WINDOW AREA

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

Dear Colleague:

On behalf of the entire research group, I thank you for your continued willingness to share the details of your life to help improve the health of women everywhere. The success of the Nurses' Health Study is, of course, directly attributable to the outstanding quality of the information which you have faithfully provided for nearly a quarter of a century.

The attached questionnaire has been redesigned to make it easier to complete. We have increased the size of the print and made it generally less "crowded." We hope you like the change! We have NOT used this as an opportunity to increase the number of questions. Please be assured that this booklet contains the same number of questions as our standard six-page survey.

We value **each** member of the Nurses' Health Study as a colleague in our research, regardless of your employment (or retirement) status. Also, whether your health has been excellent or if you have been ill, your response is equally important. In short, no matter what your circumstances, we need to hear from you!

It is with our deepest gratitude that we thank you again for the time and care that you have continued to offer in furthering the study of women's health. The value of your contribution has been enormous.

Best Regards,

Frank E. Speizer, M.D.

Frank E. Speizer, M.D.
Principal Investigator

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Do we have your correct address and name?

Make any necessary changes and return this page with your completed booklet.

Do you have Internet e-mail?
If you do, please print your e-mail address in the box so that we may send you occasional updates on the progress of the Nurses' Health Study.

Please print neatly and differentiate numbers and letters (e.g., 1 vs l or i, ∅ vs O, 5 vs S)

We will not release your e-mail address to anyone!

INSTRUCTIONS

Please use an ordinary No. 2 pencil to answer all questions. Fill in the appropriate response circles completely, or write the requested information in the boxes provided. Note that some questions ask for information **since June 1998**, some ask for **current status**, and some ask about events over **longer periods**. The form is designed to be read by optical-scanning equipment, so it is important that you make **NO STRAY MARKS** and keep any write-in responses **within** the spaces provided. Should you need to change a response, erase the incorrect mark completely. If you have comments, please write them on a separate piece of paper.

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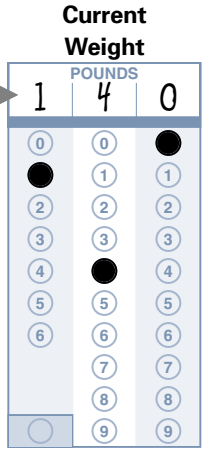
EXAMPLE 1: Write your weight in the boxes . . .

. . . and fill in the circle corresponding to the figure at the head of each column.

Please fill in the circle completely, do not mark this way: ✓ ✗ ◒



NOTE: It is important that you write in your weight in addition to completing the corresponding circles. This allows us to confirm that the correct circles have been filled in.

EXAMPLE 2: Mark "Yes" bubble and Year of Diagnosis bubble for each illness you have had diagnosed.

9. Since June 1998, have you had any of these physician-diagnosed illnesses?

	LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS: BEFORE JUNE 1 1998	JUNE 98 TO MAY 2000	AFTER JUNE 1 2000	
Diabetes mellitus	●	○	●	○	1
Elevated cholesterol	Y	○	○	○	2
High blood pressure	●	●	○	○	3

If your name and address as printed on this questionnaire are no longer correct or are incomplete, or if you are providing your e-mail address, please make any necessary changes on the letter and enclose it with your completed form.

Otherwise, please tear off the cover letter (to preserve confidentiality) and return the booklet in the enclosed postage-paid envelope.

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1. Is this your correct Date of Birth?

○ Yes

○ No → **If No, Please write correct date.**

MONTH / DAY / YEAR

2. What is your current weight?

POUNDS

3. What is the difference between your highest and lowest weight during the last two years? 3

○ No change ○ 2–4 lbs. ○ 5–9 lbs. ○ 10–14 lbs.
○ 15–29 lbs. ○ 30–49 lbs. ○ 50 or more lbs.

4. Have you had your uterus removed? 4

○ No
○ Yes → **Date of surgery:** ○ Before June 1, 1998 ○ After June 1, 1998 a

5. Have you ever had either of your ovaries surgically removed? 5

○ No
○ Yes → **a) How many ovaries do you have remaining?** a
○ None ○ One

PO

PLEASE DO NOT WRITE IN THIS AREA

2000 2001 2002

SERIAL #

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6. *Since June 1998,* have you used Evista (raloxifene) or Nolvadex (tamoxifen)?

