HARVARD MEDICAL SCHOOL

NURSES' HEALTH STUDY

Please reply to:
Channing Laboratory
181 Longwood Avenue
Boston MA 02115-5804
(617) 525-2279 Fax (617) 525-2008

Dear Colleague:

The Nurses' Health Study is celebrating its 20th anniversary! We have all grown a little older, but thanks to your continuing collaboration, we are much wiser about the factors that influence women's health. Whether or not you are still active in nursing, your on-going participation is as important as ever in the quest for greater understanding of the choices that lead to a healthy life.

The attached **very brief** questionnaire asks only for the most important information necessary for maintaining our records. We have made it as short as possible in the hope that you will take just a few minutes to complete the form.

We know that you will give this questionnaire the same careful consideration as you have given our forms since the study began 20 years ago. As always, all information is kept strictly confidential.

It is with our deepest gratitude that we thank you again for the time and care which you have continued to offer to further the study of women's health. Thanks again.

Sincerely,

Frank E. Speizer, M.D.

Frank E. Speizer, M.D.
Principal Investigator

P.S. Your prompt reply will help us continue to examine the many unresolved questions concerning the health of women. Please take just a moment to complete this short form!

NURSES' HEALTH STUDY - HARVARD MEDICAL SCHOOL

1. **What is your date of birth?** MONTH / DAY / YEAR

2. **Current Weight:** _____ **lbs.**

3. **Have your menstrual periods ceased permanently?** ☐ No ☐ Yes ➡ **Was this:** ☐ Natural ☐ Surgical

4. **Do you currently use female hormones (e.g., Premarin)?** ☐ No ☐ Yes ➡ ☐ Estrogen only ☐ Estrogen & Progesterone ☐ Other

5. **Have you had your uterus removed?** ☐ No ☐ Yes ➡ **At what age?** _____ **Age**

6. **Have you had your ovaries removed?** ☐ No ☐ One only ☐ Both removed ➡ **At what age(s)?** _____ **Age**

7. **Do you currently smoke cigarettes?** ☐ No ☐ Yes

8. **Since June 1994, have you had any of these physician-diagnosed illnesses?**

2 3 3a 4 4a 5 5a 6 6a 7 8

Cardiovascular

	LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 1994	JUNE '94 to MAY '96	After JUNE 1, 1996
Elevated Cholesterol	Y ➡	☐	☐	☐
High Blood Pressure	Y ➡	☐	☐	☐
Myocardial Infarction (heart attack) ➡ Were you hospitalized for this MI? ○ Yes ○ No	Y ➡	☐	☐	☐
Angina Pectoris ➡ Confirmed by angiogram? ○ Yes ○ No	Y ➡	☐	☐	☐
Coronary Artery Bypass or Coronary Angioplasty	Y ➡	☐	☐	☐
Stroke (CVA)	Y ➡	☐	☐	☐
Transient Ischemic Attack (TIA)	Y ➡	☐	☐	☐
Carotid Surgery (Endarterectomy)	Y ➡	☐	☐	☐
Peripheral Artery Disease	Y ➡	☐	☐	☐

Cancer/Benign Tumors

		BEFORE JUNE 1, 1994	JUNE '94 to MAY '96	After JUNE 1, 1996
Cancer of the Uterus (endometrium)	Y ➡	☐	☐	☐
Fibrocystic or other Benign Breast Disease ➡ Confirmed by breast biopsy? ○ Yes ○ No	Y ➡	☐	☐	☐
Breast Cancer	Y ➡	☐	☐	☐
Melanoma	Y ➡	☐	☐	☐
Squamous Cell Skin Cancer	Y ➡	☐	☐	☐
Basal Cell Skin Cancer	Y ➡	☐	☐	☐
Colon or Rectal Polyps (benign)	Y ➡	☐	☐	☐
Cancer of the Colon or Rectum	Y ➡	☐	☐	☐
Other Cancer (e.g. Lung, Ovary, etc.)	Y ➡	☐	☐	☐

Specify other cancer site:

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Musculoskeletal

	LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 1994	JUNE '94 to MAY '96	After JUNE 1, 1996
Hip or Wrist Fracture Specify Date, Site, and Circumstances on reverse side of this form	Y ➡	☐	☐	☐
Osteoporosis	Y ➡	☐	☐	☐
SLE (systemic lupus)	Y ➡	☐	☐	☐
Osteoarthritis	Y ➡	☐	☐	☐
Rheumatoid Arthritis	Y ➡	☐	☐	☐

Eye Diseases

		BEFORE JUNE 1, 1994	JUNE '94 to MAY '96	After JUNE 1, 1996
Glaucoma	Y ➡	☐	☐	☐
Macular Degeneration of Retina	Y ➡	☐	☐	☐
Cataract (1st diagnosis)	Y ➡	☐	☐	☐
Cataract Extraction	Y ➡	☐	☐	☐
Increased intraocular pressure (over 25mm/Hg)	Y ➡	☐	☐	☐

Other Diseases

		BEFORE JUNE 1, 1994	JUNE '94 to MAY '96	After JUNE 1, 1996
Diabetes Mellitus	Y ➡	☐	☐	☐
Alzheimer's Disease	Y ➡	☐	☐	☐
Parkinson's Disease	Y ➡	☐	☐	☐
Multiple Sclerosis or A.L.S.	Y ➡	☐	☐	☐
Interstitial Cystitis	Y ➡	☐	☐	☐
Kidney Stones	Y ➡	☐	☐	☐
Cholecystectomy	Y ➡	☐	☐	☐
Asthma (Doctor Diagnosed)	Y ➡	☐	☐	☐
Emphysema or Chronic Bronchitis	Y ➡	☐	☐	☐
Pulmonary Embolus	Y ➡	☐	☐	☐
Other Major Illness or surgery (since June 1994)	Y ➡	☐	☐	☐

Specify other major illness or surgery:

Continue on Back

1 2 4 8 P

1 2 3 4 5 6 7 8 9 10 11 12
96 97 98

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W: 0 1 2 3 4 5 6 7 8 9

5: 0 1 2 3 4 5 6 7 8 9

6a: 0 1 2 3 4 5 6 7 8 9

6b: 0 1 2 3 4 5 6 7 8 9

Please indicate the name of someone at a DIFFERENT PERMANENT ADDRESS to whom we might write in the event we are unable to contact you:

Y N

Name: _____

Address: _____

_____

Please Specify Date, Site, and Circumstances of Hip or Wrist Fracture Below:

F

Was this a fracture of: ☐ Hip ☐ Wrist

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3 3 3 3
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8 8 8 8
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0 0 0
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7 7 7
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SS V W X Y Z