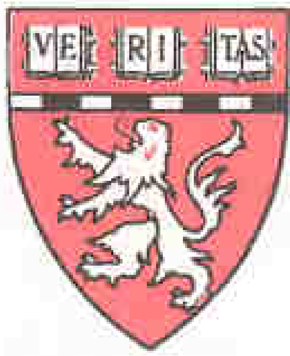
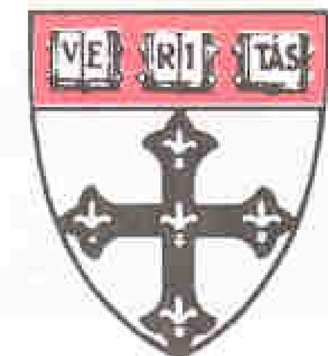


HARVARD
MEDICAL
SCHOOL

Nurses' Health Study II



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PUBLIC HEALTH

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Dear Colleague:

Many thanks for your participation in the Nurses' Health Study II. The enclosed **brief** questionnaire continues our every-other-year follow-up.

The validity of this major research undertaking depends directly on complete and accurate follow-up information for all study members. Your continued participation is critical whether or not you are currently active in nursing. As always, the information you provide is strictly confidential and will be used only for medical statistical purposes.

We understand how busy you are; however, we would be **extremely** grateful if we could receive your reply to this questionnaire in the next two weeks. Thank you again for your valuable participation in this study.

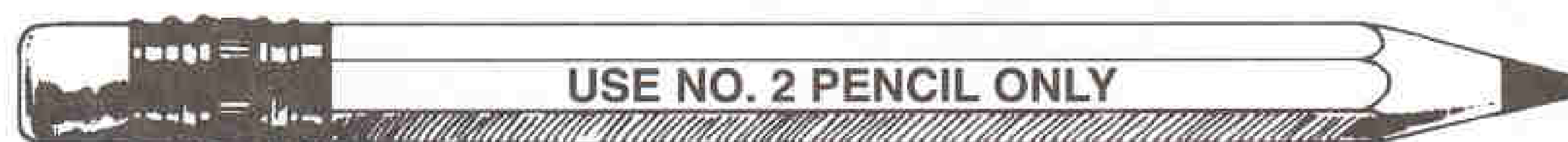
Sincerely,

Walter Willett

Professor of Epidemiology,
Nutrition, and Medicine

INSTRUCTIONS

Please use an ordinary No. 2 pencil to fill in the appropriate response circles completely, or write the requested information in the boxes provided. Note that some questions ask for information **since June 1993,** 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 make **NO STRAY MARKS** and keep write-in responses **within** the spaces provided. If you change a response, erase the incorrect mark completely, and write any comments on a separate page.



EXAMPLE 1:

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

11. **Since June 1993, have you had any of these physician-diagnosed illnesses?**

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

	Yes	YEAR OF DIAGNOSIS: BEFORE JUNE 1 1993	JUNE 93 TO MAY 95	AFTER JUNE 1 1995
Elevated cholesterol	●	○	○	●
Melanoma	Ⓨ	○	○	○
Basal cell skin cancer	●	○	●	○

EXAMPLE 2:

Keep handwriting within the borders of the response box.

	Yes	YEAR OF DIAGNOSIS: BEFORE JUNE 1 1993	JUNE 93 TO MAY 95	AFTER JUNE 1 1995	
Other major illness or surgery since June 1993:	Ⓨ	○	○	○	Please specify: APPENDICITIS W/APPENDECTOMY

Thank you for completing the 1995 Nurses' Health Study II Short Form.

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

If you need to make changes or corrections to your name/address, please note them on the cover letter and enclose it with your completed questionnaire.

1. What is your current weight? ➡ lbs.

2. Do you currently smoke cigarettes?
◯ No
◯ Yes ➡ How many cigarettes per day? ◯ 1–4 ◯ 5–14 ◯ 15–24 ◯ 25–34 ◯ 35–44 ◯ 45+

3. Do you CURRENTLY use any of these forms of contraception? (Mark all that apply.)
◯ None ◯ Tubal ligation ◯ Foam/Jelly/Sponge ◯ Condom ◯ Depo-Provera ◯ Norplant
◯ Vasectomy ◯ Oral contraceptive ◯ Intrauterine device ◯ Rhythm/NFP ◯ Diaphragm/Cervical cap ◯ Other

4. SINCE JUNE 1993, have you used oral contraceptives (OC's)?
◯ Yes ➡ a. How many months did you use OC's during the 24-month period between June 1993 and June 1995?
◯ 1 month or less ◯ 2–4 ◯ 5–9 ◯ 10–14 ◯ 15–19 ◯ 20–24 months
◯ No
b. How many months did you use OC's during the period between June 1995 and the present?
◯ 1 month or less ◯ 2–4 ◯ 5–9 ◯ 10–14 ◯ 15–19 ◯ 20+ months

5. SINCE JUNE 1993, have you been pregnant?
◯ No – go to question 6 ◯ Yes
a. Are you currently pregnant?
◯ No ◯ Yes–Continue with part b, but do NOT fill in a bubble in part b for your current pregnancy.
b. For each pregnancy *ending* after JUNE 1, 1993, fill in a response bubble for the year during which each pregnancy *ended*.