○ Yes → **a) How many months have you used <u>each</u> drug during the 24-month period between June 1998 and June 2000?**

○ No

Evista:

○ Not Used ○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months ○ Used <u>only</u> after 6/2000

Nolvadex:

○ Not Used ○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months ○ Used <u>only</u> after 6/2000

b) Are you <u>currently</u> using Evista or Nolvadex?

○ No, not currently ○ Yes, Evista ○ Yes, Nolvadex

7. *Since June 1998,* have you regularly used any over-the-counter (e.g., "alternative," "herbal," "natural" or soy-based) preparations for hormone replacement or to treat postmenopausal symptoms? (Do not include food sources such as tofu, soy milk or soy bars.)

○ Yes → **a) Please mark the type(s) of preparations you have used at least once a week, and the number of months used between June 98 and June 2000.**

○ No

	MONTHS USED BETWEEN JUNE 98 AND JUNE 2000				
○ Soy estrogen supplement (e.g., Estroven)	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20–24 mo.
○ Soy powder (e.g., Iso-Soy)	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20–24 mo.
○ Black cohosh (e.g., Remifemin)	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20–24 mo.
○ Dong quai (e.g., Rejuvex)	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20–24 mo.
○ Natural progesterone cream or wild yam cream (e.g., Progest Cream)	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20–24 mo.
○ Other, e.g., phytoestrogens (specify)	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20–24 mo.

Please Continue on Page 3

8. *Since June 1998,* have you used prescription female hormones?

○ Yes → ○ No

a) How many months have you used them during the 24-month period between June 1998 and June 2000?

○ 1–4 months ○ 5–9 ○ 10–14
○ 15–19 ○ 20–24 months ○ Used only after June 2000

b) Are you currently using them (within the last month)?

○ Yes, currently ○ No, not currently

c) Mark the types of hormones you have used the longest during this period.

Combined:

○ Prempro (Pink) ○ Prempro (Blue) ○ Premphase ○ Combipatch ○ FemHRT

Estrogen:

○ Oral Premarin ○ Patch Estrogen ○ Vaginal Estrogen
○ Ogen ○ Estrace ○ Estratest
○ Other Estrogen (specify type in box below)

Progesterone/Progestin (e.g., Provera):

○ Provera/Cycrin/MPA ○ Vaginal ○ Micronized (e.g., Prometrium)
○ Other progesterone (specify below)

Other type of hormones used, please specify:

d) If you used oral conjugated estrogen (e.g., Premarin) what dose did you usually take?

○ .30 mg/day or less (Green) ○ .625 mg/day (Brown) ○ .9 mg/day (White)
○ 1.25 mg/day (Yellow) ○ More than 1.25 mg/day ○ Dose unknown
○ Did not take oral conjugated estrogen

e) If you used oral medroxyprogesterone (e.g., Provera, Cycrin), what dose did you usually take?

○ 2.5 mg or less ○ 5–9 mg ○ 10 mg ○ More than 10 mg
○ Dose unknown ○ Not used

f) What was your pattern of hormone use (Days per Month)?

Oral or Patch Estrogen:

Days per Month ○ Not used ○ <1 day/mo ○ 1–8 days ○ 9–18 ○ 19–26 ○ 27+ days/month

Progesterone:

Days per Month ○ Not used ○ <1 day/mo ○ 1–8 days ○ 9–18 ○ 19–26 ○ 27+ days/month

Please Continue on Page 4

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9. Since June 1998, have you had any of these physician-diagnosed illnesses?

MARK "YES" BUBBLE AND YEAR OF DIAGNOSIS BUBBLE FOR EACH ILLNESS YOU HAVE HAD DIAGNOSED.

