



HARVARD
MEDICAL
SCHOOL

NURSES' HEALTH STUDY II



HARVARD
SCHOOL
of
PUBLIC HEALTH

• Harvard School of Public Health • 677 Huntington Avenue • Boston, Massachusetts 02115 • (617) 432-2279 •

Dear Colleague:

On behalf of our research group, I again want to express my thanks for your participation in the Nurses' Health Study II. We have now finished the processing of the baseline questionnaire that you returned almost two years ago. In total, 116,680 nurses fully completed the forms and thus comprise the population for this important study of lifestyle factors, diet, and oral contraceptive use in relation to breast cancer and other important health issues among women. The accuracy and completeness of the information you provided is truly impressive, and we are confident that this study will provide answers to many critical questions.

The enclosed questionnaire marks the beginning of the follow-up phase of the study. You will note that we ask about your current status for many of the same questions that we posed earlier. We also ask about new medical diagnoses and conditions that have occurred since September, 1989. This date was chosen because the vast majority of participants completed the initial questionnaire during that month or shortly thereafter. We have also included a complete dietary assessment using a questionnaire developed and validated as part of the Nurses' Health Study I. This will provide important information about the effects of diet on medical conditions that occur in later life.

We hope that you give this questionnaire the same attention and care that you did in completing the baseline form. The validity of this major research undertaking depends directly on complete and accurate follow-up information for all study members. We know that some participants are no longer in active nursing. However, the continued participation of all study members is critical regardless of current employment status. As always, the information you provide is strictly confidential and will be used only for medical statistical purposes.

Thank you again for your invaluable participation in this study. We will be sending you the next edition of our newsletter in June of 1992 to update you on the progress of the investigation.

RESEARCH GROUP

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Sincerely,

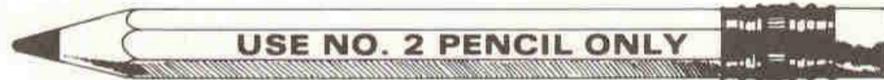
Walter Willett

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

P.S. We would be extremely grateful if you could return the questionnaire within the next 2 weeks; due to federal reductions in research support, our budget for remailings is very limited.

INSTRUCTIONS

Please use an ordinary No. 2 pencil to answer all questions. Fill in the appropriate response circles completely, or write the requested information in the boxes provided. Note that some questions ask for information **since September 1989**, some ask for **current status**, and some ask about events over **longer periods**. The form is designed to be read by optical-scanning equipment, so it is important that you make **NO STRAY MARKS** and keep any write-in responses **within** the spaces provided. Should you need to change a response, erase the incorrect mark completely. If you have comments, please write them on a separate piece of paper.



EXAMPLE 1.

Write your weight in the boxes...

...and fill in the circle corresponding to the figure at the head of each column.

Please fill in the circle completely, do not mark this way:



CURRENT WEIGHT		
POUNDS		
1	4	0
<input type="radio"/> 0	<input type="radio"/> 0	<input checked="" type="radio"/> 0
<input checked="" type="radio"/> 1	<input type="radio"/> 1	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input checked="" type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5	<input type="radio"/> 5	<input type="radio"/> 5
<input type="radio"/> 6	<input type="radio"/> 6	<input type="radio"/> 6
	<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8	<input type="radio"/> 8
<input type="radio"/> 9	<input type="radio"/> 9	<input type="radio"/> 9

EXAMPLE 2:

Keep handwriting within borders of the response box.

What specific brand do you smoke?
(e.g., "Marlboro Lights 100's")

Specify exact brand and type:

MARLBORO LIGHTS 100's

EXAMPLE 3:

Mark "Yes" bubble and Year of Diagnosis bubble for each illness you have had diagnosed.

16. Since **SEPTEMBER 1989** have you had any of these physician-diagnosed illnesses?

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

	YEAR OF DIAGNOSIS		
	BEFORE SEPT 1989	SEPT 89 TO MAY 91	AFTER JUNE 1 1991
Myocardial infarction (heart attack)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angina pectoris	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confirmed by angiography? <input checked="" type="radio"/> No <input type="radio"/> Yes			
Stroke (CVA) or TIA	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you for completing the 1991 Nurses' Health Study II Questionnaire

Please tear off the cover letter (to preserve confidentiality) and return the questionnaire in the enclosed postage paid envelope.

