NURSES' HEALTH STUDY II

HARVARD MEDICAL SCHOOL

HARVARD SCHOOL of PUBLIC HEALTH

• Channing Laboratory • 181 Longwood Avenue • Boston, Massachusetts 02115-5804 •
Telephone (617) 525-2279 • Fax (617) 525-2008 • E-Mail NHS2@channing.harvard.edu

This is your ID ➡

Dear Colleague:

In the fall of 1989, you and 116,670 other registered nurses embarked on a remarkable journey to expand our understanding of women's health. Sixteen years later, the fruits of our collaboration are bountiful. Dozens of scientific papers have been published, and as a result, many of the facts that we now take for granted about health and diet have come from the Nurses' Health Studies. Thank you for making this possible through your dedication, enthusiasm and loyal participation.

To continue to update your health status and continue our work together we are pleased to offer you the choice of completing either an on-line questionnaire or the attached traditional form. The on-line survey is available at www.NHS2.org and can be accessed with your ID number. Over 19,000 of the responses to the previous questionnaire were completed on-line. We hope that this option will make your continued involvement in the study more convenient. The questionnaire is being sent to each of the 116,671 members of NHS II and should take about 30 minutes to complete.

We know that you will give this questionnaire the same careful consideration that you have given our forms since the study began in 1989. As always, all information you provide is kept strictly confidential and is used for medical statistical purposes only. If you have any questions about the study or the questionnaire, you may contact us at the address shown above.

We value **each** member of the Nurses' Health Study II 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 would like to hear from you!**

It is with our deepest gratitude that we thank you again for the time and care that you have continued to offer to help us all learn more about women's health.

Sincerely,

Walter Willett

Walter Willett, M.D.
Professor of Epidemiology and Nutrition

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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)

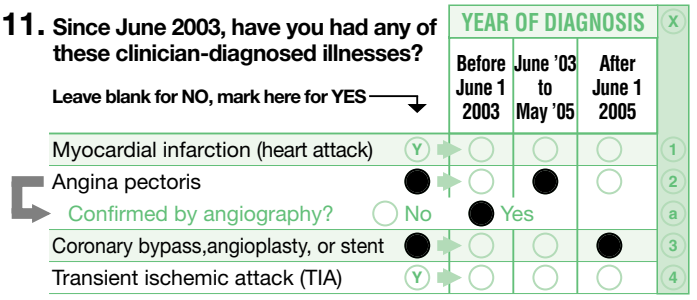
We will not release your e-mail address to anyone!

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



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

- **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 2005 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 Harvard School of Public Health (617-384-5480).

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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
	8	8
	9	9

2. SINCE JUNE 2003, have you been pregnant?

○ No–Go to Question 3. ○ Yes *(continue)*

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, 2003, 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
6/1/03 - 12/31/2003	○	○	○	○
2004	○	○	○	○
2005	○	○	○	○
2006+	○	○	○	○

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

○ None ○ Oral contraceptive ○ Condom ○ Depo Provera
○ Vasectomy ○ Foam/Jelly/Sponge ○ Rhythm/NFP ○ Other hormonal contraceptive
○ Tubal Ligation ○ Diaphragm/Cervical cap ○ IUD ○ Other

4. SINCE JUNE 2003, have you used oral contraceptives (OCs)?

○ Yes → a) How many months did you use OCs during the 24-month period between June 2003 and June 2005?
○ 1 month or less ○ 2–4 ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months

○ No

b) Please indicate the brand and type of OC used longest during this time period. Refer to the OC Brand Code Sheet enclosed with this questionnaire and write the code in this box. →

5. Have your natural menstrual periods ceased PERMANENTLY?

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

6. Have you had your uterus removed? ○ No ○ Yes → Date of surgery: ○ Before June 1, 2003 ○ After June 1, 2003

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

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

8. *Since June 2003,* have you used Evista (raloxifene) or Nolvadex (tamoxifen)?

○ Yes → a) How many months have you used each drug during the 24 month period between June 2003 and June 2005?

