



*Please reply to:*  
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Boston MA 02115-5804  
(617) 525-2279 Fax (617) 525-2008  
E-mail: NHS@Channing.Harvard.Edu

**Dear Colleague:**

Thank you for being a member of the Nurses' Health Study for over 36 years. Your continued participation and that of 120,000 other women are the bedrock of one of the most important studies of health and wellbeing. We are very proud of the work we have done together.

The attached **very brief** questionnaire asks 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. As always, your answers will be kept strictly confidential and used for medical statistical purposes only. Your prompt reply is helpful and greatly appreciated.

As an original member of the Nurses' Health Study you are an indispensable colleague in our research. Whether you are retired or still working and 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 want to hear from you!**

It is with our deepest gratitude that we thank you for the ongoing commitment and care that you have generously provided as we continue to learn more about women's health.

Best Regards,

Susan Hankinson, RN, Sc.D.

**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!

CENTER PERF

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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 2010, have you had any of these clinician-diagnosed illnesses?

**Cardiovascular**

	LEAVE BLANK FOR "NO", MARK HERE FOR "YES".	YEAR OF DIAGNOSIS		
		BEFORE JUNE 1, 2010	JUNE '10 to MAY '12	After JUNE 1, 2012
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, 2010	JUNE '10 to MAY '12	After JUNE 1, 2012
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, 2010	JUNE '10 to MAY '12	After JUNE 1, 2012
Hip 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"/>
Osteoarthritis	<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, 2010	JUNE '10 to MAY '12	After JUNE 1, 2012
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"/>
Chronic Lymphocytic Leukemia	<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. Uterus, Ovary, etc.)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify other cancer site:				
		BEFORE JUNE 1, 2010	JUNE '10 to MAY '12	After JUNE 1, 2012
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"/>
SLE (systemic lupus)	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis/ Crohn's disease	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<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 Since June 2010	<input checked="" type="checkbox"/> Y	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Include for example: Gastric/Duodenal ulcer, Asthma, COPD, Emphysema, Thyroid disease, Hyperparathyroidism, MS, Shingles, etc.				
Specify other major illness or surgery:				

Continue  
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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/Email: \_\_\_\_\_

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?**

- Husband
- Child
- Other

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

Please specify the date and circumstances of your hip fracture (including fractures at the femoral head and neck, greater trochanter, and intertrochanteric).

- Date of hip fracture: Month \_\_\_\_\_ Year \_\_\_\_\_
- Circumstances:

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

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