**HARVARD MEDICAL SCHOOL** **NURSES' HEALTH STUDY**

***Please reply to:***
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*181 Longwood Avenue*
*Boston MA 02115-5804*
*(617) 525-2279 Fax (617) 525-2008*
*E-mail: NHS@Channing.Harvard.Edu*

**Dear Colleague:**

We find ourselves at another significant milestone in the history of the Nurses' Health Study: our 30th anniversary! Over the past 3 decades your participation and that of over 120,000 other women has yielded incredible results about ways to enhance health and wellbeing. As the study begins its fourth decade, your continued participation is as important as ever.

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. As always, your answers will be kept strictly confidential and used for medical statistical purposes only. Your prompt reply is helpful and greatly appreciated.

As an original member of the Nurses' Health Study you are an indispensable colleague in our research. Whether you are retired or still working and 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 want to hear from you!**

It is with our deepest gratitude that we thank you for the ongoing commitment and care that you have generously provided as we continue to learn more about women's health.

Best Regards,

Susan Hankinson, RN, Sc.D.

**Do you have 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, Ø vs O, 5 vs S) |

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

CENTER PERF
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# NURSES' HEALTH STUDY - HARVARD MEDICAL SCHOOL

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

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

3. **Have you had your uterus or ovaries removed?** ☐ No ☐ Uterus removed ☐ Both ovaries removed ☐ One ovary removed

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

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

2 3 4 4a 5 6

6. **Since June 2004, have you had any of these clinician-diagnosed illnesses?**

## Cardiovascular

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

| | | YEAR OF DIAGNOSIS: BEFORE JUNE 1, 2004 | JUNE '04 to MAY '06 | After JUNE 1, 2006 |
|---|---|---|---|---|
| **Elevated Cholesterol** | Y ➡ | | | |
| **High Blood Pressure** | Y ➡ | | | |
| **Myocardial Infarction** (heart attack) ➡ Were you hospitalized for this MI? ◯ Yes ◯ No | Y ➡ | | | |
| **Angina** ➡ Confirmed by angiogram? ◯ Yes ◯ No | Y ➡ | | | |
| **Coronary Artery Bypass, Angioplasty, or Stent** | 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 ➡ | | | |
| **ICD-Implantable Cardiac Defibrillator** | Y ➡ | | | |

## Eye Diseases

| | | BEFORE JUNE 1, 2004 | JUNE '04 to MAY '06 | After JUNE 1, 2006 |
|---|---|---|---|---|
| **Glaucoma** | Y ➡ | | | |
| **Macular Degeneration of Retina** | Y ➡ | | | |
| **Cataract** (1st diagnosis) | Y ➡ | | | |
| **Cataract Extraction** | Y ➡ | | | |

## Musculoskeletal

| | | BEFORE JUNE 1, 2004 | JUNE '04 to MAY '06 | After JUNE 1, 2006 |
|---|---|---|---|---|
| **Hip Fracture** Specify Date, Site, and Circumstances on reverse side of this form | Y ➡ | | | |
| **Hip Replacement** | Y ➡ | | | |
| **Osteoporosis** | Y ➡ | | | |
| **Rheumatoid Arthritis, Dr. Dx** | Y ➡ | | | |
| **Vertebral fracture, X-ray confirmed** | Y ➡ | | | |

## Cancer/Other Diseases

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

| | | YEAR OF DIAGNOSIS: BEFORE JUNE 1, 2004 | JUNE '04 to MAY '06 | After JUNE 1, 2006 |
|---|---|---|---|---|
| **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 ➡ | | | |
| **Chronic Lymphocytic Leukemia** | Y ➡ | | | |
| **Colon or Rectal Polyps (benign)** | Y ➡ | | | |
| **Colon or Rectal Cancer** | Y ➡ | | | |
| **Other Cancer** (e.g. Lung, Ovary, etc.) | Y ➡ | | | |

Specify other cancer site:

| | | BEFORE JUNE 1, 2004 | JUNE '04 to MAY '06 | After JUNE 1, 2006 |
|---|---|---|---|---|
| **Diabetes Mellitus** | Y ➡ | | | |
| **Alzheimer's Disease** | Y ➡ | | | |
| **Parkinson's Disease** | Y ➡ | | | |
| **Amyotrophic Lateral Sclerosis (A.L.S.)** | Y ➡ | | | |
| **Depression, Dr. Dx** | Y ➡ | | | |
| **Kidney Stones** | Y ➡ | | | |
| **SLE (systemic lupus)** | Y ➡ | | | |
| **Gout** | Y ➡ | | | |
| **Barrett's Esophagus** | Y ➡ | | | |
| **Other Major Illness or Surgery Since June 2004** | Y ➡ | | | |

Include for example:
Ulcerative colitis/Crohn's, Pneumonia, Seizure/Epilepsy, Thyroid disease, Hyperparathyroidism,Multiple Sclerosis, etc.

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: _____

☐ **Check here if this questionnaire was completed by someone other than the participating nurse. (Please elaborate below and include your name, telephone number or email and relationship to the participant.)**

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

- **Date of hip fracture:** Month _____ Year _____
- **Circumstances:**

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