HARVARD MEDICAL SCHOOL **NURSES' HEALTH STUDY**

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This is your ID ➡

Do you have an e-mail address?
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, Ø vs O, 5 vs S)

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

INSTRUCTIONS

Please use an ordinary pencil to answer all questions. Fill in the appropriate response circles completely. The form is designed to be read by optical-scanning equipment, so it is important that you keep any write-in responses **within** the spaces provided and erase any incorrect marks completely. If you have comments, please write them on a separate piece of paper.

Please fill in the circles completely.

Do not mark this way: ✓ ✗ ◒

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

13. Since June 2012, have you had any of these clinician-diagnosed illnesses?

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

		YEAR OF DIAGNOSIS			13
		BEFORE JUNE 1 2012	JUNE '12 TO MAY 2014	AFTER JUNE 1 2014	
Fibrocystic/other benign breast disease Confirmed by breast biopsy? (N) No ● Yes	●	●	○	○	1 a
Breast cancer	●	○	●	○	2
Cancer of the ovary	(Y)	○	○	○	3

- **Please return the questionnaire in the enclosed postage-paid envelope.**
- **If your name and address as printed on this letter 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 return it to us.**
- **Thank you for completing the 2014 Nurses' Health Study Questionnaire.**

Federal research regulations require us to include the following information:
There are no direct benefits to you from participating in this study.
The risk of breach of confidentiality associated with participation in this study is very small.
Your choice to participate in this study is completely voluntary and you may decline or withdraw at any time without penalty.
Although complete information is important to the study, you may skip any question you do not wish to answer.
You will not receive monetary compensation for participating.
If you have any questions regarding your rights as a research participant, you are encouraged to call a representative of the Human Subjects Committee at the Brigham and Women's Hospital (617-424-4100).

1. Your current weight?

POUNDS

2. Do you currently smoke cigarettes?

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

3. Have you had your uterus removed?

○ No ○ Yes → **Date of surgery:** ○ Before June 1, 2012 ○ After June 1, 2012

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

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

5. Since June 2012, have you used prescription female hormones? (Not including over-the-counter/herbal/soy preparations.)

○ Yes →
○ No

a) How many months did you use hormones since June 2012?
○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–25 ○ 26-30 ○ 31-35 ○ 36+ months

b) Are you *currently* using them (within the last month)? ○ Yes ○ No **If No, skip to question 6.**

c) Mark the type(s) of hormones you are *CURRENTLY* using:
○ Prempro ○ Oral estrogen (e.g., Premarin, Estrace, etc.) ○ Patch Estrogen ○ Vaginal Estrogen
○ Estrogen gels, creams, or sprays on skin ○ Other Estrogen (specify in box below)
○ Oral Progesterone (e.g., Provera/MPA) ○ Micronized progesterone (e.g., Prometrium)
○ Vaginal progesterone ○ Other progesterone (specify in box below)

Other hormones *CURRENTLY* used (e.g., Tri-est), Specify:

6. Do you have difficulty with your balance?

○ No ○ Occasionally ○ Often

7. Do you usually use a cane, walker or wheelchair/scooter? *(Mark all that apply.)*

○ No ○ Cane ○ Walker ○ Wheelchair/scooter ○ Unable to walk

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

○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 or more

9. Do you live in any of the following special residential settings?

○ Nursing home ○ Senior/retirement housing or community exclusively for people age 55+
○ Assisted living facility ○ None of the above

10. Do you currently take multi-vitamins?

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

11. Aside from multi-vitamins, do you currently take Vitamin D (separately or in calcium supplement)?

○ No ○ Yes, seasonal only ○ Yes, most months → If Yes, Dose per day: ○ Less than 600 IU ○ 600 to 900 IU ○ 1000 to 1500 IU ○ 2000 IU or more ○ Don't know

