NURSES' HEALTH STUDY

- Harvard Medical School
- Harvard TH Chan School of Public Health

Channing Division of Network Medicine
181 Longwood Avenue • Boston, Massachusetts 02115-5804

• Tel (617) 525-2279
• Fax (617) 525-4597
• E-Mail NHS@channing.harvard.edu

To report name or address changes, update your information here and return this letter with your questionnaire.

This is your ID ➡

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Your e-mail:

Please print your e-mail address in the box as this is the most efficient way to contact you about the questionnaire and study updates. Over 70,000 NHS participants complete a web questionnaire – please join us online!

Please print neatly and differentiate numbers and letters (e.g., 1 vs I 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 and complete the survey online.

PAPER FORM:

Please use an ordinary pencil to answer all questions. Fill response circles completely.
If you have comments, please write them on a separate piece of paper.

- **Please return the questionnaire in the enclosed postage-paid envelope.**
- **If your name and address as printed on this letter 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.**

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Federal research regulations require us to include the following information:

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to protect the privacy of health information obtained for research. This is an abbreviated notice, and does not describe all details of this requirement.

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.

We have a Certificate of Confidentiality from the National Institutes of Health, which means we cannot be forced (for example by court order or subpoena) to disclose your health information or other identifying information from the research in any Federal, State or local civil, criminal, administrative, legislative, or other proceedings.

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 Brigham and Women's Hospital (857-282-1900).

To reach the Nurses' Health Study staff, please call 617-525-2279.

Thank you for completing the Nurses' Health Study Questionnaire.

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NURSES' HEALTH STUDY

1. **Current Weight:** ☐☐☐ lbs.

2. **Is this your correct date of birth?** ☐ Yes ☐ No

3. **Have you had your uterus or ovaries removed?** ☐ No ☐ Uterus removed ☐ Both ovaries removed ☐ One ovary removed

4. **Do you currently smoke cigarettes?** ☐ No ☐ Yes ① ② ③ ④ ⑤

5. **Since June 2021, have you had any of these clinician-diagnosed illnesses?**

	LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 2021	JUNE '21 to MAY '23	After JUNE 1, 2023
Diabetes Mellitus	Y			
Pre-diabetes (Glucose intolerance)	Y			
Elevated Cholesterol	Y			
High Blood Pressure	Y			
Myocardial Infarction (heart attack)	Y			
➡ Were you hospitalized for this MI? ○ No ○ Yes				
Angina pectoris	Y			
➡ Confirmed by angiogram? ○ No ○ Yes				
Coronary Bypass, Angioplasty, or Stent	Y			
Stroke (CVA)	Y			
TIA (Transient Ischemic Attack)	Y			
Carotid Artery Surgery (Endarterectomy)	Y			
Pulmonary Embolus	Y			
Atrial Fibrillation, Dr. Dx	Y			
Heart Failure	Y			
Osteoporosis	Y			
Hip Fracture	Y			
Hip Replacement	Y			
Wrist or Colles Fracture	Y			
Vertebral Fracture	Y			
Knee Replacement	Y			
Fibrocystic/other benign breast disease	Y			
➡ Confirmed by biopsy? ○ No ○ Yes				
Breast Cancer	Y			
Melanoma	Y			
Leukemia or Lymphoma	Y			
Colon or Rectal Polyps (benign)	Y			
Colon or Rectal Cancer	Y			
Other Cancer	Y			

Specify: Date:

Other cancer site (e.g., uterus, ovary, lung, skin cancer, etc.)

	LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS: BEFORE JUNE 1, 2021	JUNE '21 to MAY '23	After JUNE 1, 2023
Glaucoma	Y			
Cataract Extraction	Y			
Kidney Stones	Y			
Cholecystectomy	Y			
Alzheimer's / Dementia	Y			
Parkinson's Disease	Y			
Multiple Sclerosis	Y			
Rheumatoid Arthritis / Lupus	Y			
Sleep Apnea	Y			
Chronic Viral Hepatitis (B or C)	Y			
Gastric/Duodenal Ulcer	Y			
Diverticulitis (Not diverticulosis)	Y			
Celiac Disease	Y			
Ulcerative Colitis / Crohn's or Microscopic Colitis	Y			
Barrett's Esophagus	Y			
Endometriosis (Confirmed by laparoscopy)	Y			
Depression (Clinician diagnosed)	Y			
Osteoarthritis	Y			
Asthma (Clinician diagnosed)	Y			
COPD/Emphysema/ Chronic Bronchitis	Y			
Gout	Y			
Pseudogout	Y			
Shingles	Y			
Vaccine for Shingles	Y			
Polymyalgia Rheumatica	Y			
Temporal Arteritis (GCA)	Y			
Fatty Liver ➡ Confirmed by biopsy? ○ No ○ Yes	Y			
Liver Cirrhosis	Y			
Other Major Illness or Surgery Since June 2021	Y			

Specify: Date:

(e.g., Deep Vein Thrombosis, GERD, ALS, etc.)

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Please Continue on Back

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6. **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: _____

E-mail: _____

7. **Did you need any help from someone else to complete this questionnaire?**

○ No ○ Yes, I received help from someone else but I provided most of the input

○ Yes, someone else completed it on my behalf with minimal input from me

If Yes: I needed help with: (Mark all that apply.)

○ Vision ○ Writing ○ Memory ○ Other

Who helped?

○ Spouse/Partner ○ Adult child ○ Other family ○ Power of Attorney

Please elaborate in the space below and include your name, address, telephone number or e-mail address, and your relationship to the participant. Please explain briefly why your help was needed (e.g., macular degeneration, Parkinson's, dementia, etc.).

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