WINDOW AREA

Channing Laboratory
181 Longwood Avenue
Boston, MA 02115-5804
(617) 525-2279
Fax (617) 525-2008
www.NursesHealthStudy.org

Dear Colleague:

In the summer of 1976 you and 121,700 other registered nurses embarked on a remarkable journey to expand our understanding of the health of women. Twenty-eight years later, the fruits of our collaboration are bountiful. Hundreds of scientific papers have been published and, as a result, many of the facts that people take for granted about health and diet have come from the Nurses' Health Study. We humbly thank you for making this possible through your dedication, enthusiasm and loyal participation.

The attached questionnaire was designed to be easier to read and complete. We have increased the size of the print and made it generally less "crowded." We have NOT increased the number of questions. Please be assured that this booklet contains the same number of questions as our standard six-page survey. Your prompt reply is most helpful.

We value **each** member of the Nurses' Health Study as a colleague in our research, regardless of your retirement or employment status. Also, 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 need to hear from you!**

Your continued participation by documenting your lifestyle is fundamental to the validity of the study. It is with our deepest gratitude that we thank you again for the time and care that you have continued to offer to help us all learn more about women's health.

Best Regards,

Graham A. Colditz, MD, DrPH
Principal Investigator

Frank E. Speizer, MD
Founding Principal Investigator

Do you have an e-mail address?
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, ∅ vs O, 5 vs S)

We will not release your e-mail address to anyone!

Do we have your correct address and name?

Make any necessary changes and return this page with your completed booklet.

3/8" spine perf

INSTRUCTIONS

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.

WINDOW AREA

Please fill in the circles completely. **Do not mark this way:** ✓ ✗ ◒

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

20. Since June 2002, have you had any of these clinician-diagnosed illnesses?

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

	YEAR OF DIAGNOSIS: BEFORE JUNE 1 2002	JUNE '02 TO MAY 2004	AFTER JUNE 1 2004
Fibrocystic/other benign breast disease	●	○	○
Confirmed by breast biopsy? (N) No ● Yes			
Breast cancer	○	●	○
Cancer of the uterus (endometrium) (Y)	○	○	○

20 — 1 — a — 2 — 3

- **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 2004 Nurses' Health Study 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.
Although complete information is important to the study, 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 Brigham and Women's Hospital (617-525-3170).

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1. Is this your correct Date of Birth?

○ Yes

○ No → **If No, Please write correct date.**

MONTH / DAY / YEAR

2. What is your current weight?

POUNDS

3. What is the difference between your highest and lowest weight during the last 2 years?

○ No change ○ 2–4 lbs. ○ 5–9 lbs. ○ 10–14 lbs. ○ 15–29 lbs. ○ 30–49 lbs. ○ 50+ lbs.

4. Do you consider yourself to be Spanish/Hispanic/Latina?

○ No ○ Yes

5. Which categories best describe your race?
(Mark one or more to indicate what you consider yourself to be.)

○ White
○ Black or African American
○ American Indian/Alaska native
○ Asian
○ Native Hawaiian or Pacific Islander
○ Other

6. Do you currently smoke cigarettes?

○ No ○ Yes → How many per day? ○ 1–4 ○ 5–14 ○ 15–24 ○ 25–34 ○ 35–44 ○ 45+

7. Have you had your uterus removed?

○ No ○ Yes → **Date of surgery:** ○ Before June 1, 2002 ○ After June 1, 2002

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

3/8" spine perf

8. Have you ever had either of your ovaries surgically removed? 8

○ No ○ Yes → **a) How many ovaries do you have remaining?** ○ None ○ One a

9. In the last 10 years, have you experienced pain, discomfort or burning in your pelvis or bladder *for more than 3 months in a row* and accompanied by urinary frequency or urgency? 9