LEAVE BLANK FOR "NO," MARK HERE FOR "YES" →

		YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 1998	JUNE 98 TO MAY 2000	AFTER JUNE 1 2000	
Fibrocystic/other benign breast disease	(Y)	○	○	○	1
Confirmed by breast biopsy? → (N) No (Y) Yes					a
Breast cancer	(Y)	○	○	○	2
Cancer of the cervix (include in-situ)	(Y)	○	○	○	3
Cancer of the uterus (endometrium)	(Y)	○	○	○	4
Cancer of the ovary	(Y)	○	○	○	5
Colon or rectal polyp (benign)	(Y)	○	○	○	6
Cancer of the colon or rectum	(Y)	○	○	○	7
Cancer of the lung	(Y)	○	○	○	8
Melanoma	(Y)	○	○	○	9
Basal cell skin cancer	(Y)	○	○	○	10
Squamous cell skin cancer	(Y)	○	○	○	11
Other cancer	(Y)	○	○	○	12
Specify site of other cancer →					
Diabetes mellitus	(Y)	○	○	○	13
Elevated cholesterol	(Y)	○	○	○	14
High blood pressure	(Y)	○	○	○	15
Myocardial infarction (heart attack)	(Y)	○	○	○	16
Hospitalized for MI? → (N) No (Y) Yes					a
Angina pectoris	(Y)	○	○	○	17
Confirmed by angiogram? → (N) No (Y) Yes					a
Coronary bypass or angioplasty	(Y)	○	○	○	18
Congestive heart failure	(Y)	○	○	○	19
Stroke (CVA)	(Y)	○	○	○	20
TIA (Transient ischemic attack)	(Y)	○	○	○	21
Peripheral artery disease or claudication of legs (not varicose veins)	(Y)	○	○	○	22
Confirmed by angiogram/surgery? → (N) No (Y) Yes					a
Carotid surgery (Endarterectomy)	(Y)	○	○	○	23

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9. (Continued)
Since June 1998, have you had any of these physician-diagnosed illnesses?

MARK "YES" BUBBLE AND YEAR OF DIAGNOSIS BUBBLE FOR EACH ILLNESS YOU HAVE HAD DIAGNOSED.

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"

		YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 1998	JUNE 98 TO MAY 2000	AFTER JUNE 1 2000	
Pulmonary embolus	Y	○	○	○	24
Periodontal bone loss	Y	○	○	○	25
Osteoporosis	Y	○	○	○	26
Vertebral fracture, X-ray confirmed	Y	○	○	○	27
Hip replacement	Y	○	○	○	28
Fractures: **Wrist or Colles' Fracture**	Y	○	○	○	29
Hip fracture	Y	○	○	○	30
Gastric or duodenal ulcer	Y	○	○	○	31
Cholecystectomy	Y	○	○	○	32
Glaucoma	Y	○	○	○	33
Macular degeneration of retina	Y	○	○	○	34
Cataract—1st Diagnosis (Dx)	Y	○	○	○	35
Cataract extraction	Y	○	○	○	36
Asthma, Doctor diagnosed	Y	○	○	○	37
Emphysema or Chronic bronchitis, Dr. Dx	Y	○	○	○	38
A.L.S. (Amyotrophic Lateral Sclerosis)	Y	○	○	○	39
Parkinson's Disease	Y	○	○	○	40
Diverticulitis/diverticulosis	Y	○	○	○	41
Ulcerative colitis/Crohn's	Y	○	○	○	42
Kidney stones	Y	○	○	○	43
Interstitial Cystitis (Dx by cystoscopy)	Y	○	○	○	44
Pernicious Anemia/B12 deficiency	Y	○	○	○	45
Active TB (X-ray or culture Dx)	Y	○	○	○	46
Other major illness or surgery since June 1998	Y	○	○	○	47

Please specify: **Date:**

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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

10. Have you *ever* had any of these physician-diagnosed illnesses?

MARK "YES" BUBBLE AND YEAR OF DIAGNOSIS BUBBLE FOR EACH ILLNESS YOU HAVE HAD DIAGNOSED.

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"

		YEAR OF FIRST DIAGNOSIS				
		1996 or Before	1997–1998	1999	2000	2001
Multiple sclerosis	Y	○	○	○	○	○
Shingles	Y	○	○	○	○	○
Increased eye pressure in either eye (over 25mm/Hg)	Y	○	○	○	○	○
Depression, Dr. Dx	Y	○	○	○	○	○
SLE (systemic lupus)	Y	○	○	○	○	○
Osteoarthritis	Y	○	○	○	○	○
Rheumatoid arthritis, Dr. Dx	Y	○	○	○	○	○

a) Rheumatoid factor ○ Negative/unknown ○ Positive

11. In the past two years have you had:

(If yes, mark all that apply)

	No	Yes, for Screening	Yes, for Symptoms
A physical exam?	N	Y	Y
Exam by eye doctor?	N	Y	Y
Bimanual pelvic exam?	N	Y	Y
Breast exam by clinician?	N	Y	Y
Mammogram?	N	Y	Y
Fasting blood sugar	N	Y	Y

12. How many teeth have you lost since 1996?

○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5–9 ○ 10+

13. How many of your teeth have *ever* had root canal therapy?

○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5–9 ○ 10+

14. Have you *ever* had physician-diagnosed atrial fibrillation?

○ Yes → a) **Year of First Diagnosis**

○ Before 1986 ○ 1986–1992 ○ 1993–1996 ○ 1997+

○ No

b) **Which of the following best describes your pattern of atrial fibrillation? (Mark one)**

○ Single resolved episode
○ Recurrent episodes that end spontaneously
○ Recurrent episodes terminated by treatment
○ Permanent or chronic atrial fibrillation

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15. Have any of the following biological relatives had...

