</u> NO | ese symptoms ese symptoms y a clinician) w et enough)? Wo /ould you say: diagnosed (by e you had an <u>TINE</u> SCREEN IF YES: For Symptoms | occur only at n s worse in the e ith restless leg: ould you say: | est and does m vening/night or s syndrome ? [constantly thy often aving dry eye ing procedure as it last done? Within the past year | oving improve ompared with t No Y often someti syndrome? s or exams? If 1-2 years ago | them? □ No ne morning? 1 es → Dx date □ sometime mes □ ne No □ Yes ■ Was the proce = YES: WHEN 3-5 years ago | ☐ Yes ☐ I ☐ No ☐ Yes ④ (MO/YR): | Don't know Don't know Don't know // //YR):/ ne because o DON'T REMEMBER |
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| No ☐ Yes ➡ IF YES: a. ☐ Don't know b. 6. Have you EVER been diagno 7. How often are your eyes dry d. 8. How often are your eyes irrita 9. In the past 5 years, have you 10. SINCE THE STUDY BEGAT SYMPTOMS or as a matter o a. A physical exam b. Blood pressure check c. Blood cholesterol check | Do the Are the seed (by (not we tted? W been c N, have f ROUT | ese symptoms ese symptoms y a clinician) w ot enough)? Wo /ould you say: diagnosed (by e you had an <u>TINE</u> SCREEN IF YES: For Symptoms | occur only at r s worse in the e ith restless leg: ould you say: | est and does m vening/night co s syndrome ? [constantly tly constantly tly const | oving improve ompared with t No Y (often) someti syndrome? s or exams? N II 1-2 years ago | them? □ No ne morning? I es → Dx date □ sometime mes □ ne No □ Yes ■ Was the proce = YES: WHEN 3-5 years ago □ □ | Yes C No Yes (MO/YR): | Don't know Don't know Don't know // // //YR):/ ne because o DON'T REMEMBER |
| No Yes → IF YES: a. Don't know b. Have you EVER been diagno How often are your eyes dry (a) How often are your eyes irrita In the past 5 years, have you SINCE THE STUDY BEGAN SYMPTOMS or as a matter of a. A physical exam b. Blood pressure check c. Blood cholesterol check d. Fasting blood sugar | Do the Are the sed (by (not we ted? W been o f ROU) | ese symptoms ese symptoms y a clinician) w et enough)? We yould you say: diagnosed (by e you had an <u>TINE</u> SCREEN IF YES: For Symptoms | occur only at n s worse in the e ith restless leg: ould you say: | est and does m vening/night or s syndrome ? [constantly thy often having dry eye s ing procedure as it <u>last</u> done? | oving improve ompared with the No Y often often soundrome? soundrome? bis bis soundrome? bis sou | them? □ No ne morning? 1 es ➡ Dx date □ sometime mes □ ne No □ Yes ■ Nas the proce = YES: WHEN 3-5 years ago □ □ □ | Yes □ No Yes (MO/YR): | Don't know Don't know Don't know /// //YR):/ nne because o DON'T REMEMBER |
| No ☐ Yes → IF YES: a. ☐ Don't know b. 6. Have you EVER been diagno 7. How often are your eyes dry terms 8. How often are your eyes irrita 9. In the past 5 years, have you 10. SINCE THE STUDY BEGAT SYMPTOMS or as a matter o a. A physical exam b. Blood pressure check c. Blood cholesterol check d. Fasting blood sugar e. Rectal exam | Do the Are the esed (by (not we ated? W been o been o N, have f ROUT | ese symptoms ese symptoms y a clinician) w et enough)? We /ould you say: diagnosed (by e you had an <u>TINE</u> SCREEN IF YES: For Symptoms | occur only at n s worse in the e ith restless leg: ould you say: | est and does m vening/night or s syndrome ? [constantly thy often naving dry eye ing procedure as it last done? Within the past year | oving improve ompared with t No Y often someti syndrome? s or exams? If 1-2 years ago | them? □ No ne morning? 1 es → Dx date □ sometime mes □ ne No □ Yes ■ Was the proce = YES: WHEN 3-5 years ago □ □ □ □ | Yes □ No Yes (MO/YR): | Don't know Don't know Don't know // //YR):/ nne because d DON'T REMEMBER |
| No Yes IF YES: a. Don't know b. 6. Have you EVER been diagno 7. How often are your eyes dry (8. How often are your eyes irrita 9. In the past 5 years, have you 10. SINCE THE STUDY BEGAT SYMPTOMS or as a matter o a. A physical exam b. Biood pressure check c. Blood cholesterol check d. Fasting blood sugar e. Rectal exam f. Stool occult blood test | Do the Are the sed (by (not we steed? We been constrained on the set of ROUT) | ese symptoms ese symptoms y a clinician) w et enough)? We /ould you say: diagnosed (by e you had an <u>TINE</u> SCREEN IF YES: For Symptoms | occur only at n s worse in the e ith restless leg: ould you say: | est and does m vening/night cr s syndrome ? [constantly thy often naving dry eye a ing procedure as it last done? Within the past year | oving improve ompared with 1 No Y often someti syndrome? sor exams? N II 1-2 years ago II 1-2 years ago | them? □ No he morning? 1 les → Dx date sometime mes □ ne No □ Yes ■ Was the proce FYES: WHEN 3-5 years ago □ □ □ □ □ | Yes I No Yes (MO/YR): | Don't know Don't know Don't know I Don't Low I Don't Lo |
| No Yes IF YES: a. Don't know b. 6. Have you EVER been diagno 7. How often are your eyes dry t 8. How often are your eyes irrita 9. In the past 5 years, have you 10. SINCE THE STUDY BEGAT SYMPTOMS or as a matter o a. A physical exam b. Blood pressure check c. Blood cholesterol check d. Fasting blood sugar e. Rectal exam f. Stool occult blood test g. Colonoscopy or sigmoidoscopy | Do the Are the sed (by (not we ted? W been c of ROU) | ese symptoms ese symptoms y a clinician) w ot enough)? Wo /ould you say: diagnosed (by e you had an <u>TINE</u> SCREEN IF YES: For Symptoms | occur only at n s worse in the e ith restless leg: ould you say: | est and does m vening/night co s syndrome ? [constantig tiy] often naving dry eye ing procedure as it <u>last</u> done? Within the past year]]]]]]]]]]]] | oving improve ompared with it No Y often someti syndrome? sor exams? If 1-2 years ago If 1-2 years ago | them? □ No ne morning? 1 es → Dx date □ sometime mes □ ne No □ Yes ■ Nas the proce = YES: WHEN 3-5 years ago □ □ □ □ □ | Yes □ No Yes (MO/YR): | Don't know Don't know Don't know N/YR):/ ne because o DON'T REMEMBER |
| No Yes → IF YES: a. Don't know b. Have you EVER been diagno How often are your eyes dry (a) How often are your eyes irrita In the past 5 years, have you SINCE THE STUDY BEGAN SYMPTOMS or as a matter of Blood pressure check Blood cholesterol check Fasting blood sugar Rectal exam Stool occult blood test Colonoscopy or sigmoidoscopy Pelvic exam | Do the Are the sed (by (not we ted? W been c f ROU) | ese symptoms ese symptoms y a clinician) w tet enough)? We vould you say: diagnosed (by e you had an <u>TINE</u> SCREEN IF YES: Sport Symptoms | occur only at n s worse in the e ith restless leg: ould you say: | est and does m vening/night or s syndrome ? [constantly thy often naving dry eye ing procedure as it last done? Within the past year | oving improve ompared with the No Y often soundrome? soundrome? soundrome? If 1-2 years ago If 1-2 years ago If 1-2 years ago If If If If If If If If If If If If If | them? □ No ne morning? 1 es → Dx date □ sometime mes □ ne No □ Yes ■ Was the proce - YES: WHEN 3-5 years ago □ □ □ □ □ □ □ | Yes □ No Yes (MO/YR): | Don't know Don't know Don't know Don't know N/YR):/ nne because d DON'T REMEMBEF |
| No ☐ Yes → IF YES: a. Don't know b. 6. Have you EVER been diagno 7. How often are your eyes dry (e) 8. How often are your eyes irrita 9. In the past 5 years, have you 10. SINCE THE STUDY BEGAT SYMPTOMS or as a matter of SYMPTOMS or as a matter of SYMPTOMS or as a matter of Context of the state of the sta | Do the Are the ased (by (not we ated? We been or the ased of the a | ese symptoms ese symptoms y a clinician) w et enough)? We /ould you say: diagnosed (by e you had an TINE SCREEN IF YES: For Symptoms | occur only at n s worse in the e ith restless leg: ould you say: | est and does m vening/night cr s syndrome ? [constantly thy often naving dry eye ing procedure as it last done? Within the past year | oving improve ompared with 1 No Y often someti syndrome? sor exams? N 1-2 years ago I 1-2 years ago I I 1-2 years ago I I I 1-2 years ago I I I I I I I I I I I I I I I I I I I | them? □ No ne morning? 1 es → Dx date □ sometime mes □ ne No □ Yes ■ Was the proce = YES: WHEN 3-5 years ago □ □ □ □ □ □ □ | Yes □ No Yes (MO/YR): | Don't know Don't know Don't know I Don't kno |

