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
E-mail: NHS@Nurseshealthstudy.org

Dear Colleague:

Thank you for your participation in one of the preeminent studies of women's health, the Nurses' Health Study. As we commemorate our 25th year of investigating the factors which promote good health, your continued involvement is extremely valuable.

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 value **each** member of the Nurses' Health Study as a colleague in our research, regardless of your employment (or retirement) status. Aslo, 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 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.
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 or ovaries removed?** ☐ No ☐ Uteros removed ☐ Both ovaries removed ☐ One ovary removed

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

7. **Since June 1996, have you had any of these physician-diagnosed illnesses?**

(2) (3) (3a) (4) (4a) (5) (6) (7)

Cardiovascular

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".		YEAR OF DIAGNOSIS: BEFORE JUNE 1, 1998	JUNE '98 to MAY '00	After JUNE 1, 2000
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 Artery Surgery (Endarterectomy)	Y ➡			
Peripheral Artery Disease (not varicose veins)	Y ➡			
Pulmonary Embolus	Y ➡			
Congestive Heart Failure	Y ➡			
Atrial fibrillation, Dr. Dx	Y ➡			

Eye Diseases

		BEFORE JUNE 1, 1998	JUNE '98 to MAY '00	After JUNE 1, 2000
Glaucoma	Y ➡			
Macular Degeneration of Retina	Y ➡			
Cataract (1st diagnosis)	Y ➡			
Cataract Extraction	Y ➡			
Increased eye pressure (over 25mm/Hg)	Y ➡			

Musculoskeletal

		BEFORE JUNE 1, 1998	JUNE '98 to MAY '00	After JUNE 1, 2000
Hip or Wrist Fracture Specify Date, Site, and Circumstances on reverse side of this form	Y ➡			
Hip Replacement	Y ➡			
Osteoporosis	Y ➡			
Rheumatoid arthritis, Dr. Dx	Y ➡			

Cancer/Benign Tumors

LEAVE BLANK FOR "NO", MARK HERE FOR "YES".		YEAR OF DIAGNOSIS: BEFORE JUNE 1, 1998	JUNE '98 to MAY '00	After JUNE 1, 2000
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 ➡			
Colon or Rectal Cancer	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)

Other Diseases

		BEFORE JUNE 1, 1998	JUNE '98 to MAY '00	After JUNE 1, 2000
Diabetes Mellitus	Y ➡			
Alzheimer's Disease	Y ➡			
Parkinson's Disease	Y ➡			
Multiple Sclerosis	Y ➡			
Depression, Dr. Dx	Y ➡			
Interstitial Cystitis (Dx by cystoscopy)	Y ➡			
Kidney Stones	Y ➡			
Cholecystectomy	Y ➡			
Asthma (Doctor Diagnosed)	Y ➡			
Emphysema or Chronic Bronchitis	Y ➡			
Other Major Illness or surgery (since June 1998)	Y ➡			

Specify other major illness or surgery:

Continue on Back

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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: _____

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

Was this a fracture of: ☐ Hip ☐ Wrist

Note: Please be specific regarding circumstances (e.g., "Fell from chair I was standing on")

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