		Relative's Age at First Diagnosis (Do not count half siblings.)				
		Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
Ovarian Cancer?						
○ No	Mother (Y) →	○	○	○	○	○
	Sister (Y) →	○	○	○	○	○
Breast Cancer?						
○ No	Mother (Y) →	○	○	○	○	○
	One Sister (Y) →	○	○	○	○	○
	Additional Sister (Y) →	○	○	○	○	○
	Daughter (Y) →	○	○	○	○	○
Colon or Rectal Cancer?						
○ No	Parent (Y) →	○	○	○	○	○
	One Sibling (Y) →	○	○	○	○	○
	Additional Sibling (Y) →	○	○	○	○	○
Pancreatic Cancer?						
○ No	Parent (Y) →	○	○	○	○	○
	Sibling (Y) →	○	○	○	○	○
Lung Cancer?						
○ No	Parent (Y) →	○	○	○	○	○
	Sibling (Y) →	○	○	○	○	○
Melanoma?						
○ No	Parent (Y) →	○	○	○	○	○
	Sibling (Y) →	○	○	○	○	○
	Offspring (Y) →	○	○	○	○	○
Glaucoma?						
○ No	Parent (Y) →	○	○	○	○	○
	Sibling (Y) →	○	○	○	○	○

16. Did you have a colonoscopy or sigmoidoscopy since June 1, 1998?

○ No ○ Yes → **Why did you have the colonoscopy or sigmoidoscopy?** *(Mark all that apply.)*

- ○ Bleeding in stool
- ○ Abdominal pain
- ○ Family history of colon cancer
- ○ Diarrhea or constipation
- ○ Positive test for occult fecal blood
- ○ Barium enema
- ○ Routine or follow-up screening (no symptoms)

Please Continue on Page 8

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17. Your Blood Cholesterol (if checked within 5 years):

○ Unknown/Not checked within 5 years ○ <140 mg/dl ○ 140–159 ○ 160–179 ○ 180–199 ○ 200–219
○ 220–239 ○ 240–269 ○ 270–299 ○ 300–329 ○ 330+ mg/dl

18. How often do you have difficulty holding your urine until you can get to a toilet?

○ Never ○ Hardly ever ○ Some of the time ○ Most of the time ○ All of the time

19. During the last 12 months, how often have you leaked or lost control of your urine?

○ Never ○ Less than once/month ○ Once/month ○ 2–3 times/month ○ About once/week ○ Almost every day

a) When you lose your urine, how much usually leaks?

○ A few drops ○ Enough to wet your underwear ○ Enough to wet your outerclothing ○ Enough to wet the floor

20. Do you currently smoke cigarettes?

○ Yes → How many/day? ○ 1–4 ○ 5–14 ○ 15–24 ○ 25–34 ○ 35–44 ○ 45+
○ No

21. What is your normal walking pace outdoors?

○ Slow (less than 2 mph) ○ Normal, average (2 to 2.9 mph) ○ Brisk pace (3 to 3.9 mph)
○ Very brisk, striding (4 mph or faster) ○ Unable to walk

22. How many flights of stairs (not steps) do you climb daily?

○ No flights ○ 1–2 flights ○ 3–4 flights ○ 5–9 flights ○ 10–14 flights ○ 15 or more flights

23. a. During the last month, how often did you have pain or discomfort in or around the knee(s)?

○ Never ○ Less than once/week ○ One day/week ○ 2–6 days/week ○ Daily

b. During the last year, did you have any knee pain or knee discomfort when doing any of the following?

