



HARVARD
MEDICAL
SCHOOL

NURSES' HEALTH STUDY II



HARVARD
SCHOOL of
PUBLIC HEALTH

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This is your ID →

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 II. Example: **NHS2@channing.harvard.edu**

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

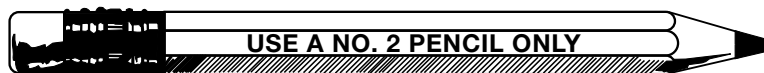
INSTRUCTIONS

INTERNET:

Go to our website at www.NHS2.org and use your ID number (see front of this page) and your birth date to log in. Follow the instructions on the screen to complete the survey on-line.

PAPER FORM:

Please use an ordinary No. 2 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.



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

17. Since June 2011, have you had any of these clinician-diagnosed illnesses?

Leave blank for NO, mark here for YES →

	YEAR OF DIAGNOSIS			17
	Before June 1 2011	June '11 TO May '13	After June 1 2013	
Myocardial infarction (heart attack)	<input checked="" type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	1
Angina pectoris	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	2
Confirmed by angiography?	<input type="radio"/> No <input checked="" type="radio"/> Yes			a
Coronary bypass, angioplasty, or stent	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	3
Transient ischemic attack (TIA)	<input checked="" type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	4

Please fill in the circles completely; do not mark this way:

EXAMPLE B)

AGE natural periods ceased:

AGE
4 6

Print numbers neatly within boxes. Your writing will be read by our scanner.

- Please tear off the cover letter (to preserve confidentiality) and return the questionnaire in the enclosed postage-paid envelope.
- 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 return it to us.
- Thank you for completing the Nurses' Health Study II 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. 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. PLEASE USE PENCIL

CURRENT WEIGHT		
POUNDS		
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

2. Do you currently smoke cigarettes?
 No Yes → How many/day? 1-4 5-14 15-24 25-34 35-44 45+
3. What is your **current** status?
 Married Divorced Widowed Domestic Partnership Separated Never Married
4. Your living arrangement: (Mark all that apply.)
 Alone With spouse or partner With minor children
 With other adult family With other people With pet(s)
5. Have you had your uterus removed?
 No Yes → Date of surgery: Before June 1, 2011 After June 1, 2011
6. Have you ever had either of your ovaries surgically removed?
 No Yes → a) How many ovaries do you have remaining? None One
7. Have your natural menstrual periods ceased PERMANENTLY?
 No: Premenopausal
 Yes: No menstrual periods → a) AGE natural periods ceased:

AGE	
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 Yes: Had menopause but now have periods induced by hormones
 Not sure (e.g., perimenopausal) → b) For what reason did your periods cease?
 Natural Surgery
 Endometrial ablation
 Radiation or Chemo.

8. Are you currently using oral contraceptives for any reason?
 No Yes

9. Are you currently using any of these over-the-counter (OTC) preparations for hormone replacement?
 Soy estrogen products Black cohosh (e.g., Remifemin) Natural progesterone cream/wild yam Other OTC

10. Since June 2011, have you used **prescription** female hormones? (Not including oral contraceptives.)
 Yes → a) How many months did you use hormones since June 2011?
 1-4 months 5-9 10-14 15-19 20-25 26-30 31-35 36+ months
 No
 b) Are you currently using them (within the last month)? Yes No If No, skip to Part d.
 c) Mark the type(s) of hormones you are CURRENTLY using:
 Combined: Prempro (beige) Prempro (gold) Prempro (peach) Prempro (light blue)
 Premphase Combipatch FemHRT
 Estrogen: Oral Premarin or conjugated estrogens Patch Estrogen Vaginal Estrogen Estrace
 Estrogen gels, creams, or sprays on skin Estratest Ogen
 Other Estrogen (specify in box below)
 Progesterone/Progestin: Provera/Cycrin/MPA Vaginal Micronized (e.g., Prometrium)
 Other progesterone (specify type)
 Other hormones CURRENTLY used (e.g., Tri-est), Specify: →

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 d) If you used oral conjugated estrogen (e.g., Premarin) since June 2011, what dose did you usually take?
 .30 mg/day or less .45 mg/day .625 mg/day .9 mg/day
 1.25 mg/day or higher Unsure Did not take oral conjugated estrogen
 e) 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/mo.
 Progesterone: Days per Month Not used <1 day/mo. 1-8 days 9-18 19-26 27+ days/mo.