PLEASE USE PENCIL!

1. CURRENT WEIGHT

POUNDS

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
	7	7
	8	8
	9	9

2. What was the natural color of your hair at age 18?

- Red
- Blonde
- Light Brown
- Dark Brown
- Black

3. Do you currently smoke cigarettes?

- Yes → a) How many per day? 1-4 5-14 15-24 25-34 35-44 45 or more
- No

b) What specific brand do you smoke? (e.g., "Marlboro Lights 100's")

Specify exact brand and type:

4. Are you CURRENTLY pregnant?

- Yes
- No

5. Since September 1989, have you been pregnant? (Do not include current pregnancy or those ending before Sept. 1, 1989.)

- Yes → a) Number of pregnancies lasting LESS THAN 6 months Zero 1 2 3 or more
- No
- b) Number of pregnancies lasting 6 months or more Zero 1 2 3
- c) Did you GIVE BIRTH to twins or triplets? No Twins Triplets

6. Have you tried to become pregnant for more than one year without success since September 1989?

Yes → What was the cause? (Mark all that apply.)

- No
- Tubal blockage
- Ovulatory disorder
- Endometriosis
- Cervical mucous factors
- Spouse
- Not investigated
- Not found
- Other

7. Have your menstrual periods ceased PERMANENTLY?

- No: Premenopausal
- Yes: No menstrual periods
- Yes: Had menopause but now have periods induced by hormones
- Not sure

a) Age natural periods ceased?

AGE

0	0
1	1
2	2
3	3
4	4
5	5
6	6
	7
	8
	9

b) For what reason did your periods cease?

- SURGERY: If due to surgery, were your ovaries removed?
 - Yes, both
 - Only uterus removed
 - One only
- RADIATION or CHEMOTHERAPY
- NATURAL: If natural (non-surgical) menopause, have you had subsequent surgery to remove ovaries or uterus?
 - No
 - One ovary removed
 - Uterus removed
 - Both ovaries removed

8. SINCE SEPTEMBER 1989, have you used female replacement hormones (other than oral contraceptives)?

- No
- Past only
- Currently

a) How many months have you used them since September 1989?

- 1-4 mo.
- 5-9
- 10-14
- 15-19
- 20+ months

b) What type of hormone have you used the longest during this period?

- Oral Premarin or other conjugated estrogen alone
- Oral progesterone alone (e.g., Provera)
- Oral conjugated estrogen and progesterone (e.g. Provera)
- Vaginal estrogen
- Patch estrogen alone
- Other → Please specify other hormone:
- Patch estrogen and progesterone (e.g. non-conjugated estrogen)

c) If this was oral conjugated estrogen (e.g. Premarin) what dose did you usually take?

- Not used
- Dose unknown
- .30 mg/day or less
- .625 mg/day
- .9 mg/day or more

d) Dose of progesterone (if taken)?

- Not used
- Dose unknown
- < 5 mg
- 5-9 mg
- 10 mg
- More than 10 mg

9. Do you CURRENTLY use any of these forms of contraception? (Mark all that apply.)

- None
- Oral contraceptive
- Norplant
- Diaphragm/Cervical cap
- Tubal ligation
- Foam or jelly
- Condom
- Intrauterine device
- Rhythm/NFP
- Vasectomy
- Sponge
- Other

10. Have you EVER used oral contraceptives (OC's) for 2 months or more for any reason (contraception, acne, etc.)?

- Yes
- No: Go to Question 12

0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9

11. SINCE SEPTEMBER 1989, have you used oral contraceptives?

- Yes → a) How many months have you used OC's since September 1989?
 - 1 or less months
 - 2-4
 - 5-9
 - 10-14
 - 15-19
 - 20 or more months
- No

b) Please indicate the brand and type of OC used longest during this time period. Refer to the OC Brand Code Sheet enclosed with this questionnaire and write the code in this box.

Specify brand and type of OC used longest during this time period.

12. Since September 1989, 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 mo.
- 5-9
- 10-14
- 15-19
- 20+ months

13. How many times per week do you engage in physical activity long enough to perspire heavily (including swimming)?

- Less than once/week
- Once/week
- 2-3 times/week
- 4-6 times/week
- 7 or more times/week

14. How many FLIGHTS of stairs (not individual steps) do you climb daily?

- 2 flights or less
- 3-4
- 5-9
- 10-14
- 15 or more flights

15. Is this your correct date of birth? →

Yes No →

If no, please write correct date.