12. Is this your correct date of birth?

○ Yes
○ No → **If No, please write correct date.** MONTH / DAY / YEAR

3/8" PERF

13. Since June 2012, have you had any of these clinician-diagnosed illnesses?

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

		YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 2012	JUNE '12 TO MAY 2014	AFTER JUNE 1 2014	
Fibrocystic/other benign breast disease Confirmed by breast biopsy? (N) No (Y) Yes	(Y)	○	○	○	1 a
Breast cancer	(Y)	○	○	○	2
Cancer of the ovary	(Y)	○	○	○	3
Colon or rectal polyp (benign)	(Y)	○	○	○	4
Cancer of the colon or rectum	(Y)	○	○	○	5
Leukemia or Lymphoma	(Y)	○	○	○	6
Melanoma	(Y)	○	○	○	7
Basal cell skin cancer	(Y)	○	○	○	8
Squamous cell skin cancer	(Y)	○	○	○	9
Other cancer	(Y)	○	○	○	10
Specify site of other cancer (e.g., uterus, pancreas, lung, etc.)					
Diabetes mellitus	(Y)	○	○	○	11
Elevated cholesterol	(Y)	○	○	○	12
High blood pressure	(Y)	○	○	○	13
Myocardial infarction (heart attack) Hospitalized for MI? (N) No (Y) Yes	(Y)	○	○	○	14 a
Angina pectoris Confirmed by angiogram? (N) No (Y) Yes	(Y)	○	○	○	15 a
Coronary bypass, angioplasty, or stent	(Y)	○	○	○	16
Congestive heart failure	(Y)	○	○	○	17
Stroke (CVA)	(Y)	○	○	○	18
TIA (Transient ischemic attack)	(Y)	○	○	○	19
Peripheral artery disease or claudication of legs (not varicose veins)	(Y)	○	○	○	20
Carotid surgery (Endarterectomy)	(Y)	○	○	○	21
Pulmonary embolus or Deep vein thrombosis	(Y)	○	○	○	22
Atrial fibrillation	(Y)	○	○	○	23

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

		YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 2012	JUNE '12 TO MAY 2014	AFTER JUNE 1 2014	13
ICD-Implantable Cardiac Defibrillator	(Y)	○	○	○	24
Osteoporosis	(Y)	○	○	○	25
Hip fracture	(Y)	○	○	○	26
Vertebral (spine) fracture	(Y)	○	○	○	27
Hyperparathyroidism	(Y)	○	○	○	28
Glaucoma	(Y)	○	○	○	29
Macular degeneration of retina	(Y)	○	○	○	30
Cataract—1st (Dx)	(Y)	○	○	○	31
Cataract extraction	(Y)	○	○	○	32
Parkinson's Disease	(Y)	○	○	○	33
Lou Gehrig's Disease/ Amyotrophic Lat Sclerosis	(Y)	○	○	○	34
Alzheimer's or other type of dementia (e.g., vascular, FTD, Lewy Body)	(Y)	○	○	○	35
Kidney stones	(Y)	○	○	○	36
Ulcerative colitis or Crohn's or microscopic colitis	(Y)	○	○	○	37
Gastric/duodenal ulcer	(Y)	○	○	○	38
Barrett's esophagus	(Y)	○	○	○	39
Celiac disease	(Y)	○	○	○	40
Rheumatoid Arthritis or Systemic Lupus (SLE)	(Y)	○	○	○	41
Gout	(Y)	○	○	○	42
Depression, clinician diagnosed	(Y)	○	○	○	43
Fatty liver disease and/or cirrhosis	(Y)	○	○	○	44
Chronic hepatitis (B or C)	(Y)	○	○	○	45
Other major illness or surgery since June 2012	(Y)	○	○	○	46

Please specify: **Date:**

(e.g., hip replacement, GERD, etc.)

3/8" PERF

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14. 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
Mammogram?	N	Y	Y
Fasting blood sugar?	N	Y	Y
Upper endoscopy?	N No	Y Yes	
(Virtual) CT Colonoscopy?	N No	Y Yes	
Colonoscopy?	N No	Y Yes	
Sigmoidoscopy?	N No	Y Yes	

Initial reason(s) you had this Colonoscopy or Sigmoidoscopy?

- ○ Visible blood
- ○ Diarrhea/constipation
- ○ Barium enema
- ○ Prior polyps
- ○ Abdominal pain
- ○ Occult fecal blood
- ○ Fecal or stool DNA testing
- ○ Family history of colon cancer
- ○ Follow-up of (virtual) CT colonoscopy
- ○ Asymptomatic or routine screening

15. 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 for transportation or errands	○	○	○	○	○	○	○	○	○	○
Running or jogging	○	○	○	○	○	○	○	○	○	○
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 resistance machines) — Arm weights	○	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises (Include free weights or resistance machines) — Leg weights	○	○	○	○	○	○	○	○	○	○