Evista	○ Not Used	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20–24 months	○ Used only after 6/05	E
Nolvadex	○ Not Used	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20–24 months	○ Used only after 6/05	N

○ No

b) Are you currently using Evista or Nolvadex? ○ No, not currently ○ Yes, Evista ○ Yes, Nolvadex

9. Are you currently using any over-the-counter (e.g., "herbal," "natural," or soy-based) preparations for hormone replacement or to treat post-menopausal symptoms? (Do NOT include food sources like tofu, soy milk, etc.)

○ No ○ Yes → What type(s)? ○ Soy estrogen products ○ Natural progesterone cream or wild yam cream
○ Dong quai (e.g., Rejuvex) ○ Black cohosh (e.g., Remifemin) ○ Other

10. Since June 2003, have you used prescription female hormones?

○ Yes → a) How many months did you use hormones since June 2003?
○ 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 e.

c) Mark the type(s) of hormones you are *CURRENTLY* using:

Combined: ○ Prempro (cream) ○ Prempro (gold) ○ Prempro (peach) ○ Prempro (light blue)
○ Premphase ○ Combipatch ○ FemHRT

Estrogen: ○ Oral Premarin ○ Patch Estrogen ○ Vaginal Estrogen ○ Ogen
○ Estrace ○ Estratest ○ 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: →

d) Since June 2003, how many months have you used the preparation(s) you marked in Part c?
○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–25 ○ 26–30 ○ 31–35 ○ 36+ months

e) If you used oral conjugated estrogen (e.g., Premarin) 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

f) If you used oral medroxyprogesterone (e.g., Provera, Cycrin), what dose did you usually take?
○ 2.5 mg or less ○ 5–9 mg ○ 10 mg ○ More than 10 mg ○ Unsure ○ Not used

g) 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.

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11. Since June 2003, have you had any of these clinician-diagnosed illnesses?

Leave blank for NO, mark here for YES →

		YEAR OF DIAGNOSIS: Before June 1 2003	June '03 to May '05	After June 1 2005	
Myocardial infarction (heart attack)	Y	○	○	○	1
Angina pectoris	Y	○	○	○	2
Confirmed by angiography?	○ No ○ Yes				a
Coronary bypass, angioplasty, or stent	Y	○	○	○	3
Transient ischemic attack (TIA)	Y	○	○	○	4
Stroke (CVA)	Y	○	○	○	5
Deep vein thrombosis/Pul. embolism	Y	○	○	○	6
Melanoma	Y	○	○	○	7
Basal cell skin cancer	Y	○	○	○	8
Squamous cell skin cancer	Y	○	○	○	9
Fibrocystic/other benign breast disease	Y	○	○	○	10
Confirmed by breast biopsy?	○ No ○ Yes				a
Confirmed by aspiration?	○ No ○ Yes				b
Breast cancer	Y	○	○	○	11
Other cancer	Y	○	○	○	12
Specify site of other cancer:					
Colon or rectal polyp (benign)	Y	○	○	○	13
Ulcerative colitis/Crohn's	Y	○	○	○	14
Gastric or duodenal ulcer	Y	○	○	○	15
Barrett's Esophagus	Y	○	○	○	16
Gallstones	Y	○	○	○	17
Did you have symptoms?	○ No ○ Yes				a
How diagnosed?	○ X-ray or ultrasound ○ Other				b
Cholecystectomy	Y	○	○	○	18
Diabetes mellitus	Y	○	○	○	19
Elevated cholesterol	Y	○	○	○	20
High blood pressure	Y	○	○	○	21
Endometriosis—1st diagnosis	Y	○	○	○	22
Confirmed by laparoscopy?	○ No ○ Yes				a
Uterine fibroids—1st diagnosis	Y	○	○	○	23
Confirmed by pelvic exam?	○ No ○ Yes				a
Confirmed by ultrasound/ hysterectomy?	○ No ○ Yes				b
Premenstrual syndrome (PMS)	Y	○	○	○	24
Kidney stones	Y	○	○	○	25
Multiple Sclerosis	Y	○	○	○	26
Asthma, doctor diagnosed	Y	○	○	○	27
Emphysema/Chronic Bronchitis DrDx	Y	○	○	○	28
Pneumonia, x-ray confirmed	Y	○	○	○	29
Graves' Disease/Hyperthyroidism	Y	○	○	○	30
Hypothyroidism	Y	○	○	○	31
Thyroid nodule (benign)	Y	○	○	○	32
Gout	Y	○	○	○	33
SLE (systemic lupus)	Y	○	○	○	34
Rheumatoid arthritis, Doctor Dx	Y	○	○	○	35
Other arthritis	Y	○	○	○	36
Depression, clinician Dx	Y	○	○	○	37
Other major illness or surgery since June 2003	Y	○	○	○	38