11. During the past 4 weeks, have you had any hot flashes or night sweats?
 No Yes → If yes, were they (mark one): Mild Moderate Severe

12. At the beginning of menopause, did you have hot flashes or night sweats? (If you took estrogen, consider the time period before starting treatment.)
 Yes → a) Were they (mark one): Mild Moderate Severe
 No → b) How long did these symptoms last? Less than 5 years 5-9 years 10 years or longer
 Haven't reached menopause

13. Which best describes your current employment status?
 ER OR ICU Other inpatient nurse Nursing education or admin
 Outpatient or community Other hospital nursing Nursing outside hospital
 Non-nursing employment F/T homemaker Disabled Retired Other

14. What year did you begin your current job? (include "retired" or "full-time homemaker")
 Before 2005 2005 2006 2007 2008 2009 2010 2011 2012 2013+

15. In the last 12 months, did you have to clean up an accidental chemical spill? No Yes

16. Thinking about your current job and the use of disinfectants (such as ethylene oxide, hydrogen peroxide, ortho-phthalaldehyde, formaldehyde, glutaraldehyde, bleach)...

- a. On how many days per week, on average, do you clean **medical instruments** with disinfectants?
 Never <1 day/week 1-3 days/week 4-7 days/week
- b. On how many days per week, on average, do you clean **surfaces** (like floors, tables) at work with disinfectants?
 Never <1 day/week 1-3 days/week 4-7 days/week
- c. In your current job, on how many days per week, on average, do you use **spray or aerosol** products?
 Never <1 day/week 1-3 days/week 4-7 days/week
- 1) Mark each task at work where you use a spray or aerosol at least once per week.
 Patient care Instrument cleaning or disinfection Surface cleaning or disinfection Air-refreshing Other None

17. Since June 2011, have you had any of these clinician-diagnosed illnesses?

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

Table with columns: YEAR OF DIAGNOSIS, Before June 1 2011, June '11 to May '13, After June 1 2013

Form for question 17 listing various illnesses such as Myocardial infarction, Angina pectoris, Coronary bypass, etc., with checkboxes for 'Yes' or 'No' and a date field for 'Other major illness or surgery since June 2011'.

Grid for specifying the date of the other major illness or surgery, with columns for month, day, and year.

FOR OFFICE USE ONLY section with a grid for recording patient identifiers and a date field.

18. Have you ever had any of these clinician-diagnosed illnesses?

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

Table with columns: YEAR OF FIRST DIAGNOSIS, Before 1995, 1995-2002, 2003-2008, 2009-2010, 2011 +

Form for question 18 listing various illnesses such as Meningioma, Atrial fibrillation, Heart failure (CHF), etc., with checkboxes for 'Yes' or 'No' and a date field for 'Other major illness or surgery since June 2011'.

19. In the past two years, have you had: (If yes, mark all that apply.)

Form for question 19 with columns: No, Yes, for screening, Yes, for symptoms. Lists activities like A physical exam, Exam by eye doctor, Mammogram, etc.

Initial reason(s) you had Colonoscopy/Sigmoidoscopy?

Form for question 19b listing reasons for colonoscopy/sigmoidoscopy such as Visible blood, Occult fecal blood, Abdominal pain, etc.

20. Resting pulse rate: (take after sitting for 5 min.)

Form for question 20 with radio button options for pulse rate ranges: <55/min, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-99, 100 or more.

21. Current usual blood pressure (if checked within 2 years):

Form for question 21 with radio button options for systolic and diastolic blood pressure ranges.

22. Is this your correct date of birth?

Form for question 22 with radio button options for 'Yes' or 'No' and a date field for 'write correct date'.