16. DURING THE PAST YEAR, on average, how many <u>HOURS PER WEEK</u> did you spend:

	TIME PER WEEK								
	Zero Hrs.	One Hour	2–5 Hrs.	6–10 Hrs.	11–20 Hrs.	21–40 Hrs.	41–60 Hrs.	61–90 Hrs.	Over 90 Hrs.
Standing or walking around at work or away from home? (hrs./week)	○	○	○	○	○	○	○	○	○
Standing or walking around at home? (hrs./week)	○	○	○	○	○	○	○	○	○
Sitting at work or away from home or while driving? (hrs./week)	○	○	○	○	○	○	○	○	○
Sitting at home while watching TV/DVD/Movies? (hrs./week)	○	○	○	○	○	○	○	○	○
Other sitting at home (e.g., reading, meal times, at desk)? (hrs./week)	○	○	○	○	○	○	○	○	○

3/8" PERF

17. What is your usual walking pace outdoors?

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

18. How many total flights of stairs (not individual steps) do you climb daily?

○ None ○ 2 flights or less ○ 3–4 ○ 5–9 ○ 10–14 ○ 15 or more flights

19. In the past two years, have you been diagnosed with an episode of:

a) Diverticulitis of the colon that required antibiotics and/or hospitalization?

○ No ○ Yes → **Surgery for diverticulitis?** ○ No ○ Yes

b) Diverticular bleeding that required blood transfusion and/or hospitalization?

○ No ○ Yes → **Surgery for diverticular bleeding?** ○ No ○ Yes

c) Diverticulosis of the colon without diverticulitis or diverticular bleeding?

○ No ○ Yes

20. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a transfusion?

○ Yes → **Site(s):** ○ Esophagus ○ Stomach ○ Duodenum ○ Colon/Rectum ○ Other ○ Site(s) unknown
○ No

21. On average, during the past year, on how many days did you consume an alcoholic beverage of any type?

○ No days ○ Less than one/month ○ 1 day/mo ○ 2–4 days/mo ○ 1–2 days/wk ○ 3–4 days/wk
○ 5–6 days/wk ○ 7 days/wk

22. In a typical month, what is the largest number of drinks of beer, wine, and/or liquor you have in one day?

○ None ○ 1 drink/day ○ 2 ○ 3 ○ 4 ○ 5–6 ○ 7–9 ○ 10–14 ○ 15 or more drinks/day

23. For each alcoholic beverage, fill in the circle indicating how often on average you have used the amount specified during the past year.

BEVERAGES	Never, or less than once per 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
Beer, regular (1 glass, bottle, can)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Light Beer e.g., Bud Light (1 glass, bottle, can)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Red wine (5 oz. glass)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
White wine (5 oz. glass)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Liquor, e.g., vodka, gin, etc. (1 drink or shot)	○	○	Ⓦ	○	○	Ⓓ	○	○	○

24. For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.

FOODS	Never, or less than once per 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
Blueberries, fresh, frozen or canned (1/2 cup)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Strawberries, fresh, frozen or canned (1/2 cup)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Olive oil, for cooking or added to food or salads (1 Tbs.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Peanuts (small packet or 1 oz.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Walnuts (1 oz.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Other nuts (small packet or 1 oz.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Peanut butter (1 Tbs.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Refined grain foods (e.g., white bread, rice, cereals, pasta, etc.)	○	○	Ⓦ	○	○	Ⓓ	○	○	○
Whole grain foods (e.g., whole grain bread, cereals, brown rice)	○	○	Ⓦ	○	○	Ⓓ	○	○	○

25. How many times each week (including weekdays and weekends) do you eat breakfast?

○ Never or almost never ○ 1–2 times per week ○ 3–4 times per week ○ 5 or more times per week

3/8" PERF

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
Total tablets per week: 1–2 | 3–5 | 6–14 | 15+ tablets

"Baby" or low dose aspirin (100 mg or less/tablet)
Days per week: 1 | 2–3 | 4–5 | 6+ days
Total tablets per week: 1–2 | 3–5 | 6–14 | 15+ tablets

Aspirin or aspirin-containing products (325mg or more/tablet)
Days per week: 1 | 2–3 | 4–5 | 6+ days
Total 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
Total tablets per week: 1–2 | 3–5 | 6–14 | 15+ tablets

Celebrex (COX-2 inhibitors)
Days per week: 1 | 2–3 | 4–5 | 6+ days

Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)