Please specify: Date:

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

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

		YEAR OF FIRST DIAGNOSIS: Before 1991	1991–1994	1995–1998	1999–2002	2003+	
Meningioma	Y	○	○	○	○	○	
Seizure (1 or more) / epilepsy	Y	○	○	○	○	○	
Shingles	Y	○	○	○	○	○	
Rosacea	Y	○	○	○	○	○	
Psoriasis	Y	○	○	○	○	○	
Hyperparathyroidism	Y	○	○	○	○	○	
Low bone density	Y	○	○	○	○	○	
Osteoporosis	Y	○	○	○	○	○	
Fractures: Wrist or Colles' Fracture	Y	○	○	○	○	○	
Hip fracture	Y	○	○	○	○	○	

13. 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	
Mammogram (or other breast imaging)?	N	Y	Y	
Fasting blood sugar?	N	Y	Y	
(Virtual) CT Colonoscopy?	N No	Y Yes		
Colonoscopy?	N No	Y Yes		
Sigmoidoscopy?	N No	Y Yes		

Initial reason(s) you had Colonoscopy/Sigmoidoscopy? a

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

14. Indicate each year in which you have had the following procedures: *(Mark all that apply)*

	YEAR(S) OF PROCEDURES: Never	1994 or earlier	'95–'96	'97–'98	'99–'00	'01–'02	'03+	
Sigmoidoscopy	○	○	○	○	○	○	○	
Colonoscopy	○	○	○	○	○	○	○	
Upper endoscopy (esophagus/stomach)	○	○	○	○	○	○	○	

15. Blood Cholesterol (most recent, within last 5 years)**:**

○ Unknown/Not checked within 5 yrs ○ <140 mg/dl ○ 140–159
○ 160–179 ○ 180–199 ○ 200–219 ○ 220–239
○ 240–269 ○ 270-299 ○ 300–329 ○ 330+ mg/dl

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

Systolic: ○ Unknown/Not checked within 2 years a
○ <105 mmHg ○ 105–114 ○ 115–124 ○ 125–134
○ 135–144 ○ 145–154 ○ 155–164 ○ 165–174 ○ 175+

Diastolic: ○ Unknown/Not checked within 2 years b
○ <65 mmHg ○ 65–74 ○ 75–84 ○ 85–89
○ 90–94 ○ 95–104 ○ 105+

17. Is this your correct date of birth? →

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

18. In a typical week during the past year, on how many days did you consume an alcoholic beverage of any type?

○ No days ○ 1 day ○ 2 days ○ 3 days ○ 4 days
○ 5 days ○ 6 days ○ 7 days

19. In a typical month during the past year, what was the largest number of drinks of beer, wine and/or liquor you may have had in one day?

○ None ○ 1–2 ○ 3–5 ○ 6–9 ○ 10–14 ○ 15 or more

20. Do you currently smoke cigarettes?

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

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21. Regular Medication *(mark if used regularly in past 2 years)*

