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Nurses' Health Study II

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:

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.

We are excited to offer you the choice of completing either an on-line questionnaire or the attached traditional form. The on-line questionnaire is available at www.NHS2.org and can be accessed with your ID number shown above. We hope that this option will make participating in the study more convenient.

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. The questionnaire is being sent to each of the 116,671 members of NHS II and should take about 10 minutes to complete.

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

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

P.S. Your prompt reply helps avoid additional mailings.

Do you have internet 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 <u>not</u> release your e-mail address to anyone!

PERF

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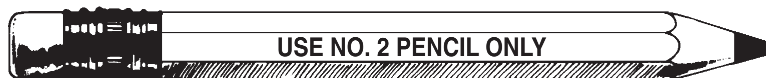
INSTRUCTIONS

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 First Diagnosis bubble for each illness you have had diagnosed.

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

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

	YES	YEAR OF FIRST DIAGNOSIS Before 1991	1991–1994	1995–1998	1999–2002	2003+
Meningioma	Ⓨ	○	○	○	○	○
Seizure (1 or more) / epilepsy	●	○	●	○	○	○
Shingles	Ⓨ	○	○	○	○	○
Psoriasis	●	○	○	○	●	○

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. 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
- ◯ Vasectomy
- ◯ Tubal ligation
- ◯ Oral contraceptive
- ◯ Foam/Jelly/Sponge
- ◯ Intrauterine device
- ◯ Condom
- ◯ Rhythm/NFP
- ◯ Diaphragm/Cervical cap
- ◯ Depo-Provera
- ◯ Other hormonal contraceptive (e.g., Nuva Ring, Ortho Evra, etc.)
- ◯ Other

4. SINCE JUNE 2003, have you used oral contraceptives (OC's)?
- ◯ Yes → a. How many months did you use OC's since June 2003?
  ◯ 1 month or less ◯ 2–4 ◯ 5–9 ◯ 10–14 ◯ 15–19 ◯ 20–25 ◯ 26–30 ◯ 31–35 ◯ 36+ months
  b. Please indicate the brand and type of OC you have used the longest during this time period (e.g., Ortho-Novum 1/50). Specify brand and type: ____
- ◯ No

5. SINCE JUNE 2003, have you been pregnant?
- ◯ 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, 2003, fill in a response bubble for the year during which each pregnancy *ended*.
- ◯ No

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+	◯	◯	◯	◯

6. Have your menstrual periods ceased PERMANENTLY?
- ◯ No: Premenopausal
- ◯ Yes: No menstrual periods
- ◯ Yes: Had menopause but now have periods induced by hormones
- ◯ Not sure (e.g., started hormones prior to cessation of periods)

a. AGE natural periods ceased: AGE ____

b. For what reason did your periods cease? ◯ Natural ◯ Surgical ◯ Radiation or chemotherapy

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

8. 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

9. SINCE JUNE 2003, have you used Evista (raloxifene) or tamoxifen (Nolvadex)?
◯ No ◯ Yes → Are you currently using Evista or tamoxifen? ◯ No, not currently ◯ Yes, Evista ◯ Yes, tamoxifen

10. SINCE JUNE 2003, have you used female replacement hormones (other than oral contraceptives)?
- ◯ No → Please continue with question 11.
- ◯ Yes, currently
- ◯ Yes, but not currently

What type of hormone did you use? ◯ Estrogen only ◯ Estrogen and progesterone ◯ Other Specify type: ____

11. 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	Ⓨ	◯	◯	◯	◯	◯
Seizure (1 or more) / epilepsy	Ⓨ	◯	◯	◯	◯	◯
Shingles	Ⓨ	◯	◯	◯	◯	◯
Psoriasis	Ⓨ	◯	◯	◯	◯	◯

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

		YEAR OF FIRST DIAGNOSIS				
		Before 1991	1991–1994	1995–1998	1999–2002	2003+
Hyperparathyroidism	Ⓨ	◯	◯	◯	◯	◯
Osteoporosis	Ⓨ	◯	◯	◯	◯	◯
Fractures: Wrist or Colles' Fracture	Ⓨ	◯	◯	◯	◯	◯
Hip fracture	Ⓨ	◯	◯	◯	◯	◯

Please Continue on Back of Form →

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12. Since June 2003, have you had any of these physician-diagnosed illnesses?

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

Illness	Yes	YEAR OF DIAGNOSIS: BEFORE JUNE 1 2003	JUNE '03 TO MAY 2005	AFTER JUNE 1 2005	Follow-up
Myocardial infarction (heart attack)	Y	◯	◯	◯	
Angina pectoris	Y	◯	◯	◯	Confirmed by angiography? ◯ No ◯ Yes
Coronary bypass/angioplasty	Y	◯	◯	◯	
Stroke (CVA)	Y	◯	◯	◯	
Transient ischemic attack (TIA)	Y	◯	◯	◯	
Deep vein thrombosis/Pul. embolism	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 of diagnosis:
Colon or rectal polyp (benign)	Y	◯	◯	◯	
Ulcerative colitis/Crohn's disease	Y	◯	◯	◯	
Gastric or duodenal ulcer	Y	◯	◯	◯	
Barrett's Esophagus	Y	◯	◯	◯	
Gallstones	Y	◯	◯	◯	Did you have symptoms? ◯ No ◯ Yes How diagnosed? ◯ X-ray or ultrasound ◯ Other
Cholecystectomy	Y	◯	◯	◯	
Diabetes	Y	◯	◯	◯	
Elevated Cholesterol	Y	◯	◯	◯	
High blood pressure	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
Premenstrual syndrome (PMS)	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	◯	◯	◯	
Gout	Y	◯	◯	◯	
SLE (systemic lupus)	Y	◯	◯	◯	
Rheumatoid arthritis, doctor diagnosed	Y	◯	◯	◯	Rheumatoid factor ◯ negative/unknown ◯ positive
Other arthritis	Y	◯	◯	◯	
Depression, clinician Dx	Y	◯	◯	◯	
Other major illness or surgery since June 2003:	Y	◯	◯	◯	Please specify: Date:

13. Is this your correct date of birth?

◯ Yes ◯ No → **If no, please write correct date.** Month / Day / Year

14. Do you currently take multi-vitamins? ◯ Yes ◯ No

15. 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: ____________________

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

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