	Never	Some-times	Usually	Always	Can't do at all
Walking 2 to 3 blocks (1/4 mile)	○	○	○	○	○
Bending your knee or squatting	○	○	○	○	○
Getting up from chair without using your arms	○	○	○	○	○

24. Have you ever noticed pain, stiffness, enlargement or swelling of the joints nearest to your fingernails?

○ Yes ○ No

25. Number of times you have fallen to the ground in the past 1 year:

○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

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26. Regular Medication *(mark if used regularly in past 2 years)*

Analgesics

- ○ Acetaminophen (e.g., Tylenol)
  - Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days → Tablets per week: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets
- ○ "Baby" or low dose aspirin
  - Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days → Tablets per week: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets
- ○ Aspirin or aspirin-containing products (325mg/tablet or more)
  - Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days → Tablets per week: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets
- ○ Ibuprofen (e.g., Advil, Motrin, Nuprin)
  - Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days → Tablets per week: ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets
- ○ Celebrex or Vioxx (COX-2 inhibitors)
- ○ Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)

Other regular medication

- ○ Thiazide diuretic ○ Lasix
- ○ Calcium blocker (e.g., Calan, Procardia, Cardizem)
- ○ Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)
- ○ ACE Inhibitors (e.g., Capoten, Vasotec, Zestril)
- ○ Other antihypertensive (e.g., Aldomet, Apresoline)
- ○ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)
- ○ Inhaled steroids ○ Inhaled bronchodilator
- ○ Digoxin ○ Antiarrhythmic
- ○ Coumadin
- ○ "Statin" cholesterol-lowering drugs [e.g., Mevacor (lovastatin), Pravachol (pravastatin), Zocor (simvastatin), Lipitor]
  - Number of years used: ○ 0–2 yrs ○ 3–5 yrs ○ 6+ yrs
- ○ Other cholesterol-lowering drug
- ○ Cimetidine (Tagamet)
- ○ Prilosec or Prevacid
- ○ Other H2 blocker (e.g., Zantac, Pepcid)
- ○ Insulin ○ Oral hypoglycemic medication
- ○ Prozac ○ Zoloft ○ Paxil ○ Celexa
- ○ Other antidepressants (e.g., Elavil, Tofranil, Pamelor)
- ○ Minor tranquilizers (e.g., Valium, Xanax, Ativan, Librium)
- ○ Meridia (sibutramine) ○ Phentermine ○ Xenical
- ○ Other regular medication (no need to specify)
- ○ No regular medication

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27. In a typical week during the past year, on how many days did you consume an alcoholic beverage of any type?

○ No days ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days ○ 6 days ○ 7 days

28. In a typical month during the past year, what was the largest number of drinks of beer, wine and/or liquor you may have had in one day?

○ None ○ 1–2 ○ 3–5 ○ 6–9 ○ 10–14 ○ 15 or more

29. What is your *current* work status? *(Mark all that apply)*

○ Retired ○ Full-time non-nursing employment ○ Nursing full-time
○ Homemaker ○ Part-time non-nursing employment ○ Nursing part-time

30. What is your *current* marital status?

○ Married ○ Widowed ○ Divorced ○ Separated ○ Never married

31. Your living arrangement:

○ Alone ○ With spouse or partner ○ With other family ○ Nursing home ○ Other

32. Have you ever received a blood transfusion? (exclude transfusions of your own blood)

○ Yes
○ No

a) Total number of units received in your lifetime?
○ None ○ 1–2 ○ 3–4 ○ 5–10 ○ 11 or more

b) Your age at transfusion(s)? (Mark all that apply)
○ Before age 30 ○ 30–39 ○ 40–49 ○ 50–59 ○ 60–69 ○ 70+

33. DURING THE PAST YEAR, what was your average time PER WEEK spent at each of the following recreational activities?

	TIME PER WEEK									
	Zero	1–4 Min.	5–19 Min.	20–59 Min.	One Hour	1–1.5 Hrs.	2–3 Hrs.	4–6 Hrs.	7–10 Hrs.	11+ Hrs.
Walking for exercise or walking to work	○	○	○	○	○	○	○	○	○	○
Jogging (slower than 10 minutes/mile)	○	○	○	○	○	○	○	○	○	○
Running (10 minutes/mile or faster)	○	○	○	○	○	○	○	○	○	○
Bicycling (include stationary machine)	○	○	○	○	○	○	○	○	○	○
Tennis, squash, racquetball	○	○	○	○	○	○	○	○	○	○
Lap swimming	○	○	○	○	○	○	○	○	○	○
Other aerobic exercise (aerobic dance, ski or stair machine, etc.)	○	○	○	○	○	○	○	○	○	○
Lower intensity exercise (yoga, stretching, toning)	○	○	○	○	○	○	○	○	○	○
Other vigorous activities (e.g., lawn mowing)	○	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises (Include free weights or machines such as Nautilus) — Arm weights	○	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises (Include free weights or machines such as Nautilus) — Leg weights	○	○	○	○	○	○	○	○	○	○

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34. Do you currently take a multi-vitamin? (Please report other individual vitamins in question 35.)