- ○ Acetaminophen (e.g., Tylenol)
  - **Days/week:** ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
  - **Total tabs/wk:** ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tab
- ○ "Baby" or low dose aspirin (100 mg/tablet or less)
  - **Days/week:** ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
  - **Total tabs/wk:** ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tab
- ○ Aspirin or aspirin-containing products (325 mg/tablet or more)
  - **Days/week:** ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
  - **Total tabs/wk:** ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tab
- ○ Ibuprofen (e.g., Advil, Motrin, Nuprin)
  - **Days/week:** ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
  - **Total tabs/wk:** ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tab
- ○ Celebrex, Vioxx or Bextra (COX-2 inhibitors)
  - **Days/week:** ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days
- ○ Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)
- ○ Thiazide diuretic ○ Lasix ○ Potassium
- ○ Calcium blocker (e.g., Calan, Procardia, Cardizem)
- ○ Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)
- ○ ACE Inhibitors (e.g., Capoten, Vasotec, Zestril)
- ○ Angiotensin receptor blocker [e.g., valsartan (Diovan), losartan (Cozaar), irbesartan (Avapro)]
- ○ Other antihypertensive (e.g., clonidine, doxazosin)
- ○ Coumadin
- **"Statin" cholesterol-lowering drug:**
  - ○ Mevacor (lovastatin) ○ Zocor (simvastatin) ○ Crestor
  - ○ Pravachol (pravastatin) ○ Lipitor (atorvastatin) ○ Lescol
- ○ Other cholesterol-lowering drug [e.g., niacin, Lopid (gemfibrozil), Tricor (fenofibrate), Questran (cholestyramine), Colestin, Zetia]
- ○ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)
- ○ Insulin ○ Oral hypoglycemic medication
- ○ Thyroid hormone (e.g., Sythroid, Levothroid, extract)
- ○ SSRI's (e.g., Prozac, Zoloft, Paxil, Celexa)
- ○ Other antidepressants (e.g., Elavil, Tofranil, Pamelor)
- ○ Minor tranquilizers (e.g., Valium, Xanax, Ativan, Librium)
- ○ Prilosec, Nexium, Prevacid (lansoprazole), Protonix, Aciphex
  - **Years used:** ○ 1–2 yrs ○ 3–5 yrs ○ 6–9 yrs ○ 10+ yrs
- ○ H2 blocker (e.g., Pepcid, Tagamet, Zantac, Axid)
- ○ No regular medication
- ○ Other regular medications (no need to specify)

22. For each of the following periods of your life, please add up the TOTAL amount of time you used antibiotics. (Exclude skin creams, mouthwash or Isoniazid.)

	Total Time Using Antibiotics							
	None	Less than 15 days	15 days to 2 Months	2–4 Months	4 Mos–2 Years	2–3 Years	3–5 Years	5+ Years
Age 20–39	○	○	○	○	○	○	○	○
Age 40–49	○	○	○	○	○	○	○	○
Age 50 to the present	○	○	○	○	○	○	○	○

a) What was the most common reason that you used an antibiotic?

○ Respiratory infection ○ UTI ○ Acne/Rosacea
○ Chronic bronchitis ○ Dental ○ Other

23. What is your *current* status?

○ Married ○ Divorced ○ Widowed
○ Domestic Partnership ○ Separated ○ Never married

24. Your living arrangement: *(Mark all that apply.)*

○ Alone ○ With minor children
○ With spouse or partner ○ Other
○ With other adult family

25. Have any of the following biological relatives had...

Relative's Age at First Diagnosis	Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown
Ovarian Cancer? ○ No					
Mother (Y)	○	○	○	○	○
Sister (Y)	○	○	○	○	○
Breast Cancer? ○ No					
Mother (Y)	○	○	○	○	○
One Sister (Y)	○	○	○	○	○
Additional Sister (Y)	○	○	○	○	○
Colon or Rectal Cancer? ○ No					
Parent (Y)	○	○	○	○	○
One Sibling (Y)	○	○	○	○	○
Additional Sibling (Y)	○	○	○	○	○
Epilepsy or Seizures? ○ No					
Father (Y)	○	○	○	○	○
Mother (Y)	○	○	○	○	○
Melanoma? ○ No					
Parent (Y)	○	○	○	○	○
Sibling (Y)	○	○	○	○	○
Diabetes? ○ No					
Mother (Y)	○	○	○	○	○
Father (Y)	○	○	○	○	○
Sibling (Y)	○	○	○	○	○
Multiple Sclerosis? ○ No					
Mother (Y)	○	○	○	○	○
Father (Y)	○	○	○	○	○
Sibling (Y)	○	○	○	○	○
Major Clinical Depression? ○ No					
Mother (Y)	○	○	○	○	○
Father (Y)	○	○	○	○	○
Sibling (Y)	○	○	○	○	○
Parkinson's Disease? ○ No					
Parent (Y)	○	○	○	○	○
Sibling (Y)	○	○	○	○	○

