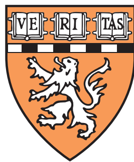

HARVARD
MEDICAL
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Nurses' Health Study II

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 ➡

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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!

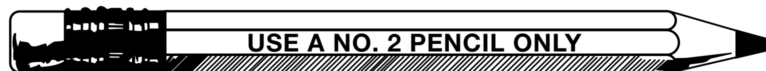
INSTRUCTIONS

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 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

	YES	Before June 1 2011	June '11 TO May '13	After June 1 2013	
Myocardial infarction (heart attack)	○ Y	○	○	○	1
Angina pectoris	●	○	●	○	2
Confirmed by angiography?	○ No	● Yes			a
Coronary bypass, angioplasty, or stent	●	○	○	●	3
Transient ischemic attack (TIA)	○ Y	○	○	○	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 2013 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

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
- Yes: Had menopause but now have periods induced by hormones
- Not sure (e.g., perimenopausal)

a) **AGE natural periods ceased:** AGE

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 → / No

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

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: →

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

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

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

YEAR OF DIAGNOSIS: Before June 1 2011 / June '11 to May '13 / After June 1 2013

1. Myocardial infarction (heart attack)
2. Angina pectoris
   a. Confirmed by angiography? No Yes
3. Coronary bypass, angioplasty, or stent
4. Transient ischemic attack (TIA)
5. Stroke (CVA)
6. Pulmonary embolus
7. Fibrocystic/other benign breast disease
   a. Confirmed by breast biopsy? No Yes
8. Breast cancer
9. Cancer of the uterus (endometrium)
10. Cancer of the ovary
11. Colon or rectal polyp (benign)
12. Cancer of the colon or rectum
13. Melanoma
14. Basal cell skin cancer
15. Squamous cell skin cancer
16. Other cancer
    Specify site of other cancer
17. Ulcerative colitis/Crohn's
18. Gastric or duodenal ulcer
19. Barrett's esophagus
20. Gallstones
    a. Did you have symptoms? No Yes
21. Cholecystectomy
22. Diabetes mellitus
23. Elevated cholesterol
24. High blood pressure
25. Endometriosis—1st diagnosis
    a. Confirmed by laparoscopy? No Yes
26. Kidney stones
27. Multiple Sclerosis
28. Asthma, Clinician diagnosed
29. Emphysema/Chronic bronchitis
30. Graves' disease/Hyperthyroidism
31. Hypothyroidism
32. Hyperparathyroidism
33. Gout
34. SLE (systemic lupus)
35. Rheumatoid arthritis
36. Other arthritis
37. Depression, Clinician diagnosed
38. Parkinson's disease
39. Gastric banding/bypass
40. Fractures: Wrist or Colles' Fracture
41. Hip Fracture
42. Other major illness or surgery since June 2011

Please specify: Date:

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

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

YEAR OF FIRST DIAGNOSIS: Before 1995 / 1995–2002 / 2003–2008 / 2009–2010 / 2011 +

- Meningioma
- Atrial fibrillation
- Heart failure (CHF)
- Deep vein thrombosis
- Osteoporosis/osteopenia
- Psoriasis
- Severe acne
- Eczema (atopic dermatitis)
- Shingles
- Peripheral neuropathy
- Fatty liver
  - a. Confirmed by liver biopsy? No Yes
- Liver cirrhosis
- Hepatitis (type B or C)
- Macular degeneration
- Glaucoma
- Cataracts
- Hip replacement
- Non-Alzheimer's dementia (e.g. Lewy body, vascular, FTD)
- Alzheimer's disease
- Vertebral Fracture
  - a. If Yes, was fracture due to trauma?
  - Yes → b. Was this a result of: Traffic accident / A fall from an elevated position (standing on a chair, etc.) / A fall while standing/walking (e.g., trip & fall) / Other
  - No
  - Unsure

19. 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
Exam by eye doctor?	N	Y	Y
Mammogram (or other breast imaging)?	N	Y	Y
Fasting blood sugar?	N	Y	Y

- Upper endoscopy: No / Yes
- (Virtual) CT Colonoscopy?: No / Yes
- Colonoscopy?: No / Yes
- Sigmoidoscopy?: No / Yes