MONTH / DAY / YEAR

16. Since **SEPTEMBER 1989** have you had any of these physician-diagnosed illnesses?

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

	YEAR OF DIAGNOSIS		
	BEFORE SEPT 1989	SEPT 89 TO MAY 91	AFTER JUNE 1 1991
Myocardial infarction (heart attack) <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angina pectoris <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confirmed by angiography? <input checked="" type="radio"/> No <input type="radio"/> Yes			
Stroke (CVA) or TIA <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Melanoma <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Basal cell skin cancer <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Squamous cell skin cancer <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fibrocystic/other benign breast dis. <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confirmed by breast biopsy? <input checked="" type="radio"/> No <input type="radio"/> Yes			
Confirmed by aspiration? <input checked="" type="radio"/> No <input type="radio"/> Yes			
Breast cancer <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other cancer: <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify site of other cancer →			
High blood pressure (excluding during pregnancy) <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes: Gestational <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes: Not pregnancy-related <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elevated cholesterol <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deep vein thrombosis/Pul. embolism <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatoid arthritis, doctor diagnosed <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatoid factor <input type="radio"/> Negative/Unknown <input type="radio"/> Positive			
Other arthritis <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon or rectal polyp (benign) <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cholecystectomy <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gastric or duodenal ulcer <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gall stones <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a) Did you have symptoms? <input checked="" type="radio"/> No <input type="radio"/> Yes			
b) How diagnosed? <input type="radio"/> X-ray or <input type="radio"/> Other ultrasound			
Toxemia/Pre-eclampsia of pregnancy (raised blood pressure and proteinuria) <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other major illness or surgery since Sept. 1989 <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Please specify other major illness or surgery:			

1	1	1	1	1	1	1	1	2	3	4	
2	2	2	2	2	2	2	2	5	6	7	8
4	4	4	4	4	4	4	4	9	10	11	12
8	8	8	8	8	8	8	8	91	92	93	
P	P	P	P	P	P	P	P	A	B	C	D

← THIS IS YOUR ID

17. Have you **EVER** had any of these physician-diagnosed illnesses?

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

	YEAR OF DIAGNOSIS		
	BEFORE SEPT 1989	SEPT 89 TO MAY 91	AFTER JUNE 1 1991
Vaginal yeast infection <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney stones <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urinary tract infection <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pneumonia <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hirsutism (excess facial hair) <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Multiple sclerosis-1st Dx <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hydatidiform mole (of preg.) <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma-1st Physician Dx <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcerative colitis/Crohn's <input checked="" type="radio"/> Y <input type="radio"/> N	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. In how many months did you practice breast self-examination in the past year?

None One 2-3 4-6 7-11 12

19. Since September 1989, have you had:

	NO	YES, FOR SCREENING	YES, FOR SYMPTOMS
Mammogram <input checked="" type="radio"/> N <input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast exam by clinician <input checked="" type="radio"/> N <input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colonoscopy/Sigmoidoscopy <input checked="" type="radio"/> N <input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. Mark if you use: Insulin Oral Hypoglycemic

21. Regarding **YOUR** infancy:

a) Were you breast fed?

Yes → Number of months?
 No Unknown 3 or less
 Don't know 4-8 months 9+ months

b) Your birthweight in pounds: Unknown

< 5.5 lbs. 5.5-6.9 7-8.4 8.5-9.9 10+ lbs.

c) Were you:

Full-term 2+ weeks premature Multiple birth

22. 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: _____

GO TO QUESTION 17

23. 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 or hiking outdoors (include walking to work)	<input type="radio"/>									
Jogging (slower than 10 minutes/mile)	<input type="radio"/>									
Running (10 minutes/mile or faster)	<input type="radio"/>									
Bicycling (include stationary machine)	<input type="radio"/>									
Calisthenics/Aerobics/Aerobic Dance/Rowing Machine	<input type="radio"/>									
Tennis, Squash, Racquetball	<input type="radio"/>									
Lap Swimming	<input type="radio"/>									
Other aerobic recreation (e.g., lawn mowing)	<input type="radio"/>									

24. On average, how many **HOURS PER WEEK** do you spend:

	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)	<input type="radio"/>								
Standing or walking around at home? (hrs./week)	<input type="radio"/>								
Sitting at work or away from home or while driving? (hrs./week)	<input type="radio"/>								
Sitting at home while watching TV/VCR? (hrs./week)	<input type="radio"/>								
Other sitting at home (e.g., reading, meal times, at desk)? (hrs./week)	<input type="radio"/>								

PLEASE GO TO PAGE 3 AND BEGIN BY WRITING YOUR ID NUMBER.