Calendar Year	Pregnancies lasting 6 months or more		Pregnancies lasting less than 6 months	
	Single Births	Twins/Triplets	Miscarriages	Induced Abortions
6/1/93–12/31/93	◯	◯	◯	◯
1994	◯	◯	◯	◯
1995	◯	◯	◯	◯
1996+	◯	◯	◯	◯

6. SINCE JUNE 1993, have you tried to become pregnant for more than one year without success?
◯ Yes ➡ What was the cause? (Mark all that apply.) ◯ Tubal blockage ◯ Ovulatory disorder ◯ Endometriosis ◯ Cervical mucous factors ◯ Spouse/Partner ◯ Not investigated ◯ Not found ◯ Other
◯ No

7. SINCE JUNE 1993, have you taken Clomid (Clomiphene) or Pergonal/Metrodin to induce ovulation?
◯ Yes ➡ a. In how many months was Clomid used: ◯ 0 months ◯ 1 ◯ 2–3 ◯ 4–5 ◯ 6–11 ◯ 12+ months
◯ No b. In how many months was Pergonal/Metrodin used: ◯ 0 months ◯ 1 ◯ 2–3 ◯ 4–5 ◯ 6–11 ◯ 12+ months

8. Have your menstrual periods ceased PERMANENTLY?
◯ No: Premenopausal
◯ Yes: No menstrual periods ➡ a. AGE natural periods ceased: AGE ➡ b. For what reason did your periods cease?
◯ Yes: Had menopause but now have periods induced by hormones
◯ Not sure
◯ Natural
◯ Surgical
◯ Radiation or chemotherapy

9. Have you EVER had surgery to remove your uterus or ovaries? (Mark all that apply.)
◯ No ◯ Uterus removed ◯ Both ovaries removed ◯ One ovary removed

10. SINCE JUNE 1993, have you used female replacement hormones (other than oral contraceptives)?
◯ No ➡ Please continue with the questions on the back of this form
◯ Yes, currently ➡ What type of hormone did you use?
◯ Yes, but not currently ➡ ◯ Estrogen only ◯ Estrogen and progesterone ◯ Other Specify type:

Please continue on the back of this form ➡

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11. Since June 1993, have you had any of these physician-diagnosed illnesses?

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

Illness	Yes	YEAR OF DIAGNOSIS: BEFORE JUNE 1 1993	JUNE 93 TO MAY 95	AFTER JUNE 1 1995	
Myocardial infarction (heart attack)	Ⓨ	◯	◯	◯	
Angina pectoris	Ⓨ	◯	◯	◯	Confirmed by angiogram? ◯ No ◯ Yes
Coronary bypass/angioplasty	Ⓨ	◯	◯	◯	
Stroke (CVA) or TIA	Ⓨ	◯	◯	◯	
Deep vein thrombosis/Pul. embolism	Ⓨ	◯	◯	◯	
Elevated cholesterol	Ⓨ	◯	◯	◯	
Melanoma	Ⓨ	◯	◯	◯	
Basal cell skin cancer	Ⓨ	◯	◯	◯	
Squamous cell skin cancer	Ⓨ	◯	◯	◯	
Fibrocystic/other benign breast disease	Ⓨ	◯	◯	◯	Confirmed by breast biopsy? ◯ No ◯ Yes Confirmed by aspiration? ◯ No ◯ Yes
Breast cancer	Ⓨ	◯	◯	◯	
Other cancer	Ⓨ	◯	◯	◯	Specify site:
Colon or rectal polyp (benign)	Ⓨ	◯	◯	◯	
Ulcerative colitis/Crohn's disease	Ⓨ	◯	◯	◯	
Gastric or duodenal ulcer	Ⓨ	◯	◯	◯	
Gallstones	Ⓨ	◯	◯	◯	Did you have symptoms? ◯ No ◯ Yes How diagnosed? ◯ X-ray or ultrasound ◯ Other
Cholecystectomy	Ⓨ	◯	◯	◯	
High blood pressure (not pregnancy-related)	Ⓨ	◯	◯	◯	
Pregnancy-related high blood pressure	Ⓨ	◯	◯	◯	
Toxemia/Pre-eclampsia of pregnancy	Ⓨ	◯	◯	◯	
Diabetes: Not pregnancy-related	Ⓨ	◯	◯	◯	
Diabetes: Gestational	Ⓨ	◯	◯	◯	
Hydatidiform mole of pregnancy	Ⓨ	◯	◯	◯	
Ectopic pregnancy	Ⓨ	◯	◯	◯	
Endometriosis, 1st diagnosis	Ⓨ	◯	◯	◯	Confirmed by laparoscopy or hysterectomy? ◯ No ◯ Yes
Uterine fibroids, 1st diagnosis	Ⓨ	◯	◯	◯	Confirmed by pelvic exam? ◯ No ◯ Yes Confirmed by ultrasound or hysterectomy? ◯ No ◯ Yes
Premenstrual syndrome (PMS)	Ⓨ	◯	◯	◯	
Kidney stones	Ⓨ	◯	◯	◯	
Multiple sclerosis	Ⓨ	◯	◯	◯	
Asthma, physician-diagnosed	Ⓨ	◯	◯	◯	
Migraine headaches	Ⓨ	◯	◯	◯	
Active TB (X-ray or culture confirmed)	Ⓨ	◯	◯	◯	
Graves' Disease/Hyperthyroidism	Ⓨ	◯	◯	◯	
Hypothyroidism	Ⓨ	◯	◯	◯	
Thyroid nodule (benign)	Ⓨ	◯	◯	◯	
Other major illness or surgery since June 1993:	Ⓨ	◯	◯	◯	Please specify:

12. Is this your correct date of birth? ◯ Yes ◯ No → If no, please write correct date. Month / Day / Year

13. 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:

THANK YOU! PLEASE RETURN THIS QUESTIONNAIRE IN THE ENCLOSED POSTAGE-PAID ENVELOPE TO: DR. WALTER WILLETT, NURSES' HEALTH STUDY II, 677 HUNTINGTON AVENUE, BOSTON, MA 02115