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

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

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

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

22. Is this your correct date of birth?
- Yes
- No → If no, please write correct date. MONTH / DAY / YEAR

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23. 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+ tablets
- "Baby" or low dose aspirin (100 mg or less/tablet)
  - Days/week: 1 / 2–3 / 4–5 / 6+ days
  - Total tabs/wk: 1–2 / 3–5 / 6–14 / 15+ tablets
- Aspirin or aspirin-containing products (325 mg or more/tablet)
  - Days/week: 1 / 2–3 / 4–5 / 6+ days
  - Total tabs/wk: 1–2 / 3–5 / 6–14 / 15+ tablets
- 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+ tablets
- Celebrex (COX-2 inhibitors)
  - Days/week: 1 / 2–3 / 4–5 / 6+ days
- Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Clinoril, Indocin, Relafen)
- Thiazide diuretic / Lasix / Potassium
- Calcium blocker (e.g., Calan, Procardia, Cardizem, Norvasc)
- Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)
- ACE Inhibitors (e.g., Capoten, Vasotec, Zestril)
- Angiotensin receptor blocker (e.g., Diovan, Cozaar, Avapro)
- Other anti-hypertensive (e.g., clonidine, doxazosin)
- Coumadin (Warfarin) / Plavix / Prasugrel (Effient)
- Xabans (e.g., Pradaxa, Xarelto)
- Digoxin / Antiarrhythmic
- **"Statin" cholesterol-lowering drugs:**
  - Mevacor (lovastatin) / Zocor (simvastatin) / Crestor
  - Pravachol (pravastatin) / Lipitor (atorvastatin) / Other
- Other cholesterol-lowering drug [e.g., niacin, Lopid (gemfibrozil), Tricor (fenofibrate), Questran (cholestyramine), Colestid, Zetia]
- Steroids taken orally (e.g., Prednisone, Decadron, Medrol)
- **Diabetes drugs:**
  - Insulin
  - Metformin (Glucophage)
  - Other hypoglycemic agents
- Thyroid hormone (e.g., Synthroid, Levothroid)
- Triptans (e.g., Imitrex, Maxalt, Zomig, Amerge, Replax)
- Bisphosphonates (e.g., Fosamax, Boniva, Actonel)
- Evista (raloxifene) / Nolvadex (tamoxifen)
- Anticholinergics (e.g., Detrol, Ditropan, Vesicare)
- SSRIs (Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox, fluoxetine, citalopram)
- Tricyclics (e.g., amitriptyline, nortriptyline, imipramine)
- SNRIs/Other antidepressants (Wellbutrin, Effexor, Remeron, Cymbalta, venlafaxine, bupropion)
- Minor tranquilizers (e.g., Valium, alprazolam, lorazepam)
- Prilosec, Nexium, Prevacid (lansoprazole), Protonix, Aciphex
- H2 blocker (e.g., Pepcid, Tagamet, Zantac, Axid)
- Other regular medications (no need to specify)

24. Have you EVER used Metformin (aka Glucophage)?

- Yes → **a. When did you FIRST take it?** Before 1996 / 1997–2000 / 2001–2004 / 2005–2008 / 2009–2012 / After 2012
  - **b. In all, how many years have you used Metformin?** Less than 1 year / 1–2 / 3–5 / 6–8 / 9–12 / 13–15 / 15+ years
- No

25. In general, would you say your health is:

Excellent / Very good / Good / Fair / Poor

1 1 1 1 1 1 1

26. Have any of your biological siblings, offspring, or your parents ever had any of the following diseases?

Disease	N	Y	Relative's Age at First Diagnosis: Before Age 40	Age 40 to 59	Age 60+	Age Unknown
Ovarian cancer	N	Y				
Breast cancer	N	Y				
Melanoma	N	Y				
Colon or Rectal cancer	N	Y				
Diabetes	N	Y				
Parkinson's disease	N	Y				
Rheumatoid arthritis	N	Y				
Asthma	N	Y				
Crohn's disease	N	Y				
Ulcerative colitis	N	Y				
Multiple Sclerosis	N	Y				
Stroke	N	Y				
Myocardial infarction (heart attack)	N	Y				

27. In the past two years, have you had gastrointestinal bleeding that required hospitalization or a transfusion?

- Yes → **a. What was the site of the bleeding?** Esophagus / Stomach / Duodenum / Colon/rectum / Other / Site unknown
- No

28. In the last year, how often have you had heartburn or acid-reflux?

None in the past year / Less than once a month / About once a month / About once/week / Several times/week / Daily

29. In the past 2 years, have you had migraine headaches?

- Yes → Did you sometimes have an aura? No / Yes
  - On average, on *how many days per month* do you get migraine headaches? <1 day / Daily / 1–7 days / 8–14 / 15–29 days/month
- No

30. Do you have unpleasant sensations (like crawling, paraesthesia, or pain) in your legs combined with an urge or need to move your legs?