Please copy your ID from page 2 to here.

ID: -

4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9				
0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9

25. Do you currently take multi-vitamins? (Please report other individual vitamins in question 26.)

- No Yes → If YES, a) How many do you take per week?
 2 or less 3 - 5 6 - 9 10 or more
 b) What specific brand do you usually use? → Specify exact brand and type

26. Not counting multi-vitamins, do you take any of the following preparations:

- a) Vitamin A? No Yes, seasonal only Yes, most months → If YES, { How many years? 0-1 yr. 2-4 years 5-9 years 10+ years Don't know
 What dose per day? Less than 8,000 IU 8,000 to 12,000 IU 13,000 to 22,000 IU 23,000 IU or more Don't know
- b) Vitamin C? No Yes, seasonal only Yes, most months → If YES, { How many years? 0-1 yr. 2-4 years 5-9 years 10+ years Don't know
 What dose per day? Less than 400 mg. 400 to 700 mg. 750 to 1250 mg. 1300 mg. or more Don't know
- c) Vitamin E? No Yes → If YES, { How many years? 0-1 yr. 2-4 years 5-9 years 10+ years Don't know
 What dose per day? Less than 100 IU 100 to 250 IU 300 to 500 IU 600 IU or more Don't know
- d) Vitamin B₆? No Yes → If YES, { How many years? 0-1 yr. 2-4 years 5-9 years 10+ years Don't know
 What dose per day? Less than 10 mg. 10 to 39 mg. 40 to 79 mg. 80 mg. or more Don't know
- e) Selenium? No Yes → If YES, { How many years? 0-1 yr. 2-4 years 5-9 years 10+ years Don't know
 What dose per day? Less than 80 mcg. 80 to 130 mcg. 140 to 250 mcg. 260 mcg. or more Don't know
- f) Iron No Yes → If YES, { How many years? 0-1 yr. 2-4 years 5-9 years 10+ years Don't know
 What dose per day? Less than 51 mg. 51 to 200 mg. 201 to 400 mg. 401 mg. or more Don't know
- g) Zinc No Yes → If YES, { How many years? 0-1 yr. 2-4 years 5-9 years 10+ years Don't know
 What dose per day? Less than 25 mg. 25 to 74 mg. 75 to 100 mg. 101 mg. or more Don't know
- h) Calcium (include Calcium in Dolomite and Tums, etc.) No Yes → If YES, { How many years? 0-1 yr. 2-4 years 5-9 years 10+ years Don't know
 What dose per day? Less than 400 mg. 400 to 900 mg. 901 to 1300 mg. 1301 mg. or more Don't know
- i) Are there other supplements that you take on a regular basis?
 Vitamin D Cod liver oil Fish oil Niacin Beta-carotene Other (please specify)
 B-Complex vitamins Folic acid Brewer's yeast Iodine Magnesium

27. For each food listed, fill in the circle indicating how often on average you have used the amount specified during the past year.

	AVERAGE USE LAST YEAR								
	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MONTH	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
DAIRY FOODS									
Skim or low fat milk (8 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Whole milk (8 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cream, e.g. coffee, whipped (Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Sour cream (Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Non-dairy coffee whitener (tsp.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Sherbet, ice milk or frozen yogurt (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Ice cream (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Yogurt (1 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cottage or ricotta cheese (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cream cheese (1 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Other cheese, e.g. American, cheddar, etc., plain or as part of a dish (1 slice or 1 oz. serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Margarine (pat), added to food or bread; exclude use in cooking	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Butter (pat), added to food or bread; exclude use in cooking	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

PLEASE TURN TO PAGE 4

a) What form of margarine do you usually use? →
 None Form? Stick Tub Squeeze (liquid)
 Type? Regular Light Extra Light

What specific brand and type (e.g., Parkay Corn Oil Spread)?