Other Regularly Used Medications

Thiazide diuretic | Lasix | Potassium

Calcium blocker (e.g., Calan, Procardia, Cardizem, Norvasc)

Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)

ACE Inhibitors (e.g., Capoten, Vasotec, Zestril)

Angiotensin receptor blocker (e.g., Diovan, Losartan, Avapro)

Other anti-hypertensive (e.g., clonidine, doxazosin)

Coumadin | Pradaxa/Xarelto/Eliquis | Plavix

Digoxin | Antiarrhythmic

"Statin" cholesterol-lowering drug:
Mevacor (lovastatin) | Lipitor (atorvastatin)
Pravachol (pravastatin) | Crestor
Zocor (simvastatin) | Other

Other cholesterol-lowering drug

Steroids taken orally (e.g., Prednisone, Decadron, Medrol)

Insulin | Metformin (glucophage) | Actos

Other oral hypoglycemic medication

Opioid pain medications (e.g., codeine, Percocet, Vicodin, tramadol)

Evista (raloxifen) | Nolvadex (tamoxifen)

SSRIs (Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox, fluoxetine, citalopram)

Tricyclics (e.g., amitriptyline, nortriptyline, imipramine)

SNRIs /Other antidepressants (Wellbutrin, Effexor, Remeron, Cymbalta, veniafaxine, bupropion)

Minor tranquilizers (e.g., Valium, alprazolam, lorazepam)

Prilosec, Nexium, Prevacid, Protonix, Aciphex

H2 blocker (e.g., Pepcid, Zantac, Axid, Tagamet)

Aricept, Exelon, Razadyne | Namenda

Fosamax, Actonel, or other bisphosphonate

Thyroid hormone (e.g., Synthroid, Levothroid, extract)

Ambien, Sonata, Lunesta or zolpidem

Other prescription sleep medications (e.g., Trazodone, Rozerem)

Other regular medications (no need to specify)

3/8" PERF

27. Have you EVER used Metformin (aka Glucophage)? 27

○ Yes → **a) When did you FIRST take it?** a
○ Before 1996 ○ 1997-2000 ○ 2001-2004 ○ 2005-2008 ○ 2009-2012 ○ After 2012

○ No

b) In all, how many years have you used Metformin? b
○ Less than 1 year ○ 1–2 ○ 3–5 ○ 6–8 ○ 9–12 ○ 13–15 ○ 16+ years

28. Choose the best answer for how you felt the *past month*: 28

Are you basically satisfied with your life?	○ Yes	○ No
Have you dropped <u>many</u> of your activities and interests?	○ Yes	○ No
Do you feel that your life is empty?	○ Yes	○ No
Do you often get bored?	○ Yes	○ No
Are you in good spirits <u>most</u> of the time?	○ Yes	○ No
Are you afraid that something bad is going to happen to you?	○ Yes	○ No
Do you feel happy <u>most</u> of the time?	○ Yes	○ No
Do you <u>often</u> feel helpless?	○ Yes	○ No
Do you prefer to stay at home, rather than going out and doing new things?	○ Yes	○ No
Do you feel you have <u>more</u> problems with memory than most?	○ Yes	○ No
Do you think it is wonderful to be alive now?	○ Yes	○ No
Do you feel pretty worthless the way you are now?	○ Yes	○ No
Do you feel full of energy?	○ Yes	○ No
Do you feel that your situation is hopeless?	○ Yes	○ No
Do you think that <u>most</u> people are better off than you are?	○ Yes	○ No

29. Over the last 4 weeks, how often have you been bothered by any of the following problems? 29

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Worrying too much about different things	○	○	○	○
Trouble relaxing	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○
Feeling afraid as if something awful might happen	○	○	○	○

3/8" PERF

The following questions relate to your usual sleep habits during the past month. Your answers should indicate the most accurate reply for the majority of days and nights in the past month.