No / Once/month or less / 2–4 times/month / 5–14/month / 4–5/week / 6+ times/week

- a. Do these symptoms occur only at rest? No / Yes
- b. Does moving improve them? No / Yes
- c. Are these feelings/symptoms worse in the evening/night than in the morning? No / Yes

31. In the past two years, has there been a time lasting 2 weeks or longer:

- a. When most of the day you felt sad, empty or depressed? Yes / No
- b. When most of the day you were very discouraged about how things were going in your life? Yes / No
- c. When you lost interest in most things you usually enjoy like work, hobbies, and personal relationships? Yes / No
- d. When most days you felt much more anxious and worried than other people with the same problems as you? Yes / No

32. How many full marathons have you ever run?

None / 1 / 2–5 / 6–15 / 16–24 / 25+

33. Have you ever used talcum, baby or deodorizing powder AT LEAST WEEKLY in the genital/rectal area or on sanitary napkins, tampons or underwear?

Never / Less than 1 year / 1 to <10 years / 10 to <20 years / 20 to <30 years / 30+ years

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34. How frequently do you have a bowel movement?
○ More than twice a day ○ Twice a day ○ Daily ○ Every other day ○ Every 3–4 days ○ Every 5 days or less

35. In the past 3 months, how often did you have hard or lumpy stools?
○ Never or rarely ○ Occasionally ○ About 25% of the time ○ About 50% ○ About 75% ○ Almost always

36. In the past 3 months, how often did you have loose, mushy or watery stools?
○ Never or rarely ○ Occasionally ○ About 25% of the time ○ About 50% ○ About 75% ○ Almost always

37. How often do you use a laxative (such as softeners, bulking agents, fiber supplements or suppositories)?
○ Never ○ < Once/month ○ 1–3 times/month ○ Once/week ○ 2–3 times/wk ○ 4–5 times/wk ○ Daily ○ 2+ times/day

38. How often in the past year have you experienced any amount of accidental bowel leakage? Answer a) and b)
a) Liquid stool: ○ Never ○ Less than 1/month ○ 1–3/month ○ About once/wk ○ Several times/wk ○ Nearly daily
b) Solid stool: ○ Never ○ Less than 1/month ○ 1–3/month ○ About once/wk ○ Several times/wk ○ Nearly daily

39. During the last 12 months, how often have you leaked or lost control of your urine?
○ 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?
○ A few drops ○ Enough to wet your underwear ○ Enough to wet your outerclothing ○ Enough to wet the floor

ii) When you lose urine, what is the usual cause?
ⓐ Coughing, sneezing, laughing, or doing physical activity ⓑ A sudden and urgent need to go to the bathroom
ⓒ Both a) and b) equally ⓓ In other circumstances

40. Have you talked to your healthcare provider about leaking urine or accidental bowel leakage? *(Mark all that apply.)*
○ No I have not ○ Yes, about leaking urine ○ Yes, about bowel leakage

41. How much do you think your leaking urine or accidental bowel leakage affects your life?
○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

42. Have you ever had the following treatments for urinary incontinence? Answer a) and b)
a) Kegel exercises or physical therapy to strengthen pelvic muscles? ○ No ○ Yes
b) Surgery? ○ No ○ Yes ➡ **When?** ○ Before 2001 ○ 2001–2002 ○ 2003–2004 ○ 2005–2006 ○ 2007–2009 ○ 2010+

43. 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)

44. How many total flights of stairs (not individual steps) do you climb daily?
○ None ○ 2 flights or less ○ 3–4 ○ 5–9 ○ 10–14 ○ 15 or more flights

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

	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 for transportation/errands	○	○	○	○	○	○	○	○	○	○
Running or jogging	○	○	○	○	○	○	○	○	○	○
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 (Include free weights or resistance machines) — **Arm weights**	○	○	○	○	○	○	○	○	○	○
Leg weights	○	○	○	○	○	○	○	○	○	○