34

○ Yes → **a) How many do you take per week?** a
○ No
○ 2 or less ○ 3–5 ○ 6–9 ○ 10 or more

b) What type of multivitamin do you take? (Mark brand name equivalent if generic is used, e.g., *Sentury* is equivalent to *Centrum*) b

Mark the ONE type used most frequently.

○ Allbee + C	○ Formula 100, Nutri-100	○ Shaklee Vita-Lea
○ Caltrate 600	○ Health Balance Daily Pack	○ Solotron for Women
○ CVS Daily	○ Healthy Directions Forward Plus	○ Stresstabs
○ CVS Daily with Minerals	○ Nuskin Life Pack	○ Surbex T
○ CVS Pro-Vite	○ Ocuvite	○ Theragran
○ CVS Mega Multi	○ Ocuvite Plus	○ Theragran M
○ Central Vite	○ One A Day Antioxidant Plus	○ Unicap
○ Central Vite Plus	○ One A Day Essential	○ Unicap-M
○ Central Vite Select	○ One A Day Maximum	○ Unicap Senior
○ Centrum, Century, Sentury	○ One A Day Womens	○ VI-MIN 75
○ Centrum Silver	○ Protegra	○ Women Power Pack
		○ Z-Bec

If your type is not listed, write exact brand/type here → Specify exact brand and type.

c) Does your multivitamin include iron? c
○ No ○ Yes ○ Not Sure

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
0 1 2 3 4 5 6 7 8 9

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35. Do you take the following separate preparations?

35

DO NOT REPORT CONTENTS OF MULTI-VITAMINS MENTIONED ABOVE.

			AMOUNT PER DAY					
Vitamin A	○ No	○ Yes, seasonal only ○ Yes, most months → If Yes, Dose per day:	○ Less than 8,000 IU	○ 8,000 to 12,000 IU	○ 13,000 to 22,000 IU	○ 23,000 IU or more	○ Don't know	A
Beta-carotene	○ No	○ Yes → If Yes, Dose per day:	○ Less than 8,000 IU	○ 8,000 to 12,000 IU	○ 13,000 to 22,000 IU	○ 23,000 IU or more	○ Don't know	BC
Vitamin C	○ No	○ Yes, seasonal only ○ Yes, most months → If Yes, Dose per day:	○ Less than 400 mg	○ 400 to 700 mg	○ 750 to 1250 mg	○ 1300 mg or more	○ Don't know	C
Folic acid	○ No	○ Yes → If Yes, Dose per day:	○ Less than 100 mcg	○ 100 to 300 mcg	○ 301 to 500 mcg	○ 501 mcg or more	○ Don't know	F
Vitamim E	○ No	○ Yes → If Yes, Dose per day:	○ Less than 100 IU	○ 100 to 250 IU	○ 300 to 500 IU	○ 600 IU or more	○ Don't know	E
Calcium (Include Calcium in Tums, etc.) (1 Tum = 200 mg elemental calcium)	○ No	○ Yes → If Yes, Dose per day (elemental calcium):	○ Less than 400 mg	○ 400 to 900 mg	○ 901 to 1300 mg	○ 1301 mg or more	○ Don't know	CA
Niacin	○ No	○ Yes → If Yes, Dose per day:	○ Less than 50 mg	○ 50 to 300 mg	○ 400 to 800 mg	○ 900 mg or more	○ Don't know	N
Zinc	○ No	○ Yes → If Yes, Dose per day:	○ Less than 25 mg	○ 25 to 74 mg	○ 75 to 100 mg	○ 101 mg or more	○ Don't know	Z

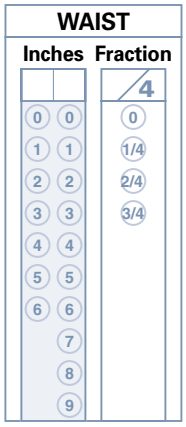
36. Question 36, which should only be answered if a tape measure is available, asks about body measurements. This information will be more accurate if you follow these suggestions:

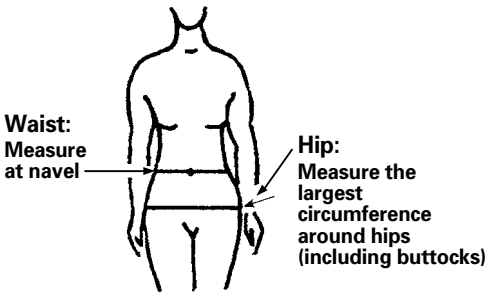
- Make measurements while standing
- Avoid measuring over bulky clothing
- Try to record answers to the nearest 1/4 inch (do not estimate)

If a tape measure is not available, please leave blank.