27. (Continued) Please fill in your **average use, during the past year**, of each specified food.

Please try to average your seasonal use of foods over the entire year. For example, if a food such as cantaloupe is eaten 4 times a week during the approximate 3 months that it is in season, then the **average use** would be once per week.

	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MONTH	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
FRUITS									
Raisins (1 oz. or small pack) or grapes	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Prunes (7 prunes or 1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Bananas (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cantaloupe (1/4 melon)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Avocado (1/2 fruit or 1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Fresh apples or pears (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Apple juice or cider (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Oranges (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Orange juice (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Grapefruit (1/2)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Grapefruit juice (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Other fruit juices (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Strawberries, fresh, frozen or canned (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Blueberries, fresh, frozen or canned (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Peaches, apricots or plums (1 fresh, or 1/2 cup canned)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MONTH	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
VEGETABLES									
Tomatoes (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Tomato juice, V8 (small glass)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Tomato sauce (1/2 cup) e.g. spaghetti sauce	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Red chili sauce (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Tofu or soybeans (3-4 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
String beans (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Broccoli (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cabbage or cole slaw (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Cauliflower (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Brussels sprouts (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Carrots, raw (1/2 carrot or 2-4 sticks)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Carrots, cooked (1/2 cup) or carrot juice (2-3 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Beets - not greens (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Corn (1 ear or 1/2 cup frozen or canned)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Peas or lima beans (1/2 cup fresh, frozen, canned)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Mixed vegetables (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Beans or lentils, baked or dried (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Dark orange (winter) squash (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Eggplant, zucchini or other summer squash (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Yams or sweet potatoes (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Spinach, cooked (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Spinach, raw as in salad (serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Kale, mustard or chard greens (1/2 cup)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Iceberg or head lettuce (serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Romaine or leaf lettuce (serving)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Celery (4" stick)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Green peppers (3 slices or 1/4 pepper)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Onions as a garnish, or in salad (1 slice)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Onions as a vegetable, rings or soup (1 onion)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MONTH	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
EGGS, MEAT, ETC.									
Eggs (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Chicken with skin (4-6 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Chicken without skin (4-6 oz.)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Turkey, including ground (4-6 oz. or 2 Turkey dogs)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Hot dogs (1)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					
Bacon (2 slices)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>					

27. (Continued) Please fill in your **average use, during the past year,** of each specified food.

EGGS, MEAT, ETC. (continued)		NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MONTH	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
Processed meats, e.g. sausage, salami, bologna, etc. (piece or slice)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hamburger (1 patty)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beef, pork, or lamb as a sandwich or mixed dish, e.g. stew, casserole, lasagna, etc.		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pork as a main dish, e.g. ham or chops (4-6 oz.)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beef or lamb as a main dish, e.g. steak, roast (4-6 oz.)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Canned tuna fish (3-4 oz.)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dark meat fish, e.g. mackerel, salmon, sardines, bluefish, swordfish (3-5 oz.)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other fish (3-5 oz.)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shrimp, lobster, scallops as a main dish		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BREADS, CEREALS, STARCHES		NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MONTH	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
Cold breakfast cereal (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cooked oatmeal/cooked oat bran (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other cooked breakfast cereal (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White bread (slice), including pita bread		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dark bread (slice), including wheat pita bread		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
English muffins, bagels, or rolls (1)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muffins or biscuits (1)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brown rice (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White rice (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasta, e.g. spaghetti, noodles, etc. (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tortillas (1)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other grains, e.g. bulgur, kasha, couscous, etc. (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pancakes or waffles (serving)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
French fried potatoes (4 oz.)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Potatoes, baked, boiled (1) or mashed (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Potato chips or corn chips (small bag or 1 oz.)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crackers, Triscuits, Wheat Thins (5)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pizza (2 slices)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BEVERAGES		NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MONTH	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY
CARBONATED BEVERAGES	LOW-CALORIE (sugar free) TYPES	Low-calorie cola, e.g. Diet Coke with caffeine		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Low-calorie caffeine-free cola		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Other low-calorie carbonated beverage, e.g. Fresca, Diet 7-Up, diet ginger ale		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
	REGULAR TYPES (not sugar-free)		Coke, Pepsi, or other cola with sugar		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Caffeine Free Coke, Pepsi, or other cola with sugar		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Other carbonated beverage with sugar, e.g. 7-Up		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
OTHER BEVERAGES		Hawaiian Punch, lemonade, or other non-carbonated fruit drinks (1 glass, bottle, can)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Regular Beer (1 glass, bottle, can)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Light Beer, e.g., Bud Light (1 glass, bottle, can)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Red wine (4 oz. glass)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		White wine (4 oz. glass)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Liquor, e.g. whiskey, gin, etc. (1 drink or shot)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Plain water, bottled or tap (1 cup or glass)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Tea (1 cup), not herbal tea		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Decaffeinated coffee (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
		Coffee with caffeine (1 cup)		<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

