HARVARD
MEDICAL
SCHOOL

NURSES' HEALTH STUDY II

HARVARD
SCHOOL of
PUBLIC HEALTH

• Channing Laboratory • 181 Longwood Avenue • Boston, Massachusetts 02115 •
Telephone (617) 525-2279 • Facsimile (617) 525-2008

Dear Colleague:

The attached Nurses' Health Study II "short form" continues our follow-up of the information which you first provided in 1989. We have made this questionnaire as brief as possible, knowing how busy your life can be. We would be **extremely** grateful to receive your completed survey in the next few weeks.

The validity of this major research undertaking depends directly on complete and accurate follow-up information for all study members. Your continued participation is critical whether or not you are currently active in nursing. As always, the information you provide is strictly confidential and will be used only for medical statistical purposes.

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.

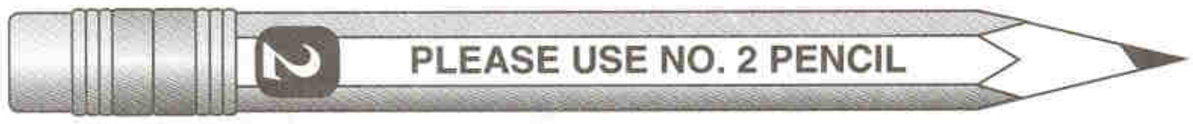
Sincerely,

Walter Willett

Professor of Epidemiology,
Nutrition, and Medicine

INSTRUCTIONS

Please use an ordinary No. 2 pencil to fill in the appropriate response circles completely, or write the requested information in the boxes provided. If you change a response, erase the incorrect mark completely, and write any comments on a separate page.



EXAMPLE 1:

Mark "Yes" circle and Year of Diagnosis circle for each illness you have had diagnosed.

12. Since June 1997, have you had any of these physician-diagnosed illnesses?

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

		YEAR OF DIAGNOSIS		
		BEFORE JUNE 1 1997	JUNE 97 TO MAY 99	AFTER JUNE 1 1999
Elevated cholesterol	●	○	○	●
Melanoma	Ⓨ	○	○	○
Basal cell skin cancer	●	○	●	○

EXAMPLE 2:

Keep handwriting within the borders of the response box.

		YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 1997	JUNE 97 TO MAY 99	AFTER JUNE 1 1999	
Other major illness or surgery since June 1997:	Ⓨ	○	○	○	Please specify: APPENDICITIS W/APPENDECTOMY

Thank you for completing the 1999 Nurses' Health Study II Short Form.

Please tear off the cover letter (to preserve confidentiality) and return the questionnaire in the enclosed postage paid envelope.

If you need to make changes or corrections to your name/address, please note them on the cover letter and enclose it with your completed questionnaire.

1. What is your current weight? ➡ lbs.

2. Do you currently smoke cigarettes?

- ○ No
- ○ Yes ➡ **How many cigarettes per day?** ○ 1–4 ○ 5–14 ○ 15–24 ○ 25–34 ○ 35–44 ○ 45+

3. Do you CURRENTLY use any of these forms of contraception? (Mark all that apply.)

○ None ○ Tubal ligation ○ Foam/Jelly/Sponge ○ Condom ○ Depo-Provera ○ Norplant
○ Vasectomy ○ Oral contraceptive ○ Intrauterine device ○ Rhythm/NFP ○ Diaphragm/Cervical cap ○ Other

4. SINCE JUNE 1997, have you used oral contraceptives (OC's)?

- ○ Yes ➡ **a. How many months did you use OC's during the 24-month period between June 1997 and June 1999?**
  ○ 1 month or less ○ 2–4 ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months
- ○ No

b. How many months did you use OC's during the period between June 1999 and the present?
○ 1 month or less ○ 2–4 ○ 5–9 ○ 10–14 ○ 15–19 ○ 20+ months

5. SINCE JUNE 1997, have you been pregnant?

○ No – go to question 6 ○ Yes

a. Are you currently pregnant?
○ No ○ Yes–Continue with part b, but do NOT fill in a bubble in part b for your current pregnancy.

b. For each pregnancy *ending* after JUNE 1, 1997, fill in a response bubble for the year during which each pregnancy *ended*.

