HARVARD MEDICAL SCHOOL

NURSES' HEALTH STUDY

Frank E. Speizer, M.D.
Harvard Medical School
Channing Laboratory
PLEASE REPLY TO:
180 Longwood Ave.
Boston, Mass. 02115
617-731-8909

APPENDIX 3a
1976 Questionnaire

Our research group at Harvard Medical School is conducting a study of a major public health issue - whether there are long term health effects of various forms of contraception. In this study, funded by the National Institutes of Health, we are sending questionnaires to a large sample of women selected from a roster of registered nurses supplied to us by the American Nurses' Association. We believe that registered nurses--because of their knowledge, training, and interest in health issues--will provide a higher response rate as well as more complete and accurate information than other groups.

The success of this work rests on your willingness to answer the questions on the attached form. We would greatly appreciate your taking a few minutes to complete the questionnaire, detach it, and return it to us promptly in the enclosed prepaid envelope. Your responses will be identified by study number only and will be used only for medical statistical purposes. We intend to publish findings of this study in the American Journal of Nursing to provide the most current information about this public health issue to participants in the study.

We would like to stress that the validity of the findings will be crucially dependent on receiving completed questionnaires from all women who receive them, even those who have never used any contraceptive method or who may be post-menopausal.

Thank you for your help.

Very truly yours,

Charlene F. Belanger

Charlene F. Belanger, M.A.

Charles H. Hennekens

Charles H. Hennekens, M.D., Dr.P.H.

Bernard Rosner

Bernard Rosner, Ph.D.

Frank E. Speizer

Frank E. Speizer, M.D.

_____ 01
(1) (7)

HARVARD MEDICAL SCHOOL

NURSES' HEALTH QUESTIONNAIRE

Please answer all 11 questions by filling in the appropriate box or writing in the information requested. You will find extra room on the back of the form for any additional remarks you may wish to add. All information will be regarded as strictly confidential and will be used only for medical statistical purposes.

1. What is your date of birth? _____ _____ _____
month (18) day (20) year (22)

2. What is your height? _____ _____
feet (24) inches (25)

What is your current weight? _____ (27)
pounds

3. At what age did your menstrual periods begin?
_____ (30)
years of age

Have your menstrual periods ceased permanently?

☐ YES (32) ☐ NO or DON'T KNOW

At what age? _____ (33)
years of age

For what reason? (35)
- ☐ naturally
- ☐ due to radiation
- ☐ due to surgery

If due to surgery, were BOTH ovaries removed?
☐ yes ☐ no ☐ don't know (36)

After your menstrual periods ceased, did you take female hormones?
☐ YES (37) ☐ NO

For how long? _____ _____
years (38) months (40)

4. Have you ever had a pregnancy lasting 6 months or more?

☐ YES (42) ☐ NO

How many pregnancies lasting 6 months or more have you had? _____ (43)

How old were you at the end of your first pregnancy lasting 6 months or more? _____ (45)
years of age

Did any of your pregnancies lasting 6 months or more result in stillbirth?

☐ YES (47) ☐ NO

How many? _____ (48)

5. Do you use any method of contraception CURRENTLY?

☐ YES (50) ☐ NO

- ☐ oral contraceptives (birth control pills)? (51)
- ☐ rhythm? (52)
- ☐ diaphragm? (53)
- ☐ condom? (54)
- ☐ intrauterine device (loop or coil)? (55)
- ☐ foam or jelly? (56)
- ☐ tubal ligation? (57)
- ☐ husband's vasectomy? (58)
- ☐ other? (59)

Have you EVER used oral contraceptives in the past?

☐ yes (60) ☐ no

(Please detach along perforated edge)

02
(7)

6. IF YOU ARE NOW USING or HAVE EVER USED ORAL CONTRACEPTIVES, please indicate intervals of ORAL CONTRACEPTIVE use starting from first use and continuing up until the present time. If applicable, please indicate reasons for stopping.