| NTHE PAST YEAR, have you experienced any of | the following? Plea | se check NO | or YES | for EACH | l item. | | | | | | |
|---|--|------------------------------------|---------------------|------------------|--------------------|--------------------|-------------------|-----------------|-------------------|-------------------|--------|
| | NO YES | S | | | | | | | | NO | YES |
| a Symptoms suggestive of gastric upset | |] | h. Eas | y bruisin | g | | | | | | |
| Symptoms suggestive of peptic ulcer | | | i. Nos | e bleed | (epistaxis | 5) | | | | | |
| c. Nausea | | | | n rash | | | | | | | |
| d. Constipation | | | k. Fati | | | | | | | | |
| e Diarrhea f. Skin discoloration | | | | wsiness | | | | | | | |
| g. Blood in urine (hematuria) | | | m. Hea | laache | | | <u>.</u> | · | | | |
| | | | | | | | | C' | | | |
| | O THE NEXT COL | | | | | | | | | | |
| URING THE PAST MONTH, on approximately how to NOT include your study pills. Please respond for | | ou take any o | f the follo | wing? | | | D | AYS IN | THE PAS | ST MON | TH |
| | | | | | | Γ | 0 | 1-3 | 4-10 | 11-20 | 2 |
| a. Acetaminophen (e.g., Tylenol, Excedrin P.M.) | | | | | | | | | | | [|
| b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin | Ecotrin) | • • • • • | | · ~ ~ | | | | | | |] [|
| c. Medications containing aspirin (e.g., Alka-Seltz | er, Doan's Pills, Fi | orinal) | | | | | | | | | [|
| d. COX-2 inhibitors (e.g., Celebrex, Vioxx) | and the second sec | | | | | 1 | | П | | Гп |] [|
| e. Other nonsteroidal, anti-inflammatory agents (| a.a., Motrin, Advil, A | Aleve, Ibuprof | en) | | | | | | | | T i |
| f. Statins (e.g., Mevacor, Lipitor, Pravachol, Zoco | | | | | | | | | | | |
| g. Multivitamins: Specify brand name: | ., | | | | | | $\overline{\Box}$ | | | | 1 I |
| Specify: Does multivitamin contain vitamin E? Contain vitamin A (including beta-caro | INO tene)? No | ☐Yes ➡ ☐Yes ➡ | | | IU IU | | | | | | |
| h. Individual supplements of vitamin C (not includ | ing multivitamins) | | | | · | | | | | | 1 |
| i. Individual supplements of beta-carotene (not in | icluding multivitam | ins) | | | | | | | | | [|
| Individual supplements of vitamin E (not includ | ing multivitamins) | | | | | | | | | | 1 |
| k. Individual supplements of vitamin A (not includ | ing multivitamins) | | | | | | | | | | [|
| I. Other vitamin preparations containing beta-car Specify EXACT BRAND and TYPE: | otene, vitamins E c | or A (not inclu | ding muli | tivitamins | 5) | | | | | | [|
| m. Individual supplements of folic acid (not includi | ng multivitamins) | | | | | | | | | | [|
| n. Individual supplements of zinc (not including m | ultivitamins) | | | | | | | | | | 1 |
| o. Individual supplements of chromium (not includ | ling multivitamins) | | | | | | | | | | [|
| lease record your average consumption of the follo | owing beverages | | | | | | <u>.</u> | | | 1 | |
| ver the LAST YEAR: | | Never or Less Than One/Month | 1-3 Per Month | 1 Per Week | 2-4 Per Week | 5-6 Per Week | P | 1 Per Pay | 2-3 Per Day | 4-5 Per Day | P D |
| a. Beer (1 glass, bottle, can) | | | | W | | | 0 | อ | | | E |
| | | | | W | | | | D | | | |
| b. Red wine (include sherry, port) (4 oz. glass) | a an an an an Arrison | | | | | | | | | | |
| b. Hed wine (include sherry, port) (4 oz. glass) c. White wine (4 oz. glass) | | | | W | | | [| D | | | C |

FORM 108 / PAGE 3

14. What is your CURRENT weight and height?

15. Did any of these relatives

WOMEN'S HEALTH STUDY

Weight: _____ pounds AND Height: _____ ft. ____ in.

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

AGE AT FIRST DIAGNOSIS

HARVARD MEDICAL SCHOOL

| ever nave | | | | | | | | | |
|---------------------------|--------------------|--------|---------------|--------|----------------|---------|--|--|--|
| | RELATIVE | | | | | | | | |
| | UNKNOWN OR NONE | MOTHER | ANY SISTER | FATHER | ANY BROTHER | | | | |
| a. Diabetes? | | | | | | | | | |
| b.Colon or rectal cancer? | | | | | | \land | | | |
| c. Ovarian cancer? | | | | | | | | | |
| | PLEA | SE GO | TO THE | ENEXT | COLUMN | J | | | |

| | | | DIAGNOSIS | | | | | | | | |
|----|---|------------------|-----------|------------------|-----------------|-----------------|------------|-----|--|--|--|
| a) | Myocardial Infarction? | NO or UNKNOWN | YES | BEFORE AGE 40 | AGE 40 TO 49 | AGE 50 TO 59 | AGE 60+ | AGE | | | |
| | Mother | | | • | | | | | | | |
| | Father | | | | | | | | | | |
| b) | Breast Cancer? | 1.1 | | | | | | | | | |
| | Mother | | | ➡ □ | | | | | | | |
| | Any sister | | | ➡ □ | | | | | | | |
| | Maternal grandmothe | r 🗋 | | ➡ □ | | | | | | | |
| 2 | Paternal grandmother | | | | | | | | | | |
| | The second se | | | | | | | | | | |

| WOMEN'S HEALTH STUDY | F | ORM 108 / | PAGE 4 | | | |
|---|--------------------------------------|---|--|--|-----------------------------------|----------------------------|
| uestions 17-23* ask for your views about you | ır health Pleas | | | by marking o | ne box lf vou are | uneuro about |
| ow to answer, please give the best answer you | | e answer ev | ery question | by marking of | ie box. Il you ale | ំ រ |
| A second sec second second sec | - | | | | | |
| 7. In general, would you say your health is: | Excellent | Very go | | | | |
| | L . | <u>Ц</u> | C C | l 🗖 | | |
| 8. The following items are about activities you | might do during | g a typical d | ay. Does <u>you</u> | r health now I | imit you in these | activities? |
| | | · · · · · · · · · · · · · · · · · · · | | 2010 - 100 - | | - ⁻ . |
| | | Yes, lim a lot | | | No, not limited | |
| | | | a | ittle | at all | |
| a. Moderate activities, such as moving a ta | | | | | | |
| pushing a vacuum cleaner, bowling, or pl | aying goir | | | | | ····· |
| b. Climbing several flights of stairs | | | | | | |
| | | | | | | |
| 9. During the past 4 weeks , have you had any | / of the followin | g problems | with your wo | k or other reg | ular daily activition | es <u>as a result of y</u> |
| physical health? | | | Y | s | No | |
| a. Accomplished less than you would like | | | E |] | | |
| | | | | | | |
| b. Were limited in the kind of work or other | activities | | L |] | | |
| a. Accomplished less than you would like | | | | - | | |
| b. Didn't do work or other activities as carel | fully as usual | 18) 19 | ļ |] | | |
| | | | | | | |
| 1. During the past 4 weeks how much did pai | | | | | | e and housework) |
| | Not at all | A little | | 11. I I I I I I I I I I I I I I I I I I | · · · · · · · · · · · · · · · · · | xtremely |
| | | | | | | |
| | a 18 5 il 5 5 il 5. | wo hoon will | h vou duirine | the past 4 v | | |
| 2. These questions are about how you feel an | | | | the time durin | | ake |
| These questions are about how you feel an the one answer that comes closest to the w | ay you have be | en feeling. I | How much of | | | |
| | ay you have be All of | en feeling. I Most of | How much of A good bit | Some of | A little of | None of |
| the one answer that comes closest to the w | ay you have be All of the time | Most of the time | How much of A good bit of the time | Some of the time | A little of the time | None of the time |
| the one answer that comes closest to the w a. Have you felt calm and peaceful? | ay you have be All of the time | Most of the time | How much of A good bit of the time | Some of the time | A little of the time | None of the time |
| the one answer that comes closest to the w a. Have you felt calm and peaceful? b. Did you have a lot of energy? | ay you have be All of the time | en feeling. I Most of the time | How much of A good bit of the time | Some of the time | A little of the time | None of the time |
| the one answer that comes closest to the w a. Have you felt calm and peaceful? | ay you have be All of the time | Most of the time | How much of 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? 3. During the past 4 weeks , how much of the | ay you have be All of the time | Most of the time | How much of 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? | ay you have be All of the time | Most of the time | How much of A good bit of the time | Some of the time | A little of the time | None of the time |
| a. Have you feit caim and peaceful? b. Did you have a lot of energy? c. Have you feit downhearted and blue? 3. During the past 4 weeks, how much of the | ay you have be All of the time | Most of the time | How much of 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? 3. During the past 4 weeks , how much of the visiting with friends, relatives, etc.)? | ay you have be All of the time | Most of the time | How much of 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? 3. During the past 4 weeks , how much of the visiting with friends, relatives, etc.)? THE INFORMATION BELOW ASSISTS I | ay you have be All of the time | Most of the time by sical hea Most of the time | How much of A good bit of the time | Some of the time | A little of the time | None of the time |
| the one answer that comes closest to the w a. Have you felt calm and peaceful? b. Did you have a lot of energy? c. Have you felt downhearted and blue? 3. During the past 4 weeks , how much of the visiting with friends, relatives, etc.)? THE INFORMATION BELOW ASSISTS I A. Please provide us with your phone nu | ay you have be All of the time | Most of the time by sical hea Most of the time | How much of 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? 3. During the past 4 weeks , how much of the visiting with friends, relatives, etc.)? THE INFORMATION BELOW ASSISTS I | ay you have be All of the time | Most of the time by sical hea Most of the time | How much of A good bit of the time | Some of the time | A little of the time | None of the time |
| the one answer that comes closest to the w a. Have you felt calm and peaceful? b. Did you have a lot of energy? c. Have you felt downhearted and blue? 3. During the past 4 weeks , how much of the visiting with friends, relatives, etc.)? THE INFORMATION BELOW ASSISTS I A. Please provide us with your phone nu | ay you have be All of the time | Most of the time by visical hea Most of the time NING HIGH may contact WORK: | How much of 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? 3. During the past 4 weeks, how much of the visiting with friends, relatives, etc.)? THE INFORMATION BELOW ASSISTS I A. Please provide us with your phone nu HOME: () | ay you have be All of the time | Most of the time by visical hea Most of the time NING HIGH may contact WORK: r of SOMEC | How much of A good bit of the time | Some of the time | A little of the time | None of the time |

ADDRESS: ______STATE / ZIP: ______ C. Your birthdate: ______AND = D. LAST 6-digits of Social Security Number: XIXIX--_-_____ MO DAY YR AND = D. LAST 6-digits of Social Security Number: XIXIX--_-____ (OPTIONAL) E. Your Maiden Name: (LAST NAME ONLY) ______F. e-mail address: ______

Thank you! Please call (800) 633-6911 if you have any questions.