WAIST

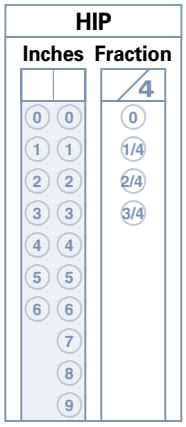
Inches Fraction





HIP

Inches Fraction



37. 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?
(Mark one response on each line.)

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	○	○	○
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
Lifting or carrying groceries	○	○	○
Climbing *several* flights of stairs	○	○	○
Climbing *one* flight of stairs	○	○	○
Bending, kneeling, or stooping	○	○	○
Walking *more than a mile*	○	○	○
Walking *several blocks*	○	○	○
Walking *one* block	○	○	○
Bathing or dressing yourself	○	○	○

38. 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:

Name: _____

Address: _____

_____

Phone Number: _____

39. 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* ...
(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
Did you feel full of pep?	○	○	○	○	○	○
Have you been a very nervous person?	○	○	○	○	○	○
Have you felt so down in the dumps nothing could cheer you up?	○	○	○	○	○	○
Have you felt calm and peaceful?	○	○	○	○	○	○
Did you have a lot of energy?	○	○	○	○	○	○
Have you felt downhearted and blue?	○	○	○	○	○	○
Did you feel worn out?	○	○	○	○	○	○
Have you been a happy person?	○	○	○	○	○	○
Did you feel tired?	○	○	○	○	○	○
Have you felt hopeless about the future?	○	○	○	○	○	○
Have you thought about or wanted to commit suicide?	○	○	○	○	○	○
Have you felt no interest in things?	○	○	○	○	○	○
Did you have difficulty falling asleep or staying asleep?	○	○	○	○	○	○

40. During the *past 4 weeks*, how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting with friends, relatives, etc.)?

○ All of the time ○ Most of the time ○ Some of the time ○ A little of the time ○ None of the time

41. Please choose the answer that best describes how true or false each of the following statements is for you. *(Mark one response on each line.)*

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
Over the past 4 weeks, I have felt about the same as I have felt during the past year	○	○	○	○	○
I seem to get sick a little easier than other people	○	○	○	○	○
I am as healthy as anybody I know	○	○	○	○	○
I expect my health to get worse	○	○	○	○	○
My health is excellent	○	○	○	○	○

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42. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of any *emotional problems* (such as feeling depressed or anxious)? *(Mark one response on each line.)*

a) Cut down the amount of time you spent on work or other activities	◯ Yes	◯ No
b) Accomplished less than you would like	◯ Yes	◯ No
c) Didn't do work or other activities as carefully as usual	◯ Yes	◯ No

43. During the *past 4 weeks*, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

44. How much *bodily* pain have you had during the *past 4 weeks*?

◯ None ◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very severe

45. During the *past 4 weeks*, how much did *bodily pain* interfere with your normal work (including both work outside the home and housework)?

◯ Not at all ◯ A little bit ◯ Moderately ◯ Quite a bit ◯ Extremely

46. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your *physical health*? *(Mark one response on each line.)*

a) Cut down the amount of time you spent on work or other activities	◯ Yes	◯ No
b) Accomplished less than you would like	◯ Yes	◯ No
c) Were limited in the kind of work or other activities	◯ Yes	◯ No
d) Had difficulty performing the work or other activities (for example, it took extra effort)	◯ Yes	◯ No

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

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

48. How often do you go to religious meetings or services?

◯ More than once a week ◯ Once a week ◯ 1 to 3 times per month
◯ Less than once per month ◯ Never or almost never

49. How many hours each week do you participate in any groups such as social or work group, church-connected group, self-help group, charity, public service or community group?

◯ None ◯ 1 to 2 hours ◯ 3 to 5 hours ◯ 6 to 10 hours ◯ 11 to 15 hours ◯ 16 or more hours

50. How many living children do you have?

Daughters	◯ None	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5 or more
Sons	◯ None	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5 or more

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51. How many of your children do you see at least once a month?