26. Have you ever had gastrointestinal bleeding that required hospitalization or a transfusion?

○ Yes → **a) What was the site of the bleeding?** *(Mark all that apply.)*
○ Esophagus ○ Stomach ○ Duodenum
○ Colon/rectum ○ Other ○ Site unknown

○ No

b) What year(s) did this happen? *(Mark all that apply.)*
○ Before 1991 ○ '91–'92 ○ '93–'94 ○ '95–'96
○ '97–'98 ○ '99–2000 ○ 2001–'02 ○ 2003+

27. How many squamous or basal cell carcinoma lesions have you ever had removed by surgery, cryotherapy or other means? (Exclude melanoma and benign lesions like moles or actinic keratoses.)

○ Never had squamous or basal cell carcinoma
○ 1 ○ 2–4 ○ 5–10 ○ 11+

28. In the past two years, have you had two weeks or longer when nearly every day you felt sad, blue or depressed for most of the day?

○ No ○ Yes

29. Do you consider yourself to be Spanish/Hispanic/Latina?

○ No ○ Yes

30. Which categories best describe your race?

(Mark one or more to indicate what you consider yourself to be.)

○ White ○ Asian
○ Black or African American
○ American Indian/Alaska Native
○ Native Hawaiian or Pacific Islander
○ Other

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31. **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) 31

32. **How many flights of stairs (not individual steps) do you climb daily?** ○ 2 flights or less ○ 3–4 ○ 5–9 ○ 10–14 ○ 15 or more flights 32

33. **DURING THE PAST YEAR, what was your average time PER WEEK spent at each of the following recreational activities?** 33

	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 to work	○	○	○	○	○	○	○	○	○	○
Jogging (slower than 10 minutes/mile)	○	○	○	○	○	○	○	○	○	○
Running (10 minutes/mile or faster)	○	○	○	○	○	○	○	○	○	○
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 — Arm weights	○	○	○	○	○	○	○	○	○	○
(Include free weights or machines such as Nautilus) — Leg weights	○	○	○	○	○	○	○	○	○	○

34. **DURING THE PAST YEAR, on average, how many HOURS PER WEEK did you spend:** 34

	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/VCR/DVD? (hrs./week)	○	○	○	○	○	○	○	○	○
Other sitting at home (e.g., reading, meal times, at desk)? (hrs./week)	○	○	○	○	○	○	○	○	○

35. **In an average week, on how many days do you usually exercise (include brisk walking or more strenuous activity)?** 35
○ None ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days ○ 6 days ○ 7 days

36. **Since JUNE 2001, have you tried to become pregnant for more than one year without success?** 36
○ Yes → **What was the cause? (Mark all that apply.)** ○ Tubal blockage ○ Ovulatory disorder ○ Endometriosis ○ Cervical mucous factors a
○ No ○ Spouse/Partner ○ Not investigated ○ Not found ○ Other

37. **Since JUNE 2001, have you taken Clomiphene (e.g. Clomid) or Gonadotropin injections (e.g., Gonal-f, Metrodin, Follistim) to induce ovulation?** 37 a
○ Yes → **In how many months were these used?**
a. Clomiphene ○ Not used ○ 1 ○ 2–3 ○ 4–5 ○ 6–11 ○ 12+mo.
b. Gonadotropins ○ Not used ○ 1 ○ 2–3 ○ 4–5 ○ 6–11 ○ 12+mo. b
○ No

38. **On average, how many hours per week did you spend outdoors in direct sunlight in the middle of the day - 10 am to 3 pm - (including work, recreation, gardening, sports, etc.) during these time periods?** 38

	AVERAGE HOURS PER WEEK		
	< 1 hour/week	2–4 hours/week	5+ hours/week
Summer months in **High School/College/Nursing School**	○	○	○
Summer months **ages 25–35**	○	○	○
Summer months **over the last 2 years**	○	○	○
Winter months **over the last 2 years**	○	○	○

39. **Number of times per year you used an artificial tanning light or tanning booth during these time periods:** 39