*Question nos. 17-23 are the SF-12® Health Survey (Medical Outcomes Trust) © QualityMetric Incorporated

WOMEN'S HEALTH STUDY

| . Are you CURRENTLY taking the wl | hite pills O No | ? O Yes | | 2. IN THE PAST YEAR, have you exper following? Please fill NO or YES for | | - |
|---|--------------------------|---------------|---|---|--------------|----------------|
| Are you CURRENTLY taking the an For each of the TWO study agents | O No | O Yes | | a. Symptoms suggestive of gastric upset | | O Yes |
| please indicate below the % of pills over the PAST YEAR: | you hav WHITE PILL | AMBER CAPS | | b. Symptoms suggestive of peptic ulcer | O No O No | O Yes O Yes |
| Took 100%, or missed none | 0 | 0 | | d. Constipation | O No | O Yes |
| Took 93-99%, or missed only a few | 0 | 0 | | e. Diarrhea | O No | O Yes |
| Took 75-92%, or missed between 1-3 months | 0 | 0 | | f. Skin Discoloration | O No | O Yes |
| Took 67-74%, or missed between 3-4 months | ο | 0 | | g. Blood in urine (hematuria) | O No | O Yes |
| Took 50-66%, or missed between 4-6 months | 0 | 0 | | h. Easy bruising | O No | O Yes |
| Took 33-49%, or missed between 6-8 months | 0 | 0 | | i. Nose bleed (epistaxis) | O No | O Yes |
| Took less than 33% or missed more than 8 months | 0 | 0 | ↑ | j. Skin rash k. Fatigue | O No O No | O Yes |
| Took none, or missed all | 0 | 0 | | I. Drowsiness | O No | O Yes |
| If you missed taking your pills, wha reason? | t was the | e main | | m. Headache | O No | O Yes |

3. IN THE PAST YEAR, were you NEWLY DIAGNOSED with any of the following? Please fill NO or YES for each item. If YES, please provide the month and year of the diagnosis or procedure. Also, IF YES, please complete the consent form at the end of this question, on page 4.

| a. Myocardial infarction (heart attack) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
|---|----------|---------|---------------|---------------------|------------|
| b. Arıgina pectoris | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo / yr |
| If YES, confirmed by: angiogram | m/cardia | c cath? | O No | O Yes stress test? | O No O Yes |
| c. Coronary angioplasty (PTCA) | O No | O Yes | \rightarrow | MO/YR of procedure: | mo yr |
| d. Coronary bypass surgery (CABG) | O No | O Yes | \rightarrow | MO/YR of procedure: | |
| e. Congestive heart failure | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo / yr |
| f. Ventricular tachycardia | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| g. Atrial fibrillation | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| h. Intermittent claudication | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo / yr |
| | | Р | age 1 | | (OVER) |

WOMEN'S HEALTH STUDY / FORM 120

| i. Pulmonary embolism (PE) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
|--|---------|---------|---------------|---|-------|
| j. Deep vein thrombosis (DVT) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| k. Stroke | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| I. TIA (transient ischemic attack) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| m. Carotid artery surgery (endarterectomy) | O No | O Yes | \rightarrow | MO/YR of procedure: | |
| n. Peripheral artery surgery (not varicose veins) | O No | O Yes | \rightarrow | MO/YR of procedure: | |
| o. Parkinson's disease | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| p. Asthma | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| q. Other chronic lung disease (e.g., emphysema, chronic bronchitis) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| r. Elevated cholesterol (dx by a clinician |) O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| s. Hypertension (dx by a clinician) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| t. Melanoma | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| u. Non-melanoma skin cancer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| If YES, what type? O basal ce | 11 O s | quamous | cell | O unknown | |
| v. Breast cancer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| w. Lung cancer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| x. Colon cancer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| y. Other cancer (non-skin) SITE: | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| z. Colon polyp | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| | | | | | mo yr |
| aa. Fibrocystic or other benign breast disease | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| | | | → Yes | MO/YR of diagnosis: aspiration? O No | |
| breast disease | | | → Yes → | | |
| breast disease If YES, confirmed by: breast bio | opsy? C | No O | | aspiration? O No | |

WOMEN'S HEALTH STUDY

| ee. Gallstones | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
|---|-----------------------|------------|---------------|---|---------|
| If YES, how was it diagnosed? | O x-ray, | ultrasour | nd (| O other | mo yr |
| ff. Gallbladder removal | O No | O Yes | \rightarrow | MO/YR of procedure: | mo / yr |
| gg. Active or chronic liver disease | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| hh. Kidney disease (other than kidney stones) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo / yr |
| If YES, specify type of disease: | | | | | |
| ii. Chronic kidney failure | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| jj. Migraine headaches | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| kk. Depression (dx by a clinician) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| II. Bleeding hemorrhoids | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| mm. Any other gastrointestinal bleeding | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| nn. Coagulation disorder | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| oo. Periodontal disease Number of teeth lost : | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| pp. Macular degeneration RIGHT eye | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo yr |
| qq. Macular degeneration LEFT eye | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo / yr |
| rr. Cataract RIGHT eye | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| ss. Cataract LEFT eye | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo / yr |
| tt. Cataract extraction RIGHT eye | O No | O Yes | \rightarrow | MO/YR of procedure: | mo yr |
| uu. Cataract extraction LEFT eye | O No | O Yes | \rightarrow | MO/YR of procedure: | mo yr |
| vv. Shingles (Varicella-zoster virus) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| ww. Rheumatoid arthritis | O No | O Yes | \rightarrow | MO/YR of diagnosis: | mo / r |
| IF YES, was rheumatoid factor | O nega | tive / unk | nown | O positive | |
| xx. If you have had OTHER MAJOR ILL | NESSES, IER ILLNES | | ded in | the above, please list th MO/YR OF DIAGNOS | |
| OTHER ILLNESS 1: | | | | | |
| OTHER ILLNESS 2: | | | | | |
| OTHER ILLNESS 3: | | | | | |

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WOMEN'S HEALTH STUDY / FORM 120

| CONSENT FORM: If you responded YES to any of the items in quest information we request will be used solely for medical statistical purposes and I grant permission to Dr. Julie Buring, Professor, Harvard Medical Schoo records of my hospitalization/treatment for: | maintai | ned in the strict | est confidence. | | | | | | |
|---|----------|-------------------|-----------------|-------------------|--|--|--|--|--|
| DIAGNOSIS / PROCEDURE: | 0 | ATE OF HOSP | ITALIZATION / | TREATMENT: | ······································ | | | | |
| Name of hospital/physician: | | Pł | none #: | | - A Philad de cast cases - | | | | |
| Address of hospital/physician: | | | | | | | | | |
| City: | | | State: | _ Zip code: | | | | | |
| YOUR FULL NAME AT TIME OF DIAGNOSIS: | | | | | | | | | |
| | | | | | | | | | |
| Your Signature (COPY VAL | ID AS C | RIGINAL) | | Date | | | | | |
| I. DURING THE PAST MONTH, on approximately how many days did you take any of the following? Do not include your study pills. Please respond on each line. DAYS USED IN THE PAST MONTH | | | | | | | | | |
| a. Acetaminophen (e.g., Tylenol, Excedrin P.M.) | Ο 0 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| d. COX-2 inhibitors(e.g., Celebrex, Vioxx) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| f. Statins (e.g., Mevacor, Lipitor, Pravachol, Zocor) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| g. Multivitamins (provide BRAND, vits. E and A/beta-carotene contents below) | Ο 0 | O 1-3 days | O 4-10 days | 🔿 11-20 days | O 21+ days | | | | |
| BRAND NAME OF MULTIVITAMIN VITAMIN E CONTE | INTS (IL | | MIN A/BETA-C | AROTENE CONTE | NTS (IU) | | | | |
| h. Individual supplements of vitamin C (not including multivitamins) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| i. Individual supplements of beta-carotene (not including multivitamins) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| j. Individual supplements of vitamin E (not including multivitamins) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| k. Individual supplements of vitamin A (not including multivitamins) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| I. Other, NON-multivitamins, containing beta-carotene, vitamins E or A | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| Specify EXACT BRAND and type: | | | | | | | | | |
| m. Individual supplements of folic acid (not including multivitamins) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| n. Individual supplements of zinc (not including multivitamins) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| o. Individual supplements of chromium (not including multivitamins) | 00 | O 1-3 days | O 4-10 days | O 11-20 days | O 21+ days | | | | |
| 5. THE INFORMATION BELOW ASSISTS US IN FOLLOW-UP | | SSURES PI | | ITIFICATION O | FDATA | | | | |
| | | (|) - [| | | | | | |
| | SSN: | x x x - | [| | | | | | |
| Please provide the name, address and phone number of SOMEONE AT A E unable to reach you: NAME: | | | | om we can contact | 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1 | | | | |
| STREET: | | | | | | | | | |
| | | | 711 | P CODE | | | | | |
| CITY: | | | 21 | | | | | | |

| YOU LAST RETURNED A QUESTIONNAIRE | INI | | | WHS HEALTH HISTORY FORM |
|--|-------|---------------|---|---|
| TOO LAST RETURNED A QUESTIONNAIRE | | | |] |
| For each of the TWO study agents below the % of pills you have taken RETURNED A QUESTIONNAIRE. | | | | 2. SINCE YOU LAST RETURNED A QUESTIONNAIRE (se above), have you experienced any of the following? |
| (see above for date of last return) | WHITE | AMBER CAPS | Cherricz, Połski | a. Symptoms suggestive of gastric upset O No O Yes b. Symptoms suggestive of peptic ulcer O No O Yes |
| Took 100%, or missed none | 0 | 0 | an ann dealth a' tha an tha an tha | b. Symptoms suggestive of peptic ulcer O No O Yes c. Nausea O No O Yes |
| Took 93-99%, or missed only a few | 0 | 0 | eralise ett 2000-telleg | d. Constipation O No O Yes |
| Took 75-92% | 0 | 0 | | e. Diarrhea O No O Yes |
| Took 67-74% | 0 | 0 | a series and a series of the series of th | f. Headache O No O Yes |
| Took 50-66% | 0 | 0 | 1.37 JH , M , M - J | g. Blood in urine (hematuria) O No O Yes |
| Took 33-49% | ο | 0 | | h. Easy bruising O No O Yes |
| Took less than 33% | 0 | 0 | A | i. Nose bleed (epistaxis) O No O Yes |
| Took none, or missed all | 0 | 0 | | j. Skin rash O No O Yes |
| 3 | | | | k. Fatigue O No O Yes |
| PLEASE CONTINUE WITH NEXT COLUMN | | ‡2 IN | 7772-132-4546373 2772-132-454674 | I. Drowsiness O No O Yes |

