



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:

Twenty-eight years ago when you completed the first Nurses' Health Study questionnaire, you made a historic decision that has yielded innumerable benefits for women all over the world! As we approach the third decade of working together, your involvement continues to be important. (Check out www.NursesHealthStudy.org to see the hundreds of scientific papers that have been published from NHS data.)

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. Also, 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.

Best Regards,

Graham A. Colditz, MD, DrPH
Principal Investigator

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!

PERF

PERF

CENTER PERF



PERF

PERF

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 2002, have you had any of these clinician-diagnosed illnesses?

Cardiovascular

	LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS		
		BEFORE JUNE 1, 2002	JUNE '02 to MAY '04	After JUNE 1, 2004
Elevated Cholesterol	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction (heart attack) → Were you hospitalized for this MI? <input type="radio"/> Yes <input type="radio"/> No	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina → Confirmed by angiogram? <input type="radio"/> Yes <input type="radio"/> No	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Bypass, Angioplasty, or Stent	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke (CVA)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transient Ischemic Attack (TIA)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carotid Artery Surgery (Endarterectomy)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Artery Disease (not varicose veins)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Embolus	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation, Dr. Dx	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICD-Implantable Cardiac Defibrillator	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Eye Diseases

		BEFORE JUNE 1, 2002	JUNE '02 to MAY '04	After JUNE 1, 2004
Glaucoma	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration of Retina	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract (1st diagnosis)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataract Extraction	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal

		BEFORE JUNE 1, 2002	JUNE '02 to MAY '04	After JUNE 1, 2004
Hip or Wrist Fracture Specify Date, Site, and Circumstances on reverse side of this form	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip Replacement	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis, Dr. Dx	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SLE (systemic lupus)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cancer/Other Diseases

	LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS		
		BEFORE JUNE 1, 2002	JUNE '02 to MAY '04	After JUNE 1, 2004
Cancer of the Uterus (endometrium)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibrocystic or other Benign Breast Disease → Confirmed by breast biopsy? <input type="radio"/> Yes <input type="radio"/> No	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Skin Cancer	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Skin Cancer	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon or Rectal Polyps (benign)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon or Rectal Cancer	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer (e.g. Lung, Ovary, etc.)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify other cancer site:		BEFORE JUNE 1, 2002	JUNE '02 to MAY '04	After JUNE 1, 2004
Diabetes Mellitus	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amyotrophic Lateral Sclerosis (A.L.S.)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression, Dr. Dx	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholecystectomy	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma (Clinician Diagnosed)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or Chronic Bronchitis	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barrett's Esophagus	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Major Illness or Surgery	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Include for example: Ulcerative colitis/Crohn's, Pneumonia, Seizure/Epilepsy, Gout, Thyroid disease, Multiple Sclerosis, Chronic renal failure, 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: _____

Y
N

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

• Was this a fracture of: Hip Wrist

• Date of fracture: Month _____ Year _____

• Circumstances:

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