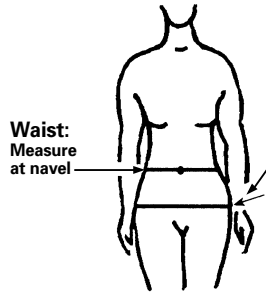
During **High School/College/Nursing School**	○ None	○ 1–2 times/year	○ 3–5	○ 6–11	○ 12–23	○ 24+ times/year
During **ages 25–35**	○ None	○ 1–2 times/year	○ 3–5	○ 6–11	○ 12–23	○ 24+ times/year
Over the **last 2 years**	○ None	○ 1–2 times/year	○ 3–5	○ 6–11	○ 12–23	○ 24+ times/year

40. **Question 40, which should only be answered if a tape measure is available, asks about body measurements. This information will be more accurate if you follow these suggestions** 40 W H

- ► Make measurements while standing
- ► Avoid measuring over bulky clothing
- ► Try to record answers to the nearest 1/4 inch (do not estimate)

If a tape measure is not available, please leave blank.

WAIST — Inches: 0 1 2 3 4 5 6 7 8 9 — Fraction: 0, 1/4, 2/4, 3/4



HIP — Inches: 0 1 2 3 4 5 6 7 8 9 — Fraction: 0, 1/4, 2/4, 3/4

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41. **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:** 41

Name: _____ Address: _____

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42. Do you have unpleasant leg sensations (like crawling, paraesthesias, or pain) combined with motor restlessness and the urge to move? (42)

○ No ○ Once a month or less ○ 2–4 times /month ○ 5–14 times/month ○ 15+ times/month

a) Do these symptoms occur only at rest and does moving improve them? ○ Yes ○ No (a)

b) Are these symptoms worse in the evening/night compared with the morning? ○ Yes ○ No (b)

43. In the last 10 years, have you experienced pain, discomfort or burning in your pelvis or bladder *for more than 3 months in a row* and accompanied by urinary frequency or urgency? (43)

○ Yes ○ No

44. During the last 12 months, how often have you leaked or lost control of your urine? (44)

○ Never ○ Less than once/month ○ Once/month ○ 2–3 times/month ○ About once/week ○ Almost every day

i) When you lose your urine, how much usually leaks? (i)

○ A few drops ○ Enough to wet your underwear ○ Enough to wet your outer clothing ○ Enough to wet the floor

ii) When you lose urine, what is the usual cause? (ii)

(a) Coughing, sneezing, laughing, or doing physical activity (b) A sudden and urgent need to go to the bathroom

(c) Both a) and b) equally (d) In other circumstances

45. During the following time periods, how many months have you worked ROTATING night shifts (at least 3 nights/month in addition to other days and evenings in that month)? (45)

June 2001–June 2003:	○ None	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20+
Since June 2003	○ None	○ 1–4 months	○ 5–9	○ 10–14	○ 15–19	○ 20+

45a. During the time periods that you worked ROTATING night shifts, what was the average number of nights you worked per month? (45a)

○ Didn't work rotating nights ○ 1–2 ○ 3–4 ○ 5–6 ○ 7–8 ○ 9–10 ○ 11–12 ○ 13–14 ○ 15 or more

46. Have you ever regularly had heartburn/acid reflux 1 or more times a week? (46)

○ No ○ Yes → **a)** How long did this last? ○ 5 years or less ○ 6–14 years ○ 15 years or longer (a)

b) In the past year, how often have you had heartburn/acid reflux? (b)

○ None in the last year ○ Less than once a month ○ Once a month

○ About once a week ○ Several times a week ○ Daily

47. What is the difference between your highest and lowest weight during the last 2 years? (47)

○ No change ○ 2–4 lbs. ○ 5–9 lbs. ○ 10–14 lbs. ○ 15–29 lbs. ○ 30–49 lbs. ○ 50+ lbs.

48. During the past 2 years, did you intentionally lose weight? (48)

○ Yes → **a)** What is the maximum number of pounds that you lost in any attempt? (a)

○ < 5 lbs. ○ 5–9 lbs. ○ 10–14 lbs. ○ 15–19 lbs. ○ 20–29 lbs. ○ 30–39 lbs. ○ 40–49 lbs. ○ 50+ lbs.