3. SINCE YOU LAST RETURNED A QUESTIONNAIRE (see above), have you been <u>NEWLY DIAGNOSED</u> with any of the following? Please fill NO/ YES for each item. If YES, please provide the month/ year of the diagnosis or procedure.

| a. Myocardial infarction (heart attack) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
|--|----------|---------|---------------|---------------------|------------|
| b. Angina pectoris | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| If YES, confirmed by: angiogra | m/cardia | c cath? | O No | O Yes stress test? | O No O Yes |
| c. Coronary angioplasty (PTCA) | O No | O Yes | \rightarrow | MO/YR of procedure: | |
| d. Coronary bypass surgery (CABG) | O No | O Yes | \rightarrow | MO/YR of procedure: | |
| e. Congestive heart failure | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| f. Ventricular tachycardia | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| g. Atrial fibrillation | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| h. Intermittent claudication | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| i. Peripheral artery surgery (not varicose veins) | O No | O Yes | \rightarrow | MO/YR of procedure: | |
| j. Pulmonary embolism (PE) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |

(over)

Page 2

WHS HEALTH HISTORY FORM

| REPAIRS AND | and the second second second | in a party of start press real sectors. | eren interes e | TTER A AND TATES OF STATISTICS, TRANS. MANNELSCH. AND | AND AND AND AN ADDRESS OF AN ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS AND ADDRESS ADDR |
|---|------------------------------|---|----------------|---|---|
| k. Deep vein thrombosis (DVT) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| I. Stroke | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| m. TIA (transient ischemic attack) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| n. Carotid artery surgery (endarterectomy) | O No | O Yes | \rightarrow | MO/YR of procedure: | |
| o. Elevated cholesterol (dx by a clinicial | n) O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| p. Hypertension (dx by a clinician) | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| q. Bleeding hemorrhoids | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| r. Any other gastrointestinal bleeding | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| s. Coagulation disorder | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| t. Periodontal disease Number of teeth lost : | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| u. Asthma | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| v. Other chronic lung disease (e.g., emphysema, chronic bronchitis | S) O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| w. Melanoma | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| x. Non-melanoma skin cancer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| If YES, what type? O basal of | ell Os | squamous o | cell | O unknown | |
| y. Breast cancer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| z. Lung cancer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| aa. Colon cancer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| bb. Other cancer SITE: | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| cc. Colon polyp | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| dd. Fibrocystic or other benign breast disease | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| If YES, confirmed by: breast b | piopsy? | ONO O | Yes | aspiration? O No | O Yes |
| ee. Diabetes mellitus | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| ff. Gout | ONo | O Yes | \rightarrow | MO/YR of diagnosis: | |
| gg. Peptic ulcer | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |
| | | | | | |
| hh. Gallstones | O No | O Yes | \rightarrow | MO/YR of diagnosis: | |

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PLEASE GO TO THE TOP OF THE NEXT PAGE ----

| Page 3 | | | - | - | | - / |
|--|---------------------------------------|-------------------------|----------------------|---------------|---|---|
| ii. Gallbladder removal | | No C |) Yes | \rightarrow | MO/YR of p | |
| jj. Active or chronic liver d | sease O | No C |) Yes | \rightarrow | MO/YR of d | iagnosis: |
| kk. Kidney disease (other th | nan kid. stones) O | No C |) Yes | \rightarrow | MO/YR of d | iagnosis: |
| II. Chronic kidney failure | 0 | No C |) Yes | \rightarrow | MO/YR of d | iagnosis: |
| mm. Migraine headaches | 0 | No C |) Yes | \rightarrow | MO/YR of d | iagnosis: |
| nn. Depression (dx by a clir | nician) O | No C |) Yes | \rightarrow | MO/YR of d | iagnosis: |
| oo. Macular degeneration: | - | | | - | | iagnosis (R): / / |
| pp. Cataract: | | | | - | | iagnosis (R): |
| qq. Cataract extraction: | | | | | | rocedure (R): / / |
| rr. Shingles (Varicella-zoste | er virus) O | No C |) Yes | \rightarrow | MO/YR of d | iagnosis: |
| ss. Rheumatoid arthritis | 0 | No C |) Yes | \rightarrow | MO/YR of d | iagnosis: |
| O No O Yes → MO/YI . Have you <u>Vin</u> been diagno a. Parkinson's disease? | osed with: ON | 0 O Y | | |] D/YR of diag | |
| b. Restless legs syndrome (by | | | | | - | nosis: / ombined with motor restlessnes |
| IF YES, Do these symptoms o Are these symptoms o What is your current blood p Are you currently being treated | vorse in the evenir pressure? | nd does ng/night | compar / dias | red to | o the mornin] mmHg ure? O N | O Don't know lo O Yes |
| you responded YES to any o ection below. We may wish to | f the items in que contact you for | stion # | 3 (start nal info | ing cormat | on page 1), a ion. If more | #4 or #5, please complete the than 2 diagnoses or procedures tion. Thank you. |
| NAGNOSIS #1: | | | D | ate c | f hospitaliza | tion/treatment: |
| ame of hospital/physician: | | <i>1.</i> | | | _ Phone no. | of physician: |
| ddress of hospital/physician. | | | | | | |
| | | | | | | |
| | | | | | | ation/treatment |
| DIAGNOSIS #2: | | | C | Date | of hospitaliza | |

(OVER)

| f you have had another MAJOR ILLNESS SINCE YOU LAST RETURNED | | FO | R OFFICE L | SE ONLY | |
|---|------|---------------|----------------|-----------|-------|
| A GUESTIONNAIRE (see above date) and it is not included in #3, 4 or 5 bove, please list it below and provide the month/year of diagnosis: OTHER MAJOR ILLNESS: MO/YR OF DIAGNOSIS: a | | | | | |
| IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Do not include your study pills. Please answer on | | 1 | D IN THE | 1 | 1 |
| each line. | None | 1-3 | 4-10 | 11-20 | 21- |
| a. Acetaminophen (e.g., Tylenol, Excedrin P.M.) | 0 | 0 | 0 | 0 | 0 |
| b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin) | 0 | 0 | 0 | 0 | 0 |
| c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal) | 0 | 0 | 0 | 0 | 0 |
| d. COX-2 inhibitors (e.g., Celebrex, Vioxx) | 0 | 0 | 0 | 0 | 0 |
| e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve) | 0 | 0 | 0 | 0 | 0 |
| f. Statins (e.g., Mevacor, Lipitor, Pravachol, Zocor) | 0 | 0 | 0 | 0 | 0 |
| g. Multivitamins (please provide BRAND and contents below) Specify BRAND name: Vitamin E contents:IU | 0 | 0 | 0 | 0 | 0 |
| Combined vitamin A/beta-carotene contents: IU | | Office us | se: O el |) O in | Unk/ |
| h. Individual supplements of vitamin C (not including multivitamins) | 0 | 0 | 0 | 0 | 0 |
| i. Individual supplements of beta-carotene (not including multivitamins) | 0 | 0 | 0 | 0 | 0 |
| j. Individual supplements of vitamin E (not including multivitamins) | 0 | 0 | 0 | 0 | 0 |
| k. Individual supplements of vitamin A (not including multivitamins) | 0 | 0 | 0 | 0 | 0 |
| I. Other, NON-multivitamins, containing vitamin A, vitamin E or beta-carotene Specify EXACT BRAND and type: | 0 | O Office u | O Ise: O el | O O in | O unk |
| n. Individual supplements of folic acid (not including multivitamins) | 0 | 0 | 0 | 0 | 0 |

| | | in the second | | | |
|---|-------------------------------|---|-----------------|---------------------|----------------|
| | | | STATE: | ZIP CODE: | <u></u> |
| | STREET: | · · · · · · · · · · · · · · · · · · · | | | |
| inable to reach you. | NAME: | | _ PHONE NUMBER | R: | |
| Please provide the na unable to reach you: | ame, address and phone number | r of SOMEONE AT A DIFFEREN | IT ADDRESS THAN | YOU whom we can cor | ntact if we ar |
| | | LAST 6 DIGITS OF SSN:) (OPTIONAL) | × × × - 📋 | | |
| · · · · · · · · · · · · · · · · · · · | | | | | |
| | HOME PHONE NU | | | | |

| WOMEN'S HEALTH STUDY RISK FACTOR FORM | | | |] - | / | | |] |
|---|---------|--------------|---------------|-------------|--------------|--------------|--------------|-------------|
| 1. What is your date of birth? | | [| - <u>WEI</u> | <u>GHT:</u> | | r | ounds | |
| 2. In the space to the right, please provide your current weight | and hei | ght. | <u>HEI0</u> | <u>GHT:</u> | fe | et | | inches |
| 3. What is your usual walking pace outdoors? | | | | | | - | | - |
| O Don't walk regularly O Easy, casual (less than 2 mph) |) C |) Norma | al, aver | age (2- | -2.9mp | h) | | |
| O Brisk pace (3-3.9 mph) O Very brisk/striding (4 mph or fa | aster) | | | | | | | |
| 4. DURING THE PAST YEAR, what was your approximate | | | AVER | AGE T | IME PI | ER WE | EK | |
| average time per week spent at each of the following recreational activities? | 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) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| b. Jogging (slower than 10 minute miles) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| c. Running (10 minute miles or faster) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| d. Bicycling (include stationary bike) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| e. Aerobic exercise / aerobic dance / exercise machines | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| f. Lower intensity exercise / yoga / stretching / toning | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| g. Tennis, squash, or raquetball | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| h. Lap swimming | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| i. Weight lifting / strength training | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| j. Other: Please specify activity: | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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 <u>MOST RECENT</u> procedure/exam, please indicate <u>why it was done</u> (whether because of SYMPTOMS or as a matter of ROUTINE SCREENING) and <u>when it was done</u> (how many years ago).