Calendar Year	Pregnancies lasting 6 months or more		Pregnancies lasting less than 6 months	
	Single Births	Twins/Triplets	Miscarriages	Induced Abortions
6/1/97–12/31/97	○	○	○	○
1998	○	○	○	○
1999	○	○	○	○
2000+	○	○	○	○

6. SINCE JUNE 1997, have you tried to become pregnant for more than one year without success?

- ○ Yes ➡ **What was the cause?** (Mark all that apply.) ○ Tubal blockage ○ Ovulatory disorder ○ Endometriosis ○ Cervical mucous factors ○ Spouse/Partner ○ Not investigated ○ Not found ○ Other
- ○ No

7. Have your menstrual periods ceased PERMANENTLY?

- ○ No: Premenopausal
- ○ Yes: No menstrual periods ➡ **a. AGE natural periods ceased:** AGE ➡ **b. For what reason did your periods cease?** ○ Natural ○ Surgical ○ Radiation or chemotherapy
- ○ Yes: Had menopause but now have periods induced by hormones
- ○ Not sure (e.g., started hormones prior to cessation of periods)

8. Have you EVER had surgery to remove your uterus or ovaries? (Mark all that apply.)
○ No ○ Uterus removed ○ Both ovaries removed ○ One ovary removed

9. Are you *currently* using any of these medications for osteoporosis or any other reason?
○ Evista (raloxifene) ○ Fosamax (alendronate) ○ Miacalcin (calcitonin) ○ Didronel ○ Not using any of these

10. SINCE JUNE 1997, have you used female replacement hormones (other than oral contraceptives)?

- ○ No ➡ **Please continue with the questions on the back of this form**
- ○ Yes, currently
- ○ Yes, but not currently

What type of hormone did you use? ○ Estrogen only ○ Estrogen and progesterone ○ Other — Specify type:

11. Highest level of education completed by your current spouse/partner:
○ Less than high school ○ High school ○ 2-year college ○ 4-year college ○ Graduate school ○ Not applicable

Please continue on the back of this form ➡

12. Since June 1997, have you had any of these physician-diagnosed illnesses?

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

		YEAR OF DIAGNOSIS: BEFORE JUNE 1 1997	JUNE 97 TO MAY 99	AFTER JUNE 1 1999	
Myocardial infarction (heart attack)	Y	○	○	○	
Angina pectoris	Y	○	○	○	Confirmed by angiogram? ○ No ○ Yes
Coronary bypass/angioplasty	Y	○	○	○	
Stroke (CVA) or TIA	Y	○	○	○	
Deep vein thrombosis/Pul. embolism	Y	○	○	○	
Elevated cholesterol	Y	○	○	○	
Melanoma	Y	○	○	○	
Basal cell skin cancer	Y	○	○	○	
Squamous cell skin cancer	Y	○	○	○	
Fibrocystic/other benign breast disease	Y	○	○	○	Confirmed by breast biopsy? ○ No ○ Yes Confirmed by aspiration? ○ No ○ Yes
Breast cancer	Y	○	○	○	
Other cancer	Y	○	○	○	Specify site and date:
Colon or rectal polyp (benign)	Y	○	○	○	
Ulcerative colitis/Crohn's disease	Y	○	○	○	
Gastric or duodenal ulcer	Y	○	○	○	
Gallstones	Y	○	○	○	Did you have symptoms? ○ No ○ Yes How diagnosed? ○ X-ray or ultrasound ○ Other
Cholecystectomy	Y	○	○	○	
High blood pressure	Y	○	○	○	○ pregnancy-related ○ not pregnancy-related
Toxemia/Pre-eclampsia of pregnancy	Y	○	○	○	
Diabetes	Y	○	○	○	○ gestational ○ not pregnancy-related
Hydatidiform mole of pregnancy	Y	○	○	○	
Ectopic pregnancy	Y	○	○	○	
Endometriosis, 1st diagnosis	Y	○	○	○	Confirmed by laparoscopy? ○ No ○ Yes
Uterine fibroids, 1st diagnosis	Y	○	○	○	Confirmed by pelvic exam? ○ No ○ Yes Confirmed by ultrasound or hysterectomy? ○ No ○ Yes
Polycystic ovarian syndrome	Y	○	○	○	
Kidney stones	Y	○	○	○	
Multiple sclerosis	Y	○	○	○	
Asthma, doctor-diagnosed	Y	○	○	○	
Emphysema/Chronic Bronchitis DrDx	Y	○	○	○	
Pneumonia, x-ray confirmed	Y	○	○	○	
Graves' Disease/Hyperthyroidism	Y	○	○	○	
Hypothyroidism	Y	○	○	○	
Thyroid nodule (benign)	Y	○	○	○	
Interstitial cystitis (not UTI)	Y	○	○	○	
Herniated lumbar disk, CT/MRI confirmed	Y	○	○	○	
SLE (systemic lupus)	Y	○	○	○	
Rheumatoid arthritis, doctor diagnosed	Y	○	○	○	Rheumatoid factor ○ negative/unknown ○ positive
Other arthritis	Y	○	○	○	
Other major illness or surgery since June 1997:	Y	○	○	○	Please specify:

13. Is this your correct date of birth?

○ Yes ○ No ➡ If no, please write correct date.

Month / Day / Year

14. Please name someone at a DIFFERENT PERMANENT ADDRESS to whom we might write in the event we are unable to contact you:

Name: _____

Address: _____

THANK YOU! PLEASE RETURN FORM IN ENCLOSED ENVELOPE TO DR. WALTER WILLETT • NURSES' HEALTH STUDY II • 181 LONGWOOD AVENUE • BOSTON, MA 02115