



HARVARD
MEDICAL
SCHOOL

NURSES' HEALTH STUDY II



HARVARD
SCHOOL of
PUBLIC HEALTH

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This is your ID →

Dear Colleague:

The attached Nurses' Health Study II "short form" continues our follow-up of the information which you first provided in 1989. We have made this questionnaire as brief as possible, knowing how busy your life can be. We would be **extremely** grateful to receive your completed survey in the next few weeks.

We are excited to offer you the choice of completing either an on-line questionnaire or the attached traditional form. The on-line questionnaire is available at www.NHS2.org and can be accessed with your ID number shown above. We hope that this option will make participating in the study more convenient.

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. The questionnaire is being sent to each of the 116,671 members of NHS II and should take about 10 minutes to complete.

It is with our deepest gratitude that we thank you again for the time and care that you have continued to offer in furthering the study of women's health.

Sincerely,

Walter Willett

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

P.S. Your prompt reply helps avoid additional mailings.

Do you have internet 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 II. Example: **NHS2@channing.harvard.edu**

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!

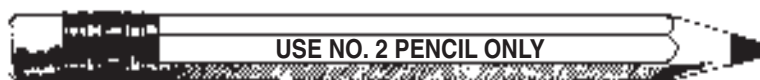
INSTRUCTIONS

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. Follow the instructions on the screen to complete the survey on-line.

PAPER FORM:

Please use an ordinary No. 2 pencil to answer all questions. Fill in the appropriate response circles completely. The form is designed to be read by optical-scanning equipment, so it is important that you keep any write-in responses **within** the spaces provided and erase any incorrect marks completely. If you have comments, please write them on a separate piece of paper.



EXAMPLE:

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

11. Since June 2001, have you had any of these physician-diagnosed illnesses?

Leave blank for NO, mark here for YES →

	YEAR OF DIAGNOSIS			X
	Before June 1 2001	June '01 to May '03	After June 1 2003	
Myocardial infarction (heart attack)	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	1
Angina pectoris	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	2
Confirmed by angiography?	<input type="radio"/> No	<input checked="" type="radio"/> Yes		a
Coronary bypass/angioplasty	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	3
Stroke (CVA) or TIA	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	4

Please fill in the circles completely; do not mark this way:

- Please tear off the cover letter (to preserve confidentiality) and return the questionnaire in the enclosed postage-paid envelope.
- If your name and address as printed on this questionnaire 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.
- Thank you for completing the 2003 Nurses' Health Study II Questionnaire.

Federal research regulations require us to include the following information:

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. 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 Harvard School of Public Health (617-384-5480).

1. What is your current weight? →

lbs.

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

2. Do you currently smoke cigarettes?

No

Yes →

How many cigarettes per day?

1-4

5-14

15-24

25-34

35-44

45+

1	6	03	A
2	7	04	B
3	8	05	C
4	9	11	
5	10	12	E

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

None

Tubal ligation

Foam/Jelly/Sponge

Condom

Ortho Evra Patch

Depo-Provera

Nuva Ring

Vasectomy

Oral contraceptive

Intrauterine device

Rhythm/NFP

Diaphragm/Cervical cap

Other

4. SINCE JUNE 2001, have you used oral contraceptives (OC's)?

Yes →

No

a. How many months did you use OC's since June 2001?

1 month or less

2-4

5-9

10-14

15-19

20-25

26-30

31-35

36+ months

b. Please indicate the brand and type of OC you have used the longest during this time period (e.g., Ortho-Novum 1/50).

Specify brand and type:

5. SINCE JUNE 2001, have you been pregnant?

Yes →

No

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, 2001, 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/Triples	Miscarriages	Induced Abortions
6/1/01-12/31/2001	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2002	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2003	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2004+	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. Have your menstrual periods ceased PERMANENTLY?

No: Premenopausal

Yes: No menstrual periods

Yes: Had menopause but now have periods induced by hormones

Not sure (e.g., started hormones prior to cessation of periods)

a. AGE natural periods ceased:

AGE

b. For what reason did your periods cease?