| | | | Most recent | , why done? | Mos | t recent, | how ma | iny years | s ago? |
|---|----|-----|--------------------|----------------------|-------|--------------|--------------|-------------|-----------------|
| PROCEDURE/EXAM DONE SINCE THE STUDY BEGAN? | No | Yes | Result of symptoms | Routine screening | <1 yr | 1-2 years | 3-5 years | >5 years | Don't recall |
| a. Stool occult blood test | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| b. Sigmoidoscopy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| c. Colonoscopy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| d. Pap smear | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| e. Mammogram | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| f. A physical exam | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| g. Fasting blood sugar | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| h. Blood pressure check | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| i. Blood cholesterol check | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| j. An eye examination | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

1162530457

WOMEN'S HEALTH STUDY / RISK FACTOR FORM



WOMEN'S HEALTH STUDY

| 0. Did any of these relatives | | | RELATIV | /E | | |
|-------------------------------|------|------------|---------|------------|--------|-------------|
| ever have | None | Don't know | Mother | Any sister | Father | Any brother |
| a. Diabetes? | 0 | 0 | 0 | 0 | 0 | 0 |
| b. Hypertension? | 0 | 0 | 0 | 0 | 0 | 0 |
| c. Colon or rectal cancer? | 0 | 0 | 0 | 0 | 0 | 0 |
| d. Ovarian cancer? | 0 | 0 | 0 | 0 | | |

-

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 | 0 | 0 | 0 | \rightarrow | Age when first diagnosed: O Don't know age |
| Father | 0 | 0 | 0 | | 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 | 0 | 0 | 0 | $\left \rightarrow \right $ | Age when first diagnosed: O Don't know age |
| Any sister | 0 | 0 | 0 | \rightarrow | Age when first diagnosed: O Don't know age |
| Maternal grandmother | 0 | 0 | 0 | | Age when first diagnosed: O Don't know age |
| Paternal grandmother | 0 | 0 | 0 | | Age when first diagnosed: O Don't know age |

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

| | Year of bi | rth | Is par | rent alive o | 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 E | <u>VER</u> smoked ciga | rettes? O No | O Yes → | IF YES, ho | w many TOTA | L YEARS have yo | u smoked? y |
| | time that you smok REENTLY smoke c | | | Yes | rettes that you (1 pac | smoked per day? k = 20 cigarettes) | cigs/day |
| lf you are | a CURRENT smol | ker, please answe | r the questi | ons below. | If NOT A CUR | RENT SMOKER, | go to the next page. |
| a. ON A | VERAGE, how ma | ny cigarettes / day | | rrently smo 20 cigarette | | cigarettes per da | ay (on average) |
| b. How | soon after you wak | e up do you smok | e your first | cigarette? | | | |
| 0 | Within 5 mins. | O 6-30 mins. | O 31 | -60 mins. | O After 6 | 0 mins. | |
| | u find it difficult to re ema, etc.? O N | | | where it is | forbidden, e.g | ., in church, at the | library, |
| d. Whicl | h cigarette would yo | ou hate most to gi | ve up? (| O The first | one in the mor | ning O All oth | ers |
| e. Do yo | ou smoke more freq | uently during the | first hours a | after waking | than during th | e rest of the day? | O No O Yes |
| f. Do yo | u smoke if you are : | so ill that you are | in bed most | t of the day | ? O No (|) Yes | |

WOMEN'S HEALTH STUDY / RISK FACTOR FORM

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

| | -AILO - | |
|--|---------|-------|
| 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 |
| I. 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 For a typical cold in the past year: a. For how many days were symptoms usually present? O 1-3 days O 4-7 days O > 1 week b. For how many days were you usually confined to home? O None O 1-3 days O 4-7 days O > 1 week 16. What are your most recent cholesterol levels (both total cholesterol level and HDL cholesterol level)? mg/100 ml O Don't know TOTAL cholesterol: 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 V IF YES, when were you diagnosed (mo/yr)? 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),