○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 or more

52. Apart from your children, how many relatives do you have with whom you feel close?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 9 ○ 10 or more

53. Apart from your children, how many close relatives do you see at least once a month?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 9 ○ 10 or more

54. How many close friends do you have?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 9 ○ 10 or more

55. How many of these friends do you see at least once a month?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 9 ○ 10 or more

56. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with?

○ Yes → **a)** How often do you see or talk with this person?
○ No ○ Daily ○ Weekly ○ Monthly ○ Several times/year ○ Once/year or less

57. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?

○ None of the time ○ A little of the time ○ Some of the time ○ Most of the time ○ All of the time

58. How many people can you count on to provide you with emotional support?

○ None ○ One ○ Two ○ Three or more

59. Have you been employed within the past 2 years?

○ Yes → To what extent would you agree or disagree with the following statement?
○ No

My job security is good

○ Strongly Disagree ○ Disagree ○ Agree ○ Strongly Agree ○ Not currently employed

60. How many total hours of actual sleep do you get in a 24-hr period?

○ 5 hours or less ○ 6 hours ○ 7 hours ○ 8 hours ○ 9 hours ○ 10 hours ○ 11+ hours

61. Do you snore?

○ Every night ○ Most nights ○ A few nights a week ○ Occasionally ○ Almost never

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62. Outside of your employment, do you provide regular care to any of the following?
(Mark one response on each line. For people to whom you do not provide regular care, mark "Zero Hours.")

	HOURS PER WEEK					
	Zero Hrs.	1–8 Hrs.	9–20 Hrs.	21–35 Hrs.	36–72 Hrs.	73+ Hrs.
Your children	○	○	○	○	○	○
Grandchildren	○	○	○	○	○	○
Disabled or ill spouse	○	○	○	○	○	○
Disabled or ill parent	○	○	○	○	○	○
Disabled or ill other person	○	○	○	○	○	○

63. How *stressful* would you say it is to provide care to the individuals mentioned above?

○ Not applicable ○ Not at all ○ Just a little bit ○ Moderately ○ Extremely ○ Don't know

64. How *rewarding* would you say it is to provide care to the individuals mentioned above?

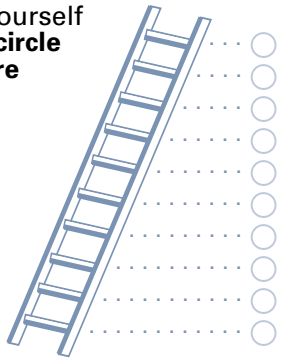
○ Not applicable ○ Not at all ○ Just a little bit ○ Moderately ○ Extremely ○ Don't know

65. The following questions relate to how you feel about your standing in US society and in your community.

a) Think of this ladder as representing where people stand in the United States.

- At the top of the ladder are the people who are the best off—those who have the most money, the most education, and the most respectable jobs.
- At the bottom of the ladder are the people who are the worst off—those who have the least money, the least education, and the least respected jobs or no job.

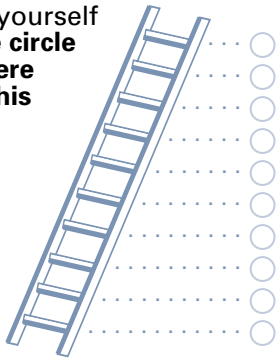
Where would you place yourself on this ladder? **Fill in the circle that best represents where you think you stand, relative to other people in the United States.**



b) Now think of this ladder as representing where people stand in their communities. People define community in different ways. Please define it in whatever way is most meaningful to you.

- At the top of the ladder are the people who have the highest standing in their community.
- At the bottom of the ladder are the people who have the lowest standing in their community.

Where would you place yourself on this ladder? **Fill in the circle that best represents where you think you stand at this time in your life, relative to other people in your community.**



66. Did you need any help from someone else to complete this questionnaire?

○ No
○ Yes → What kind of help did you need? (Mark all that apply.)

○ Help with vision ○ Help with memory ○ This questionnaire was completed by someone other than the participating nurse. (Please elaborate on the next page and include your name, telephone number and relationship to the participant.)
○ Help with writing ○ Other

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Thank you!

Please check to make sure you have not accidentally skipped any pages.

Please return form in prepaid envelope to:

Frank E. Speizer, MD
Nurses' Health Study
181 Longwood Ave.
Boston, MA 02115