○ No

b) How did you lose the weight? *(Mark all that apply.)* (b)

○ low calorie diet	○ low fat diet	○ low carbohydrate diet	○ gastric surgery
○ limiting portion size	○ increased exercise	○ crash dieting/fasting	○ not eating between meals
○ commercial program (e.g., Weight Watchers/Jenny Craig)	○ reduced alcohol	○ commercial diet products (e.g., Slimfast)	○ diet pills/medications
			○ other method

49. During the past 2 years, did you UNintentionally lose weight (e.g., due to illness, stress, or depression)? (49)

○ No ○ Yes → **Number of pounds?** ○ < 5 lbs. ○ 5–9 lbs. ○ 10–14 lbs. ○ 15–19 lbs. ○ 20+ lbs. (a)

50. How many times per day do you eat? Include meals and snacks. (For snacks, count juice and non-diet soda, but exclude coffee and diet soda.) (50)

○ 1 or 2 times per day ○ 3/day ○ 4/day ○ 5/day ○ 6/day ○ 7/day ○ 8/day ○ 9 or more times per day

51. What do you USUALLY have for breakfast? *(Mark all that apply.)* (51)

○ Nothing	○ Tea/coffee	○ Milk	○ Cereal	
○ Donut/muffin/danish	○ Juice/fruit	○ Bacon/meat	○ Toast/bagel	
○ Protein bar/breakfast bar	○ Eggs	○ Breakfast sandwich	○ Yogurt/breakfast shake	○ Other items

52. In a typical week, on how many days do you eat breakfast? (52)

○ Zero ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

53. Thinking about what you usually eat, which meal usually contains the most calories (i.e., the "biggest meal" of the day)? (53)

○ Breakfast ○ Lunch ○ Dinner

54a) Do you have an unreasonable fear of being in enclosed spaces, such as stores, elevators, etc.? (54) (a)

○ Often ○ Sometimes ○ Never

b) Do you find yourself worrying about getting some incurable illness? ○ Often ○ Sometimes ○ Never (b)

c) Are you scared of heights? ○ Very ○ Moderately ○ Not at all (c)

d) Do you feel panicky in crowds? ○ Always ○ Sometimes ○ Never (d)

e) Do you worry unduly when relatives are late coming home? ○ Yes ○ No (e)

f) Do you feel more relaxed indoors? ○ Definitely ○ Sometimes ○ Not particularly (f)

g) Do you dislike going out alone? ○ Yes ○ No (g)

h) Do you feel uneasy traveling on buses or trains, even if they are not crowded? (h)

○ Very ○ A little ○ Not at all

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55. Do you currently take a multi-vitamin? (Please report other individual supplements in question 56.) 55

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

56. Do you take any of the following separate preparations on a regular basis? (DO NOT REPORT THE CONTENTS OF MULTI-VITAMINS.) 56

○ Vitamin C	○ Vitamin E	○ Calcium	○ Selenium
○ Vitamin A	○ Zinc	○ B-Complex	○ Iron
○ Vitamin D	○ Beta Carotene	○ Folic Acid	○ Niacin

57. To update our records regarding your lifetime pregnancy history, please mark the bubble corresponding to EACH year in which you gave birth (include both live births and stillbirths for pregnancies lasting at least 6 months). Do not report miscarriages/abortions before the 6th month. 57

If you NEVER had a pregnancy lasting 6 months or more, mark here → ○

○ 1960	○ 1961	○ 1962	○ 1963	○ 1964	○ 1965	○ 1966	○ 1967	○ 1968	○ 1969
○ 1970	○ 1971	○ 1972	○ 1973	○ 1974	○ 1975	○ 1976	○ 1977	○ 1978	○ 1979
○ 1980	○ 1981	○ 1982	○ 1983	○ 1984	○ 1985	○ 1986	○ 1987	○ 1988	○ 1989
○ 1990	○ 1991	○ 1992	○ 1993	○ 1994	○ 1995	○ 1996	○ 1997	○ 1998	○ 1999
○ 2000	○ 2001	○ 2002	○ 2003	○ 2004	○ 2005	○ 2006			