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

| 1. Do you currently take a multi-vitamin? (Please report other individing the second of the second of | dual vit | - | | | | | | | |
|--|-----------------|---|---|---|----------------------------|--|----------------------------------|--------------|---------|
| Yes Image: A bit is | | - | | | | | | | |
| Centrum Silver Centrum Theragran M | | 0 3-5 | 5 (| 0 6-9 | 9 | 010 | 0 or mo | ore | |
| | ? | | | | | | _ | | _ |
| | | | | | | | | | |
| | | | | | | | | | |
| Shaklee Vita-Lea Nutrilite Double X Other | | AARP Alp | habot II I | Formula | 642 M | lultivitor | nine and | Minoral | |
| 2. Do you take the following separate preparations? (DO NOT report the | | | | | | | | | 5 |
| a) Vitamin A No Yes, seasonal only If Dose Less than | 8,00 | | () 13.0 | | |) 23.00 | | - | on't |
| Yes, most months Yes, per day: 8,000 IU | · · · | 00 IU | | 000 IU | | or mo | | - | now |
| | 400 | to | 750 | to | C |) 1300 | ma | | on't |
| b) Vitamin C No Yes, seasonal only If Dose Less than (Yes, most months Yes , Per day: 400 mg. | 700 | | - | 0 mg. | C | or mo | - | · · · | now |
| , | | | ~ | | 0 | | | | |
| c) Vitamin B ₆ No Yes If Yes, Dose Less than per day: 10 mg. |) 10 to 39 m | | () 40 i 79 i | | C |) 80 m or mo | | ~ | on't |
| , , , , , , , , , , , , , , , , , , , | | | - | | 0 | | | | |
| d) Vitamin E No Yes If Yes, Dose Less than (per day: 100 IU |) 100 250 | | 300 500 | | C |) 600 I | | · · · · | on't |
| J has and | | | - | | | or mo | ore | | |
| e) Calcium No Yes If Yes, Dose per day Less than (| 400 | | 0 901 | | C |) 1301 | 0 | <u> </u> | on't |
| (Include elemental Calcium in Tums, etc.) | 900 | mg. | 130 |)0 mg. | | or mo | ore | K | now |
| f) Vitamin D ONO Yes If Yes, Dose OLess than (| 300 | | 0 600 | | C |) 1,000 | | <u> </u> | on't |
| (In calcium supplement or separately) | 500 | IU | 900 | U (| | or mo | ore | k | now |
| g) Selenium O No O Yes If Yes, Dose O Less than | <u>80 t</u> | 0 | 0 140 |) to | C |) 260 r | mcg. | OD |)on't |
| per day: 80 mcg. | 130 | mcg. | 250 |) mcg. | | or mo | ore | k | now |
| h) Niacin No Yes If Yes, Dose Less than (|) 50 to |) | 0 400 |) to | C |) 900 r | mg. | OD |)on't |
| per day: 50 mg. | 300 | | 0 |) mg. | | or mo | | ~ | now |
| i) Zinc No Yes If Yes, Dose Less than |) 25 to |) | 75 | to | C |) 101 r | ma. | \bigcirc D |)on't |
| per day: 25 mg. | 74 m | | \sim |) mg. | | or mo | | - | now |
| Are there Metamucil/Citrucil Lutein Chromium | (|) Folic A | cid | 0 | DHEA | C | Othe | er (Please | |
| other Ocol Liver Oil Magnesium Lecithin | |) B-Com | | ~ | | | Jouro | i (i icasi | e spe |
| supplements | | | | | | | 0 | | |
| that you take Vitamin B ₁₂ Melatonin Beta-carotene | | | Biloba | | | | | | |
| on a regular O Coenzyme Q10 Fish Oil O Glucosamine | (| Garlic | | | | | | | |
| | | | | nents | | | | | |
| basis? Ginseng St. John's Wort Chondroitin | Č | Lycope | | nents | | | | | |
| | ood | | | nents | 03 | \mathbf{i} | | | |
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| basis? Ginseng St. John's Wort Chondroitin 3. How many teaspoons of sugar do you add to your beverages or faeach day? Specify cereal brance 4. What brand and type of cold breakfast cereal do you usually eat? Don't eat cold breakfast cereal. Specify cereal brance 5. What form of margarine do you usually use? Specify cereal brance Specify cereal brance 6. For each food listed, fill in the circle indicating how often on averatused the amount specified during the past year. None 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Never, or lonce per 0 1 2 3 4 9 Non-dairy coffee whitener (1 Tbs) 1 1 1 1 1 1 1 Cream, e.g., coffee, whipped or sour cream (1 Tbs) 1 2 3 2 2 2 2 2 Sogy milk Cream, e.g., coffee, whipped or sour cream (1 cup) | d & type | Vhat speci a.g., Blue l u have AVER/ 1-3 per month | ific brand Bonnet I 1 per 2- week 2- week 2- w week 2- w w w w w w w w w w w w w w w w w w w | tsp. d & type _ower F JSE I 4 per 5 | e of ma at Spre- | 1 2 1 2 argarine ead)? T YE 1 per day 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2 3 4 2 3 4 3 AR 2-3 | 4 5 6 | 6 7 6 7 |
| basis? Ginseng St. John's Wort Chondroitin 3. How many teaspoons of sugar do you add to your beverages or feeach day? Specify cereal brance 4. What brand and type of cold breakfast cereal do you usually eat? Don't eat cold breakfast cereal. Specify cereal brance 5. What form of margarine do you usually use? None Form? Stick Tub Spray Squeeze (lick 1 1 1 1 1 Nonfat Nonfat Nonfat 0 0 0 0 0 Nonfat Nonfat Nonfat 0 0 0 0 0 Nonfat Nonfat Nonfat 0 0 0 0 0 Nonfat Nonfat Never, or honce per 0 1 1 1 1 Nonfat Never, or honce per Never, or honce per 0 0 0 0 0 Nonfat Never, or honce per 1 1 1 1 1 Nonfat Never, or honce per 1 1 1 1 1 Nonfat Nonfat Nonfat <td>d & type</td> <td>Vhat speci a.g., Blue I</td> <td>ific brand Bonnet I 1 per 2- week 2- www www wwwwwwwwwwwwwwwww wwwwwwwwww</td> <td>tsp. d & type _ower F JSE I 4 per 5</td> <td>e of ma at Spre-</td> <td>1 2 1 2 1 2 argarine ead)? TYE 1 2 TYE 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>2 3 4 2 3 4 3 AR 2-3</td> <td>4 5 6</td> <td>6 7 6 7</td> | d & type | Vhat speci a.g., Blue I | ific brand Bonnet I 1 per 2- week 2- www www wwwwwwwwwwwwwwwww wwwwwwwwww | tsp. d & type _ower F JSE I 4 per 5 | e of ma at Spre- | 1 2 1 2 1 2 argarine ead)? TYE 1 2 TYE 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2 3 4 2 3 4 3 AR 2-3 | 4 5 6 | 6 7 6 7 |
| basis? Ginseng St. John's Wort Chondroitin 3. How many teaspoons of sugar do you add to your beverages or feeach day? 4. What brand and type of cold breakfast cereal do you usually eat? Specify cereal brand breakfast cereal. Specify cereal brand breakfast cereal. 5. What form of margarine do you usually use? Don't eat cold breakfast cereal. Specify cereal brand breakfast cereal. Specify cereal brand breakfast cereal. 5. What form of margarine do you usually use? None Form? Stick Tub Spray Squeeze (lick is the past year. 0 1 2 3 4 9 None Form? Stick Tub Spray Nonfat 6. For each food listed, fill in the circle indicating how often on averaused the amount specified during the past year. Nonfat 0 1 2 3 4 9 V S M 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | d & type | Vhat speci a.g., Blue I | ific brand Bonnet I Per 2- week 2- week 2- w w 1 w 1 w 2- w w 2 w 2 w 2 w 2 w 2 w 2 w 2 w 2 w 2 w | tsp. d & type _ower F JSE I 4 per 5 | e of ma at Spre- | 1 2 1 2 1 2 argarine ead)? TYE 1 per day 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2 3 4 2 3 4 3 AR 2-3 | 4 5 6 | 6 7 6 7 |
| basis? Ginseng St. John's Wort Chondroitin 3. How many teaspoons of sugar do you add to your beverages or feeach day? 4. What brand and type of cold breakfast cereal. Specify cereal brand cereal do you usually eat? Don't eat cold breakfast cereal. 5. What form of margarine do you usually use? None Form? Stick Tub Spray Squeeze (iit Type?) 0 None Form? Stick Tub Spray Squeeze (iit Type?) 0 1 1 1 1 Nonet Nonet Nonet 0 0 0 0 0 0 Nonet Nonet Nonet 0 1 1 1 1 1 1 Nonet Nonet Stick Nonet 0 0 0 0 0 0 Nonet Stick Nonet Nonet 1 1 1 1 1 1 Non-dairy coffee whitener (1 Tbs) Non-dairy coffee whitener (1 Tbs) Non-dairy coffee whitener (1 Cup) Non-dairy coffee whitener (1 Cup) Nogarine (pat), added to food or bread; exclude use in cooking 9 9 9 | d & type | Vhat speci a.g., Blue I | ific brand Bonnet I 1 per 2- week 2- www www wwwwwwwwwwwwwwwww wwwwwwwwww | tsp. d & type _ower F JSE I 4 per 5 | e of ma at Spre- | 1 2 1 2 1 2 argarine ead)? TYE 1 2 TYE 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2 3 4 2 3 4 3 AR 2-3 | 4 5 6 | 6 7 |
| basis? Ginseng St. John's Wort Chondroitin 3. How many teaspoons of sugar do you add to your beverages or feeach day? 4. What brand and type of cold breakfast cereal do you usually eat? Specify cereal brand breakfast cereal. Specify cereal brand breakfast cereal. 5. What form of margarine do you usually use? Don't eat cold breakfast cereal. Specify cereal brand breakfast cereal. Specify cereal brand breakfast cereal. 5. What form of margarine do you usually use? None Form? Stick Tub Spray Squeeze (lick is the past year. 0 1 2 3 4 9 None Form? Stick Tub Spray Nonfat 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | d & type | Vhat speci a.g., Blue vhat speci a.g., Blue a.g., | ific brand Bonnet I Per 2- week 2- week 2- w w 1 w 1 w 2- w w 2 w 2 w 2 w 2 w 2 w 2 w 2 w 2 w 2 w | tsp. d & type _ower F JSE I 4 per 5 | e of ma at Spre- | 1 2 1 2 1 2 argarine ead)? TYE 1 per day 0 0 0 0 0 0 0 0 0 0 0 0 0 | 2 3 4 2 3 4 3 AR 2-3 | 4 5 6 | 6 7 6 7 |

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| | | sted, fill in the circle indica ne amount specified <u>durin</u> g | | Never, or less | | 1 | 2-4 | 5–6 | 1 | 2–3 | 4–5 | 6+ |
|-------------------------|--------|---|---|--------------------------|-----------------------|-------------|-------------|-------------|------------|------------|------------|------------|
| | | FRU | IITS | than once per month | per month | per week | per week | per week | per day | per day | per day | per day |
| ease try to | | Raisins (1 oz. or small pacl | <) | 0 | \bigcirc | (W) | 0 | 0 | (D) | 0 | 0 | 0 |
| erage your | ł | Grapes (1 cup) | | Ŏ | Õ | W | Ŏ | Ŏ | (D) | Ŏ | Ŏ | Ŏ |
| asonal use | | Prunes (7 prunes or 1/2 cu | p) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | Õ |
| oods ovei | | Prune juice (glass) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| entire yea example, | | Bananas (1) | Artest (10) methods | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| od such a | | Cantaloupe (1/4 melon) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| italoupe is | | Applesauce (1/2 cup) | and the second second | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| en 4 times | | Fresh apples or pears (1) | | 0 | 0 | W | \bigcirc | 0 | D | 0 | 0 | 0 |
| ek during | the | Apple juice or cider (glass) | Control Antonia | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| oroximate | 3 | Oranges (1) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| nths that | | Orange juice (glass) | Calcium fortified | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| eason, th | | | Regular (not fortified) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| average u uld be ond | | Grapefruit (1/2) or grapefru | it juice (glass) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| week. | Je | Other fruit juices (glass) | | 0 | 0 | (W) | 0 | 0 | D | 0 | 0 | 0 |
| WOOK. | | Strawberries, fresh, frozen | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| 0 | - | Blueberries, fresh, frozen o | | 0 | 0 | W | 0 | 0 | D | 0 | Q | 0 |
| 1 | (1) | Peaches, apricots or plums | (1 fresh, or 1/2 cup canned | | 0 | W | 0 | \bigcirc | D | 0 | 0 | 0 |
| 2 | 2 | VEAT | | Never, or less than once | 1–3 per | 1 per | 2–4 per | 5–6 per | 1 per | 2–3 per | 4–5 per | 6+ per |
| 4 | 4 | VEGET | | per month | month | week | week | week | day | day | day | day |
| (P) | 8 P | Tomatoes (3 slices or 1/2 s Tomato or V-8 juice (small | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| C | e | Tomato sauce (1/2 cup) e.g | | 0 | $\overline{\bigcirc}$ | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Salsa, picante or taco sauce | | | $\overline{\bigcirc}$ | (W) | 0 | 0 | (D) | 0 | 0 | 0 |
| 1 | 1 | Tofu, soy burger or other so | | 0 | 0 | Ŵ | 0 | 0 | | 0 | 0 | 0 |
| 2 | 2 | String beans (1/2 cup) | | | 0 | (W) | 0 | 0 | (D) | 0 | 0 | 0 |
| 4 | 4 | Beans or lentils, baked or c | tried (1/2 cup) | 0 | 8 | Ŵ | 0 | 0 | 0 | 0 | 0 | 0 |
| 8 | 8 | Peas or lima beans (1/2 cu | | 0 | 0 | Ŵ | 0 | 0 | D | 0 | 0 | 0 |
| P | P | Broccoli (1/2 cup) | | 0 | ŏ | W | 0 | 0 | D | 0 | 0 | 0 |
| 0 | | Cauliflower (1/2 cup) | | ŏ | 0 | Ŵ | 0 | 0 | (D) | 0 | 0 | 0 |
| | | Cabbage or coleslaw (1/2 d | (au | 0 | õ | Ŵ | 0 | 0 | (D) | 0 | 0 | 0 |
| 1 | 1 | Brussels sprouts (1/2 cup) | | 0 | ŏ | (W) | õ | ŏ | (D) | Õ | 0 | ŏ |
| 2 | 2 | Carrots, raw (1/2 carrot or 2 | 2–4 sticks) | 0 | ŏ | Ŵ | Õ | Õ | (D) | ŏ | õ | ŏ |
| 4 | 4 | Carrots, cooked (1/2 cup) o | | Ŏ | ŏ | (W) | Õ | ŏ | (D) | ŏ | ŏ | ŏ |
| 8 | 8 | Corn (1 ear or 1/2 cup froze | the second design of the second se | Ő | Ŏ | Ŵ | Õ | Õ | (D) | Õ | Õ | Õ |
| P | P | Mixed vegetables, stir-fry, v | regetable soup (1/2 cup) | Õ | Õ | W | Õ | Õ | (D) | Ŏ | Õ | Õ |
| | | Yams or sweet potatoes (1) | (2 cup) | 0 | 0 | W | Õ | Õ | D | Õ | Õ | Õ |
| | | Dark orange (winter) squas | h (1/2 cup) | 0 | 0 | W | 0 | 0 | D | Õ | 0 | 0 |
| | | Eggplant, zucchini or other | summer squash (1/2 cup) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Kale, mustard greens or ch | ard (1/2 cup) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Spinach, cooked (1/2 cup) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Spinach, raw as in salad (s | erving) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Iceberg or head lettuce (se | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Romaine or leaf lettuce (se | rving) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Celery (4" stick) | SLOIL MOIN | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Green or red peppers (3 sli | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Onions as a garnish or in sa | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Onions as a vegetable, ring | s or soup (1 onion) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | | | | | | | | | | | |
| | | | | Never, or less than once | 1–3 per | 1 per | 2–4 per | 5–6 per | 1 per | 2–3 per | 4–5 per | 6+ per |
| | | EGGS, MI | | per month | month | week | week | week | day | day | day | day |
| | | Egg Beaters or egg whites | only (1/4 cup or 1 egg) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Eggs including yolk (1) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Beef or pork hot dogs (1) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Chicken or turkey hot dogs | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Chicken/Turkey sandwich o | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Other chicken or turkey, with | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 |
| | | Other chicken or turkey, with | nout skin (3 oz.) | () | () | (W) | () | () | D | () | () | () |