30. In a typical week, on how many days do you nap for at least 20 minutes? ***(You need not be in bed to nap.)***

○ None ○ 1 or 2 days ○ 3–4 days ○ 5–6 days ○ Almost every day

31. During the past month, how many hours of actual sleep did you get most nights?

○ Less than 4 hours ○ 4 hrs ○ 5 hrs ○ 6 hrs ○ 7 hrs ○ 8 hrs ○ 9 hrs ○ 10 hrs ○ 11+ hrs

32. During the past month, how long has it usually taken you to fall asleep each night?

○ 1–4 min ○ 5–19 min ○ 20–59 min ○ One hour ○ 1–1.5 hrs ○ 1.5 or more hrs

33. During the past month, how often have you had trouble sleeping because you...

	Not during the past month	Less than once a week	1 or 2 times a week	3+ times a week
cannot get to sleep within 30 minutes?	○	○	○	○
wake up in the middle of the night or early morning?	○	○	○	○
have to get up to use the bathroom?	○	○	○	○
cannot breathe comfortably?	○	○	○	○
cough or snore loudly?	○	○	○	○
feel too cold?	○	○	○	○
feel too hot?	○	○	○	○
had a bad dream?	○	○	○	○
have pain?	○	○	○	○
Other reason you have trouble sleeping	○	○	○	○

34. During the past month, how would you rate your sleep quality overall?

○ Very good ○ Fairly good ○ Fairly bad ○ Very bad

35. During the past month, how often have you taken medicine to help you sleep? ***(Prescribed or "over the counter")***

○ Not during the past month ○ Less than once a week ○ 1 or 2 times a week ○ 3+ times a week

36. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

○ Not during the past month ○ Less than once a week ○ 1 or 2 times a week ○ 3+ times a week

37. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

○ No problem at all ○ Only a very slight problem ○ Somewhat of a problem ○ A very big problem

38. Please rate your ability to do the following activities. ***(Mark one answer for each row.)***

Are you able to . . .	Without Help	With Some Help	Unable
a. Get to places out of walking distance	○ Drive car, or travel alone on bus, train, or taxi	○ Need someone to help you or go with you	○ Unable to travel except by ambulance, etc.
b. Go shopping for groceries or clothes (assuming you had transportation)	○ Can shop by yourself, assuming you had transportation	○ Need someone to help you on all shopping trips	○ Completely unable to do any shopping
c. Prepare your own meals	○ Plan and cook full meals yourself	○ Can prepare some things. Unable to cook full meals	○ Completely unable to prepare any meals
d. Do your own housework	○ Can clean floors, bathroom, etc.	○ Need help with heavy housework & cleaning	○ Completely unable to do any housework
e. Handle your own money	○ Write checks, pay bills, etc., by yourself	○ Can manage day-to-day buying. Need help with checkbook & paying bills	○ Completely unable to handle money
f. Handle your medications	○ Able to keep track of and take meds yourself	○ Need someone to help manage medications	○ Completely unable to manage medications

3/8" PERF

39. Please answer Yes or No for each of the following questions about your memory:

Have you recently experienced any change in your ability to remember things?	○ Yes	○ No
Do you have more trouble than usual remembering recent events?	○ Yes	○ No
Do you have more trouble than usual remembering a short list of items, such as a shopping list?	○ Yes	○ No
Do you have trouble remembering things from one second to the next?	○ Yes	○ No
Do you have any difficulty in understanding or following spoken instructions?	○ Yes	○ No
Do you have more trouble than usual following a group conversation or a plot in a TV program due to your memory?	○ Yes	○ No
Do you have trouble finding your way around familiar streets?	○ Yes	○ No

40. In the last month, how often have you...

	Never	Almost never	Sometimes	Fairly often	Very often
a. felt that you were unable to control the important things in your life?	○	○	○	○	○
b. felt confident about your ability to handle your personal problems?	○	○	○	○	○
c. felt that things were going your way?	○	○	○	○	○
d. felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

41. Would you be interested in completing your future NHS questionnaires online?

○ No ○ Yes → If Yes, make sure you have provided your email address, if you have one, on the bottom of the cover letter.

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

○ No
○ Yes, I received help from someone else but I provided most of the input
○ Yes, someone else completed it on my behalf with minimal input from me

If Yes: **I needed help with:** ○ Vision ○ Writing ○ Memory ○ Other
Who helped? ○ Spouse/partner ○ Child ○ Other

Please elaborate in the space below and include your name, address, telephone number or email address, and your relationship to the participant. Please explain briefly why your help was needed (e.g., macular degeneration, Parkinson's, dementia, etc.).

43. 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 or Email: _____

2014 (6) (7) (8) (9) (10) (11) (12)
2015 (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)
2016 (1) (2) (3) (4) (5) (6)

(1) (1) (1) (1) (1) (1) (1)

3/8" PERF