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

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

47. Is your biological mother still living? ○ Unsure
○ No ➡ **a) At what age did she die?** ○ <50 ○ 50–59 ○ 60–69 ○ 70–79 ○ 80–89 ○ 90+
○ Yes **b) Was this due to:** ○ Heart disease ○ Stroke ○ Cancer ○ Trauma/Accident/Suicide ○ Other

48. Is your biological father still living? ○ Unsure
○ No ➡ **a) At what age did he die?** ○ <50 ○ 50–59 ○ 60–69 ○ 70–79 ○ 80–89 ○ 90+
○ Yes **b) Was this due to:** ○ Heart disease ○ Stroke ○ Cancer ○ Trauma/Accident/Suicide ○ Other

49. Were you hospitalized over the past 12 months?
○ Yes ➡ **What was the reason?** ○ Surgery - elective ○ Surgery - emergency ○ Accident ○ Illness (e.g., pneumonia)
○ No ○ Obstetrical admission ○ Mental illness ○ Observation ○ Research study ○ Other

50. Have any of your biological children been diagnosed with attention deficit hyperactivity disorder (ADHD)? ○ No ○ Yes ➡ Year(s) of birth ________

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51. The following question asks about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as sweets, starches, salty snacks, fatty foods, sugary drinks, and others.

In the past 12 MONTHS, how often were each of these statements true for you?	Never	Once per month	2-4 times per month	2-3 times per week	4+ times per week
I find myself consuming certain foods even though I am no longer hungry.	◯	◯	◯	◯	◯
I worry about cutting down on certain foods.	◯	◯	◯	◯	◯
I feel sluggish or fatigued from overeating.	◯	◯	◯	◯	◯
I have spent time dealing with negative feelings from overeating certain foods, instead of spending time in important activities such as time with family, friends, work, or recreation.	◯	◯	◯	◯	◯
I have had physical withdrawal symptoms such as agitation and anxiety when I cut down on certain foods. (Do NOT include caffeinated drinks: coffee, tea, cola, energy drinks, etc.)	◯	◯	◯	◯	◯
My behavior with respect to food and eating causes me significant distress.	◯	◯	◯	◯	◯
Issues related to food and eating decrease my ability to function effectively (daily routine, job/school, social or family activities, health difficulties).	◯	◯	◯	◯	◯

IN THE PAST 12 MONTHS…	No	Yes	Not applicable
I kept consuming the same types or amounts of food despite significant emotional and/or physical problems related to my eating.	◯	◯	◯
Eating the same amount of food does not reduce negative emotions or increase pleasurable feelings the way it used to.	◯	◯	◯

52. Do you have any problems with your sense of smell, such as not being able to smell things or things not smelling the way they are supposed to for at least 3 months?

◯ Yes ➡ **Which problem do you have, not being able to smell things or things not smelling the way they are supposed to?** ◯ Loss of smell ◯ Things don't smell right ◯ Don't know

◯ No

53. Do you have a problem with your sense of taste, such as not being able to taste salt or sugar, or with tastes in the mouth that shouldn't be there, like bitter, salty, sour or sweet tastes, for at least 3 months?

◯ No ◯ Yes ◯ Don't know

54. Below is a list of some of the ways you may have felt or behaved during the *past month*.

Please indicate how often you have felt this way. During the past month…*(Mark one answer per line)*	Rarely or none of the time	Some or a little of the time	Occasionally or a moderate amount of time	All of the time
I was bothered by things that usually don't bother me.	◯	◯	◯	◯
I had trouble keeping my mind on what I was doing.	◯	◯	◯	◯
I felt depressed.	◯	◯	◯	◯
I felt that everything I did was an effort.	◯	◯	◯	◯
I felt hopeful about the future.	◯	◯	◯	◯
I felt fearful.	◯	◯	◯	◯
My sleep was restless.	◯	◯	◯	◯
I was happy.	◯	◯	◯	◯
I felt lonely.	◯	◯	◯	◯
I could not "get going".	◯	◯	◯	◯

55. Did you EVER use oral contraceptives at any time in your life (even one dose)?

◯ No, I never used them at all ➡ **What was the primary reason you did not use oral contraceptives? (Mark all that apply.)**
◯ Used other contraception ◯ Personal/family history of heart disease or cancer
◯ Concerns about safety/side effects ◯ Religious reasons ◯ Did not use contraception ◯ Other

◯ Yes, I used them
➡ **What was the primary reason(s) that you stopped using them? (Mark all that apply.)**
◯ Still using/current user ◯ To become pregnant ◯ Switched to other type or no longer needed contraception
◯ Cardiovascular event ◯ Worsened menstrual symptoms/mood swings
◯ Migraines ◯ Other side effects ◯ Other reason

56. How many hours each week do you participate in any groups such as a social or work group, church-connected group, self-help group, charity, public service or community group?