| you have us | ed the an | nount specifi | cle indicating how often <u>on avera</u> ed <u>during the past year</u> . | Never, c | r less | 1-3 | 1 | 2-4 | 5–6 | 1 | 2-3 | 4-5 | 6 |
|--|-----------------------------|--|--|------------|---------------|--------------|-------------|-------------|-------------|------------|------------|------------|--------|
| | | and the second s | EGGS, MEAT, ETC. | than o | | per month | per week | per week | per week | per day | per day | per day | p d |
| | s | alami, bologna | a, or other processed meat sandwiche | | \bigcirc | | W | O | | D | O | O | - (|
| | | | ed meats, e.g., sausage, kielbasa, | | ~ | | | | | | | | |
| | e | tc. (2 oz. or 2 | small links) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | н | amburger (1 p | Lean or extra lean | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | | | Regular | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | | | amb as a sandwich or mixed dish, | | | | | | | 0.00 | - alt | | |
| | _ | | serole, lasagna, frozen dinner, etc. | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | . (|
| | | | dish, e.g., ham or chops (4–6 oz.) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | | | s a main dish, e.g., steak, roast (4–6 oz | <u>z.)</u> | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | 10 m | anned tuna fis | | \bigcirc | 0 | W | 0 | 0 | D | 0 | 0 | (| |
| | | readed fish ca serving, store | | ~ | | | | 0 | 0 | | - Lienn | 100 | |
| | - | | U , | | $\frac{0}{2}$ | 0 | W | 0 | 0 | D | 0 | 0 | - (|
| | | | r, scallops as a main dish e.g., mackerel, salmon, sardines, | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | | luefish, sword | | | 0 | 0 | Ŵ | 0 | 0 | (D) | 0 | 0 | 17 |
| | _ | | , cod, haddock, halibut (3–5 oz.) | | 0 | 0 | Ŵ | 0 | 0 | (D) | 10 | 0 | 1 |
| 1) (1) | | | , 550, Haddook, Hallbut (5-5 02.) | Never, o | r less | 1-3 | 1 | 2-4 | 5-6 | 1 | 2-3 | 4-5 | e |
| 2 2 | 2 | BREA | ADS, CEREALS, STARCHES | than o | nce | per month | per week | per week | per week | per day | per day | per | р |
| 4 4 | | old breakfast | | permo | \bigcirc | | Week | Week | Week | D | day | day | d |
| 8 8 | | | al/cooked oat bran (1 cup) | | ŏ | 0 | Ŵ | 0 | 0 | (D) | 0 | 0 | (|
| P P | | | preakfast cereal (1 cup) | | ŏ | õ | Ŵ | õ | ŏ | (D) | 0 | 0 | (|
| | | | White bread, including pita | | ŏ | Õ | Ŵ | Ŏ | Ŏ | (D) | Õ | Õ | (|
| | | read | Rye/Pumpernickel | | ŏ | Õ | (W) | Õ | Õ | (D) | 0 | Õ | (|
| 1 1 | 1 | slice) | Whole wheat, oatmeal, other whole | grain | ŏ | Õ | Ŵ | Ŏ | Ŏ | (D) | Ŏ | Õ | (|
| 2 2 | 2 B | agels, English | muffins, or rolls (1) | | Ŏ | Õ | W | Õ | Õ | (D) | Õ | Õ | (|
| 4 4 | 4 N | luffins or biscu | uits (1) | | Õ | Õ | W | Õ | Õ | D | Õ | Ŏ | (|
| 8 8 | 8 P | ancakes or wa | affles (2 small pieces) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| P P | PB | rown rice (1 cu | up) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | V | /hite rice (1 cu | ip) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | |
| | Р | asta, e.g., spa | ghetti, noodles, etc. (1 cup) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| 1 1 | | ortillas (1) | | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| 2 2 | | | oz. or 1 serving) | 1 | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| 4 (4) | | | s, baked, boiled (1) or mashed (1 cup) | | | 0 | W | 0 | 0 | D | 0 | 0 | (|
| 8 (8) | | otato chips or | corn chips (small bag or 1 oz.) | | \bigcirc | · () | W | 0 | 0 | D | 0 | 0 | (|
| P (P) | C | rackers (6) | Fat free or light | | \bigcirc | 0 | W | 0 | 0 | D | 0 | 0 | |
| | D | izza (2 slices) | Regular | | \leq | 0 | (W) | 0 | 0 | D | 0 | 0 | |
| | | 1228 (2 311063) | | Never, o | less | 1-3 | 1 | 2-4 | 5-6 | 1 | 2-3 | 4-5 | 6 |
| | | | BEVERAGES | than or | nce | per month | per week | per week | per week | per day | per day | per day | р |
| CARBONATED | Law Calaria | Low-calori | e beverage with caffeine. | perme | 1111 | monun | WEEK | WEEK | WEEK | uay | uay | uay | d |
| BEVERAGES | Low-Calorie (sugar-free) | | Coke, Diet Mt. Dew | | \circ | 0 | W | 0 | 0 | D | 0 | 0 | C |
| Consider the | types | Other low- | cal bev. without caffeine, e.g., Diet 7- | Up | Ŏ | Õ | W | Õ | Ŏ | D | Õ | Ŏ | C |
| serving size as 1 glass, bottle or can for these | Regular | | d beverage with caffeine & sugar, , Pepsi, Mt. Dew, Dr. Pepper | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | .(|
| carbonated beverages. OTHER BEVERAGES | | | onated beverage with sugar, Root Beer, Ginger Ale | | \circ | 0 | Ŵ | 0 | 0 | D | 0 | 0 | C |
| | | | nonade, other non-carbonated fruit sugared ice tea (1 glass, bottle, can) | | \circ | 0 | (W) | 0 | 0 | D | 0 | 0 | 0 |
| | | Beer, regul | ar (1 glass, bottle, can) | (| ŏ | Ŏ | W | Õ | Õ | (D) | Õ | Õ | C |
| | | Light Beer, | | Ó | Õ | W | Õ | Õ | (D) | Õ | Õ | C | |
| | | Red wine (| 5 oz. glass) | (| C | 0 | W | 0 | 0 | D | 0 | Õ | (|
| | | White wine | e (5 oz. glass) | | 0 | 0 | W | Ō | Ō | D | Õ | Õ | (|
| | | Liquor, e.g. | ., vodka, gin, etc. (1 drink or shot) | (| C | 0 | W | 0 | 0 | D | Õ | Õ | (|
| | | Plain water | r, bottled, sparkling, or tap (1 cup or g | lass) | 0 | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | | | or decaffeinated tea (8 oz. cup) | (| C | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | | | affeine (8 oz. cup), including green tea | (| C | 0 | W | 0 | 0 | D | 0 | 0 | (|
| | | | ted coffee (8 oz. cup) | (| C | 0 | W | 0 | 0 | D | 0 | 0 | C |
| | | | n caffeine (8 oz. cup) | | | | W | 0 | | (D) | | | 10 |