_____
(9)

	Interval of use				Reason for stopping
	month	year	month	year	
(10) From	_____	_____	to _____	_____	_____
(20) From	_____	_____	to _____	_____	_____
(30) From	_____	_____	to _____	_____	_____
(40) From	_____	_____	to _____	_____	_____
(50) From	_____	_____	to _____	_____	_____
(60) From	_____	_____	to _____	_____	_____

PLEASE CONTINUE ON REVERSE SIDE

03
(7)

Questionnaire (continued)

7. Have you ever had any of the following conditions? If yes, please specify date of diagnosis, and whether hospitalized.

	Condition	YES	NO	Date of diagnosis month	Date of diagnosis year	Were you hospitalized? YES	Were you hospitalized? NO
(9)	High blood pressure (not including when pregnant)	☐	☐			☐	☐
(15)	Diabetes mellitus	☐	☐			☐	☐
(21)	Elevated cholesterol	☐	☐			☐	☐
(27)	Myocardial infarction (heart attack)	☐	☐			☐	☐
(33)	Angina pectoris	☐	☐			☐	☐
(39)	Peripheral venous thrombosis	☐	☐			☐	☐
(45)	Pulmonary emboli	☐	☐			☐	☐
(51)	Fibrocystic breast disease	☐	☐			☐	☐
(57)	Other benign breast disease	☐	☐			☐	☐
(63)	Breast cancer	☐	☐			☐	☐
(69)	Other cancer (please specify) _____ (75)	☐	☐			☐	☐

8. In what year was your mother born? _____ (9)
year

04
(7)

Is your mother still living?
☐ YES ☐ NO (12)

At what age did she die? _____ (13)
years of age

Did your mother ever have either of the following conditions? If YES, please specify her age at the time the condition first occurred.

	Condition	YES	NO or DON'T KNOW	Age at first occurrence of condition
(15)	Myocardial Infarction	☐	☐	_____ (16)
(18)	Breast Cancer	☐	☐	_____ (19)

In what year was your father born? _____ (21)
year

Is your father still living?
☐ YES ☐ NO (24)

At what age did he die? _____ (25)
years of age

Did your father ever have a myocardial infarction?
☐ YES (27)

At what age did he have his first myocardial infarction? _____ (28)
years of age

☐ NO or DON'T KNOW

Do you have any sisters?
☐ YES (30)

How many sisters do you have? _____ (31)

How many of your sisters have ever had breast cancer? _____ (33)

☐ NO

9. When you were 16 years of age, what was

Your father's occupation? _____ (34)

Your mother's occupation? _____ (35)

10. Do you smoke cigarettes CURRENTLY?
☐ YES (36)

On average, how many cigarettes do you smoke currently each day? (1 pack equals 20 cigarettes) _____ (37)
cigarettes per day

How old were you when you first started to smoke regularly? _____ (40)
years of age

Since you first started to smoke regularly, have you ever given up smoking cigarettes for 6 months or more?
☐ YES (42)

On average, during your first five years of smoking, how many cigarettes per day did you smoke? _____ (43)
cigarettes per day

☐ NO

Have you ever smoked cigarettes regularly in the past?
☐ YES (46)

On average, how many cigarettes per day did you smoke when you last smoked regularly? (1 pack equals 20 cigarettes) _____ (47)
cigarettes per day

How old were you when you last smoked regularly? _____ (50)
years of age

How old were you when you first started to smoke regularly? _____ (52)
years of age

From when you first started to smoke regularly until you last smoked regularly, did you ever give up smoking for 6 months or more?
☐ YES (54) ☐ NO

☐ NO

11. Do you use a permanent hair dye CURRENTLY? (Please do not include temporary rinses.)
☐ YES (55)

How often?
Every _____ weeks (56)

For how many years have you used a permanent hair dye regularly? _____ (58)
years

At what age did you first use a permanent hair dye? _____ (60)
years of age

☐ NO

Did you ever use a permanent hair dye?
☐ YES (62)

How often?
Every _____ weeks (63)

For how many years did you use a permanent hair dye regularly? _____ (65)
years

At what age did you first use a permanent hair dye? _____ (67)
years of age

☐ NC

ADDITIONAL REMARKS:

THANK YOU. Please return the completed questionnaire in the prepaid envelope to:

FRANK E. SPEIZER, M.D.
HARVARD MEDICAL SCHOOL
180 LONGWOOD AVE.
BOSTON, MASS. 02115