Natural

Surgical

Radiation or chemotherapy

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

7. Have you EVER had surgery to remove your uterus or ovaries? (Mark all that apply.)

No

Uterus removed

Both ovaries removed

One ovary removed

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

8. Are you currently using any over-the-counter (e.g., "herbal," "natural" or soy based) preparations for hormone replacement or to treat post-menopausal symptoms? (Do NOT include food sources like tofu, soy milk, etc.)

No

Yes → What type(s)?

Soy estrogen products

Natural progesterone cream or wild yam cream

Other

9. SINCE JUNE 2001, have you used Evista (raloxifene) or tamoxifen (Nolvadex)?

No

Yes → Are you currently using Evista or tamoxifen?

No, not currently

Yes, Evista

Yes, tamoxifen

10. SINCE JUNE 2001, 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?

Estrogen only

Estrogen and progesterone

Other

Specify type:

Yes, but not currently

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

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
Beer, regular (1 glass, bottle, can)	<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"/>
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 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 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 checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liquor, e.g., vodka, gin, etc. (1 drink or shot)	<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"/>

Please continue on the back of this form



1	1	1	1	1	1	1
2	2	2	2	2	2	2
4	4	4	4	4	4	4
8	8	8	8	8	8	8
P	P	P	P	P	P	P

12. Since June 2001, have you had any of these physician-diagnosed illnesses?

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

YEAR OF DIAGNOSIS

BEFORE JUNE 1 2001 JUNE '01 TO MAY 2003 AFTER JUNE 1 2003

Myocardial infarction (heart attack)	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Angina pectoris	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Confirmed by angiography? <input type="radio"/> No <input type="radio"/> Yes
Coronary bypass/angioplasty	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Stroke (CVA) or TIA	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Deep vein thrombosis/Pul. embolism	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Melanoma	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Basal cell skin cancer	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Squamous cell skin cancer	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fibrocystic/other benign breast disease	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Confirmed by breast biopsy? <input type="radio"/> No <input type="radio"/> Yes Confirmed by aspiration? <input type="radio"/> No <input type="radio"/> Yes
Breast cancer	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other cancer	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Specify site and date of diagnosis:
Colon or rectal polyp (benign)	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Ulcerative colitis/Crohn's disease	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Gastric or duodenal ulcer	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Barrett's Esophagus	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Gallstones	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Did you have symptoms? <input type="radio"/> No <input type="radio"/> Yes How diagnosed? <input type="radio"/> X-ray or ultrasound <input type="radio"/> Other
Cholecystectomy	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Elevated Cholesterol	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
High blood pressure	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Endometriosis, 1st diagnosis	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Confirmed by laparoscopy? <input type="radio"/> No <input type="radio"/> Yes
Uterine fibroids, 1st diagnosis	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Confirmed by pelvic exam? <input type="radio"/> No <input type="radio"/> Yes Confirmed by ultrasound or hysterectomy? <input type="radio"/> No <input type="radio"/> Yes
Premenstrual syndrome (PMS)	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Kidney stones	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Multiple sclerosis	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Asthma, doctor diagnosed	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Emphysema/Chronic Bronchitis DrDx	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Pneumonia, x-ray confirmed	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Graves' Disease/Hyperthyroidism	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hypothyroidism	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Thyroid nodule (benign)	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Gout	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
SLE (systemic lupus)	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Rheumatoid arthritis, doctor diagnosed	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rheumatoid factor <input type="radio"/> negative/unknown <input type="radio"/> positive
Other arthritis	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Depression, clinician Dx	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other major illness or surgery since June 2001:	<input type="radio"/> Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Please specify: _____ Date: _____

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

13. Is this your correct date of birth?

Yes No If no, please write correct date.

Month	Day	Year
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14. Do you currently take multi-vitamins? Yes No

15. 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: _____