| 8 | | | | | Pag | ge 4 | | | | | | WO | ME | N'S | HE | AL | THS | STU | DY | |
|---------------------------------------|-----------------------|---|-------------------------|-----------------------|-----------|------------|-----------------|----------|------------|------------|-------------------------|---------|------|------|-----|----------|---------|--------------|--------------|---|
| 6. (continued) |) For ea | ch food listed, fill in the | circle ir | ndicati | ng hov | v ofter | n <u>on a</u> v | /erage | | | | | | | | | | | | |
| amount spe | ecified g | during the past year. New | er, or less an once | 1–3 per | 1 per | 2-4 per | 5–6 per | 1 per | 2–3 per | 4–5 per | 6+ per | | | | | | | | | |
| SWEETS, BAKE | ED GOOI | | er month | month | | week | week | day | day | day | day | P | | | | | | | | |
| Chocolate (bar or | r packet |) e.g., Hershey's, M & M's | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 | 0 | | | | | | | | |
| Candy bars, e.g., | , Snicker | rs, Milky Way, Reese's | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 | 10 | | | | | | | | |
| Candy without ch | hocolate | (1 oz.) | 0 | 0 | W | 0 | \bigcirc | D | 0 | 0 | 0 | | | | | | | _ | | |
| | Fat fre | e or reduced fat | 0 | 0 | W | 0 | 0- | D | 0 | 0 | 0 | 0 | A | 0 | 0 | 0 | av rhu | 0 | 0 | |
| Cookies (1) | Other | ready made/frozen dough | 0 | \mathbf{O} | W) | 0 | 0 | (D) | 0 | 0 | \bigcirc | O | | 1 | 1 | 1 | mus ver | 1 | 1 | |
| | Home | baked | 0 | 0 | W | 0 | 0 | D | 0 | 0 | \bigcirc | 0 | | 2 | 2 | 2 | rad per | 2 | 2 | |
| Brownies (1) | | | 0 | 0 | Ŵ | 0 | 0 | D | 0 | 0 | 0 | 0 | | 3 | 3 | 3 | hrd pks | s 3 | 3 | |
| Doughnuts (1) | | | \bigcirc | 0 | (W) | 0 | 0 | (D) | 0 | 0 | \bigcirc | 0 | | 4 | 4 | 4 | dap pko | 4 | 4 | |
| Cake, ready mad | le (slice) | | 0 | 0 | (W) | 0 | 0 | D | 0 | 0 | 0 | -0 | | 5 | 5 | 5 | dat olv | 5 | 5 | |
| Cake, home bake | | | $\overline{\mathbf{O}}$ | Õ | (W) | 0 | 0 | (D) | 0 | 0 | $\left \right $ | 6 | | 6 | 6 | 6 | mgo sin | 6 | 6 | |
| Pie, homemade o | | | Õ | $\overline{\bigcirc}$ | (W) | Õ. | 0 | (D) | 0 | 0 | \bigcirc | 0 | | 7 | 7 | 7 | mxt en | 7 | (7) | |
| | | syrup, or honey (1 Tbs) | Ŏ | ŏ | (W) | Õ | Õ | (D) | Õ | Õ | $\overline{\mathbf{O}}$ | 0 | | 8 | 8 | 8 | pap en- | + 8 | 8 | |
| Peanut butter (1 | | 5) (up) (1 11010) (1 110) | Ő | ŏ | (W) | 0 | Õ | (D) | Õ | Õ | Ŏ | - O | | 9 | 9 | 9 | pnl pwl | b 9 | 9 | |
| • | | Fat free or light | ŏ | ŏ | (W) | Õ | ŏ | | ŏ | 0. | \overline{O} | 0 | | | | | | T | | |
| Popcorn (3 cups) |) | Regular | 0 | 0 | Ŵ | 1 A | 0 | (D) - | 0 | 0 | ñ | č | | | | | | | | |
| Duue et | | Fat free or reduced fat | 0 | 6 | Ŵ | 6 | A | (D) | 1 A | 10 | 10 | | | | | | | | | |
| Sweet roll, coffee or other pastry | and the second second | | 0 | 0 | Ŵ | 0 | R | (D) | 8 | A | 8 | | в | 0 | 0 | 0 | av rhu | 0 | 0 | |
| serving) | | Other ready made | 10 | 0 | | 8 | 8 | | 8 | 6 | H | | 0 | 00 | | \simeq | | \mathbb{Z} | \mathbf{x} | |
| | | Home baked | 0 | 2 | (W) | 0 | 10 | | 18 | 10 | 10 | | | 0 | 0 | \simeq | mus ver | | 1 | |
| Pretzels (1 small | | | 0 | 0 | (W) | 0 | 0 | D | 0 | 2 | | | | 2 | 20 | \simeq | rad per | | \simeq | |
| Peanuts (small pa | acket or | 1 oz.) | 0 | 0 | (W) | \bigcirc | Q | (D) | 0 | Q | | | | 3 | 3 | \simeq | hrd pla | \sim | 1 | |
| Walnuts (1 oz.) | | | 0 | 0 | (W) | Q | Q | (D) | 0 | 0 | 0 | | | 4 | 4 | ~ | dap pk | $1 \simeq$ | \simeq | |
| Other nuts (small | l packet | or 1 oz.) | \odot | 0 | (W) | 0 | Q | (D) | 0 | 0 | \bigcirc | | | 5 | 5 | \simeq | dat ol | | 1 | |
| Dat bran, added | | | 0 | 0 | (W) | 0 | \bigcirc | (D) | 0 | 0 | \bigcirc | 0 | | 6 | 6 | \sim | mgo sin | | 6 | |
| Other bran (e.g., | wheat), | added to food (1 Tbs) | \bigcirc | 0 | W | 0 | \bigcirc | (D) | 0 | 0 | \bigcirc | | | 7 | (7) | 7 | mxt en | r (7) | (7) | |
| Wheat germ (1 T | bs) | | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 | | | 8 | 8 | 8 | pap en | + 8 | 8 | |
| Chowder or crea | m soup | (1 cup) | \bigcirc | 0 | W | \bigcirc | \bigcirc | D | 0 | 0 | \bigcirc | 0 | | 9 | 9 | 9 | pnl pw | b 9 | 9 | |
| Ketchup or red c | hili sauc | e (1 Tbs) | \bigcirc | 0 | W | 0 | 0 | D | 0 | 0 | \odot | | | 1 | | | | | | |
| Salt added at tab | ole (1 sha | ake) | 0 | 0 | (W) | \bigcirc | 0 | (D) | | 0 | \odot | | С | | | | | | | |
| Nutrasweet or Ed | qual (1 p | acket) NOT Sweet 'N Low | 0 | 0 | W | 0 | 0 | D | 0 | 0 | 0 | | | 0 | 0 | 0 | av rhi | 0 | 0 | |
| Garlic (1 clove or | | | 0 | 0 | W | 0 | 0 | (D) | 0 | 0 | 0 | 0 | | 1 | 1 | 1 | mus vei | 1 | 1 | |
| | | ood or bread (1 Tbs) | Ō | 0 | (W) | 0 | 0 | (D) | 0 | 0 | 0 | 0 | | 2 | 2 | 2 | rad pe | p 2 | 2 | |
| _ow-fat or fat-fre | | | Õ | Ŏ | (W) | Õ | Õ | (D) | Õ | Õ | \bigcirc | 0 | | 3 | 3 | 3 | hrd pk | s 3 | 3 | |
| Regular mayonna | | | Õ | Õ | (W) | Õ | Õ | (D) | Õ | Õ | 0 | 10 | | 4 | 4 | 4 | dap pk | d 4 | 4 | |
| Salad dressing (2 | | | Õ | ŏ | (W) | ŏ | Õ | (D) | Õ | Õ | ŏ | | | 5 | 5 | 5 | dat oh | v 5 | 5 | |
| 00 | | ssing: Nonfat | Low-fa | + (| Olive | e oil | (| | er vege | table c | il | | 7 | - | | 6 | mgo sin | n 6 | 6 | |
| | | | Les | | | 01 | 1/mo | | | | /week c | r more | A | 1 | | | mxt en | | 7 | |
| | 5 % C | | Les | | | ŏ | | | 2-3/mo | | /week c | | в | 8 | | \simeq | pap en | | 8 | |
| | | visible fat on your bee | | | | | | | | | | THOIC | 8 | 9 | | \simeq | pnl pw | | | |
| | | le fat Remove most | | | | | | Remove | | | Don't ea | t most | Č | Č | ~ | 9 | 00 | 7 | ~ | |
| | | | | | | | | Terriove | enone | 0 | John ea | it meat | 9 | | | | 6 | V O | 6 | |
| | | u eat food fried, stir-fri | | | | | | ule (| DE C | timool | ale T | Daily | | | | | CA | | 1 | |
| O Never | | | Once p | | | | times/v | | | times/v | |) Daily | 10 | | | | | B 2 | | |
| | | is usually used for fryir | | | | | | | | "-type : | | | 10 | | | | | \mathbb{Z} | | |
| O Real but | | Margarine Olive | | 0 | etable | OII |) Veg | etable | snortei | ning | () L | ard | 100 | | | | | Y 3 | 3 | |
| | | is usually used for bak | | | | | | | | - | <u>.</u> | | 11 | | | | VE | \sim | 4 | |
| O Real but | | Margarine Olive | (1) | Veg | etable | oil (|) Veg | etable | shorter | ning | OL | ard | | | | | | 5 | | |
| | | king oil is usually used | | | | | | | | | | | 12 | | | | | 6 | | |
| (e.g., Maz | | | | | | | | | | | | | | | | | 2.25 | | 7 | |
| 3. How often | - | u eat deep fried chicke | | | | | | | | | | | 13 | | | | | 8 | | |
| O Never | | | 0 1-3 | | | | | 1–6 tim | | | |) Daily | 1.1 | | | | | 9 | 9 | |
| 4. What perc | ent of y | our noon and evening | meals | are pre | epared | d at ho | ome? (| exclu | de co | mmere | cially p | repare | ed m | neal | ls) | | 14 | 8 | | |
| O Almost r | - | | 50% | (| 75% | | (| | ost all | | | | | | | | | | | |
| 5. Are there | any oth | ner important foods that | at you | | | | you usi | | | ervings | 15 | | | | | | | | | |
| usually ea | t at lea | st once per week? | | 2 | eat at le | east onc | e per w | eek | pe | r week | | | 1 | 1 | 1 | 1 | 1 1 | | 1 | 1 |
| Include for e | xample: | Avocado, mushrooms, bulgu rseradish, dried apricots, dat | ir, es | (a) | | | | | | | | | 2 | 2 | 2 | 2 | 2 2 | 2 | 2 | 2 |
| fias, mango, | mixed d | ried fruit, papaya, rhubarb, c | ustard, | (b) | | | | | | | | | 4 | 4 | 4 | 4 | 4 4 | 4 | 4 | 4 |
| venison, hot | peppers | , pickles, olives, SlimFast, Er Power/Sports bars. | nsure | (0) | | | | | | | | | 8 | 8 | 8 | 8 | 8 8 | 8 | 8 | 8 |
| (regular, plus (Do not inclu | | | | (c) | | | | | | | | | P | P | P | P | PP | P | P | P |
| (DO HOL INCIU | ue ury s | 01003.) | | W. LEA | | | | | | | | | | | | | | | | |

Thank you! Please return form to: WHS, 900 Commonwealth Avenue, Boston, MA 02215.