27b. Usual method of preparing coffee } Decaffeinated: Mainly filtered Mainly instant Mainly espresso or perc. No usual method/don't know/don't use
 Caffeinated: Mainly filtered Mainly instant Mainly espresso or perc. No usual method/don't know/don't use

27. (Continued) Please fill in your **average use, during the past year**, of each specified food.

	NEVER OR LESS THAN ONCE PER MONTH	1-3 PER MONTH	1 PER WEEK	2-4 PER WEEK	5-6 PER WEEK	1 PER DAY	2-3 PER DAY	4-5 PER DAY	6+ PER DAY	P
SWEETS, BAKED GOODS, MISC.										
Chocolate (bar or packet) e.g. Hershey's, M & M's	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Candy bars, e.g. Snickers, Milky Way, Reeses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Candy without chocolate (1 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cookies, home baked (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cookies, ready made (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brownies (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doughnuts (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cake, home baked (slice)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cake, ready made (slice)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pie, homemade (slice)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pie, ready made (slice)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sweet roll, coffee cake or other pastry, home baked (serving)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sweet roll, coffee cake or other pastry, ready made (serving)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jams, jellies, preserves, syrup, or honey (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peanut butter (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Popcorn (1 cup)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peanuts (small packet or 1 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other nuts (small packet or 1 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oat bran, added to food (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other bran, added to food (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheat germ (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chowder or cream soup (1 cup)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Olive oil salad dressings (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other oil and vinegar dressing, e.g. Italian (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mayonnaise or other creamy salad dressing (1 Tbs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salt added at table (1 shake)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Garlic (1 clove or 4 shakes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

28. Liver: beef, calf or pork (4 oz.) Never Less than 1/mo. 1/mo. 2-3 mo. 1/week or more
- Liver: chicken or turkey (1 oz.) Never Less than 1/mo. 1/mo. 2-3 mo. 1/week or more
29. Which **cold** breakfast cereal do you usually eat? Don't eat cold breakfast cereal
- Specify brand and type (e.g. Kellogg's Nutrigrain Nuggets)
30. How many teaspoons of sugar do you add to your beverages or food each day? 0 1 2 3 4 5 6 7 8 9
31. When you have beef or lamb as a main dish, how well done is the meat cooked?
 Rare Medium rare Medium Medium well Well Don't know/not eaten
32. How often do you eat meat that was charred during cooking? (e.g. during barbecuing or broiling)
 Never Less than 1/mo. 1/mo. 2-3/mo. 1/week 2+/week
33. How much of the visible fat on your beef, pork or lamb do you remove before eating?
 Remove all visible fat Remove most Remove small part of fat Remove none Don't eat meat
34. What kind of fat do you usually use for frying and sautéing at home? (Exclude "Pam"-type spray)
 Real butter Margarine Vegetable oil Vegetable shortening Lard
35. What kind of fat do you usually use for baking at home?
 Real butter Margarine Vegetable oil Vegetable shortening Lard
36. How often do you eat food that is fried at home? (Exclude "Pam"-type spray)
 Less than once a week 1-3 times per week 4-6 times per week Daily
37. How often do you eat fried food away from home? (e.g. french fries, fried chicken, fried fish)
 Less than once a week 1-3 times per week 4-6 times per week Daily
38. What type of cooking oil do you usually use at home (e.g. Mazola Corn Oil)? Specify brand and type
39. How does your current diet compare to your usual diet over the past five years?
 Almost the same Slightly changed Moderately changed Greatly changed

THANK YOU! Please return the questionnaire in the enclosed postage-paid envelope to: **Walter Willett, M.D.** 677 Huntington Avenue
Nurses' Health Study II Boston, MA 02115