◯ None ◯ 1 to 2 hours ◯ 3 to 5 hours ◯ 6 to 10 hours ◯ 11 to 15 hours ◯ 16 or more hours

57. How often do you go to religious meetings or services?

◯ More than once a week ◯ Once a week ◯ 1 to 3 times per month ◯ Less than once per month ◯ Never or almost never

58. Apart from your children, how many relatives do you have with whom you feel close?

◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

59. How many close friends do you have?

◯ None ◯ 1 to 2 ◯ 3 to 5 ◯ 6 to 9 ◯ 10 or more

60. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with?

◯ Yes ➡ **How often do you see or talk to this person?**
◯ Daily ◯ Weekly ◯ Monthly ◯ Several times/year ◯ Once/year or less

◯ No

61. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)? ◯ None of the time ◯ A little of the time ◯ Some of the time ◯ Most of the time ◯ All of the time

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62. How many people can you count on to provide you with emotional support?

None 1 2 3+

63. Over the last 4 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

64. Has your spouse (or sleep partner) ever told you that you appear to "act out your dreams" while sleeping (punched or flailed arms in the air, shouted or screamed), which has occurred at least three times?

No Yes I do not have a sleep partner

65. This question asks about how well you sleep:

	Most of the time	Sometimes	Rarely or Never
How often do you have difficulty falling asleep?			
How often do you have trouble with *waking up during the night?*			
How often are you troubled by waking up *too* early and not being able to fall asleep again?			
How often do you get so sleepy during the day or evening that you have to take a nap?			
How often do you feel really rested when you wake up in the morning?			

66. How often do you snore?

Every night Most nights A few nights a week Occasionally Almost never Don't know

67. Has anyone noticed that you stop breathing during your sleep?

No Yes

68. Have you ever had physician-diagnosed sleep apnea?

No Yes → **Date of diagnosis:** Before 1986 1986–1995 1996–2005 2006–2009 2010+

69. From June 2011 to June 2013, how many months have you worked ROTATING night shifts (at least 3 nights/month in addition to other days and evenings in that month)?

None 1–4 months 5–9 10–14 15–19 20+ months

70. Which best describes your hearing?

Excellent Good A little hearing trouble Moderate hearing trouble Deaf

71. Have you noticed a change in your hearing?

Yes → **At what age did you first notice a change in your hearing?**

No

<20 20–29 30–39 40–44 45–49 50–54 55–59 Age 60+ Unsure

72. In the past 12 months, have you had ringing, roaring, or buzzing in your ears?

Never Once/month or less 2–3 times/mo About once/wk Several times/wk Almost every day

a) On the days you hear the sound, how long does it last?

A few seconds Less than 5 minutes 5 minutes to an hour Several hours All the time

b) Does the sound affect your ability to: Sleep Work Perform other activities None of these

73. Over the past 4 weeks…

How would you rate your level (degree) of sexual desire or interest?

Very high High Moderate Low Very low or none at all

How would you rate your level of sexual arousal ("turn on") during sexual activity or intercourse?

No sexual activity Very high High Moderate Low Very low or none at all

How often did you become lubricated ("wet") during sexual activity or intercourse?

No sexual activity Almost always or always Most times Sometimes A few times Almost never or never

When you had sexual stimulation or intercourse, how often did you reach orgasm?

No sexual activity Almost always or always Most times Sometimes A few times Almost never or never

How satisfied have you been with your overall sexual life?

Very satisfied Moderately satisfied About equally satisfied and dissatisfied Moderately dissatisfied Very dissatisfied

How often did you experience discomfort or pain during vaginal penetration?

Did not attempt intercourse Almost never or never A few times Sometimes Most times Almost always or always

74. 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 or E-mail: ______

Thank you! Please return form to: Nurses' Health Study, 181 Longwood Ave, Boston, MA 02115.

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