If in any calendar year you gave birth twice, (count twins as ONE birth) write that year here ▶ _____

58. Your total number of vaginal births: ○ Zero ○ One ○ Two ○ Three ○ Four ○ Five or more 58

59. Have any of your children been diagnosed with the following diseases? ○ Have no children 59

○ Multiple Sclerosis ○ Autism ○ Asperger's ○ Other Autism spectrum ○ ADHD
○ Febrile seizure ○ Epilepsy/non-febrile seizure ○ Type 1 (insulin dependent) diabetes ○ None

60. When you were an infant, how many years of education had your mother completed? ○ Don't know 60

○ < 9 years of school ○ 1–3 yrs of high school ○ 4 yrs of high school ○ 1–3 yrs of college ○ 4+ yrs of college

61. When you were an infant, how many years of education had your father completed? ○ Don't know 61

○ < 9 years of school ○ 1–3 yrs of high school ○ 4 yrs of high school ○ 1–3 yrs of college ○ 4+ yrs of college

62. Year your MOTHER was born: 62

18	0	0
19	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
○	9	9

○ Don't know

63. Year your FATHER was born: 63

18	0	0
19	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
○	9	9

○ Don't know

64. Parents' occupation during your infancy? 64

Mother	Father	
○	○	Professional (e.g., nurse, lawyer, teacher, etc.)
○	○	Executive, manager
○	○	Sales or clerical worker
○	○	Mechanic, electrician, skilled worker
○	○	Machine operator, inspector, bus/cab driver
○	○	Service worker (e.g., janitor, guard)
○	○	Laborer, unskilled worker
○	○	Farming
○	○	Military
○	○	Did not work outside the home
○	○	Don't know

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65. How tall was YOUR MOTHER, without shoes on, at her maximum adult height? 65

○ Under 5 feet ○ 5' to 5'3" ○ 5'4 to 5'6" ○ 5'7" to 5'10" ○ 5'11"+ ○ Don't know

66. How tall was YOUR FATHER, without shoes on, at his maximum adult height? 66

○ Under 5 feet 4 inches ○ 5'4 to 5'8" ○ 5'9" to 5'10" ○ 5'11" to 6' ○ 6'1" to 6'3" ○ 6'4"+ ○ Don't know

67. What was your birth order, relative to your siblings? 67

○ Only child ○ 1st born ○ 2nd ○ 3rd ○ 4th ○ 5th ○ 6th ○ 7th ○ 8th ○ 9th or later

68. Did your parents own a home at the time of your birth or infancy? ○ Yes ○ No 68

69. Is your biological mother still living? ○ Don't know 69

○ No → **a)** At what age did she die? ○ < 50 ○ 50–59 ○ 60–69 ○ 70–79 ○ 80–89 ○ 90+ a

○ Yes **b)** Was this due to: ○ Heart disease ○ Stroke ○ Cancer ○ Trauma/Accident/Suicide ○ Other b

70. Is your biological father still living? ○ Don't know 70

○ No → **a)** At what age did he die? ○ < 50 ○ 50–59 ○ 60–69 ○ 70–79 ○ 80–89 ○ 90+ a

○ Yes **b)** Was this due to: ○ Heart disease ○ Stroke ○ Cancer ○ Trauma/Accident/Suicide ○ Other b

71. Since June 2001, did you receive an influenza vaccination? 71

○ Yes → **a)** In which winter flu seasons? (Mark all that apply.)

○ No ○ 2001/2002 ○ 2002/2003 ○ 2003/2004 ○ 2004/2005 ○ 2005/2006 a

72. Please mark Yes or No for each of the following statements: 72

	Yes	No	
Shops, stores, and markets are within easy walking distance of my home.	○	○	a
There are sidewalks on most of the streets in my neighborhood.	○	○	b
The crime rate in my neighborhood makes it unsafe to go on walks at night.	○	○	c
My neighborhood has free or low cost recreation facilities, such as parks, walking trails, bike paths, recreation centers, playgrounds, public swimming pools, etc.	○	○	d

THANK YOU! Please return to Walter Willett, M.D., 181 Longwood Ave., Boston, MA, 02115-5804

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