○ Yes ○ No

10. On average, how many times do you get out of bed each night to urinate? 10

○ Zero ○ One ○ Two ○ Three ○ Four or more

11. On average, how many times do you urinate each day (from the time you get up, until you go to bed)? 11

○ Four or less ○ 5 to 8 ○ 9 to 12 ○ 13 to 15 ○ More than 15

12. During the last 12 months, how often have you leaked or lost control of your urine? 12

○ Never ○ Less than once/month ○ Once/month ○ 2–3 times/month ○ About once/week ○ Almost every day

i) When you lose your urine, how much usually leaks? i

○ A few drops ○ Enough to wet your underwear ○ Enough to wet your outerclothing ○ Enough to wet the floor

ii) When you lose urine, what is the usual cause? ii

ⓐ Coughing, sneezing, laughing, or doing physical activity
ⓑ A sudden and urgent need to go to the bathroom
ⓒ Both a) and b) equally
ⓓ In other circumstances

13. *Since June 2002,* have you used Evista (raloxifene) or Nolvadex (tamoxifen)? 13

○ Yes → **a) How many months have you used each drug during the 24 month period between June 2002 and June 2004?** a

Evista ○ Not Used ○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months ○ Used only after 6/04 E

Nolvadex ○ Not Used ○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months ○ Used only after 6/04 N

○ No

b) Are you currently using Evista or Nolvadex? b

○ No, not currently ○ Yes, Evista ○ Yes, Nolvadex

14. 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.) 14 a

○ No ○ Yes → **What type(s)?**

○ Soy estrogen products
○ Dong quai (e.g., Rejuvex)
○ Natural progesterone cream or wild yam cream
○ Black cohosh (e.g., Remifemin)
○ Other

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15. Since June 2002, have you used prescription female hormones?

○ Yes → ○ No

a) How many months did you use hormones since June 2002?
○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–25 ○ 26–30 ○ 31–35 ○ 36+ months

b) Are you *currently* using them (within the last month)? ○ Yes ○ No **If No, skip to Part e.**

c) Mark the type(s) of hormones you are *CURRENTLY* using:

Combined: ○ Prempro (cream) ○ Prempro (gold) ○ Prempro (peach) ○ Prempro (light blue) ○ Premphase ○ Combipatch ○ FemHRT

Estrogen: ○ Oral Premarin ○ Patch Estrogen ○ Vaginal Estrogen ○ Ogen ○ Estrace ○ Estratest ○ Other Estrogen (specify in box below)

Progesterone/Progestin: ○ Provera/Cycrin/MPA ○ Vaginal ○ Micronized (e.g., Prometrium) ○ Other progesterone (specify type in box below)

Other hormones *CURRENTLY* used (e.g., Tri-est), Specify: →

d) Since June 2002, how many months have you used the preparation(s) you marked in Part c?
○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–25 ○ 26–30 ○ 31–35 ○ 36+ months

e) If you used oral conjugated estrogen (e.g., Premarin) what dose did you usually take?
○ .30 mg/day or less ○ .45 mg/day ○ .625 mg/day ○ .9 mg/day ○ 1.25 mg/day or higher ○ Unsure ○ Did not take oral conjugated estrogen

f) If you used oral medroxyprogesterone (e.g., Provera, Cycrin), what dose did you usually take?
○ 2.5 mg or less ○ 5–9 mg ○ 10 mg ○ More than 10 mg ○ Unsure ○ Not used

g) What was your pattern of hormone use (Days per Month)?

Oral or Patch Estrogen:
Days per Month ○ Not used ○ <1 day/mo. ○ 1–8 days ○ 9–18 ○ 19–26 ○ 27+ days/mo.

Progesterone:
Days per Month ○ Not used ○ <1 day/mo. ○ 1–8 days ○ 9–18 ○ 19–26 ○ 27+ days/mo.

16. Do you usually use a cane or walker? ○ No ○ Yes

17. Do you have difficulty with your balance? ○ No ○ Yes

18. Number of times you have fallen to the ground in the past year:
○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 or more

Did you lose consciousness when you fell? ○ No ○ Yes, each time ○ Yes, some times

19. Since June 2000, did you receive an influenza vaccination?
○ Yes → **In what years? *(Mark all that apply)*** ○ 2000 ○ 2001 ○ 2002 ○ 2003 ○ 2004
○ No

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20. Since June 2002, have you had any of these clinician-diagnosed illnesses?

MARK "YES" BUBBLE AND YEAR OF DIAGNOSIS BUBBLE FOR EACH ILLNESS YOU HAVE HAD DIAGNOSED.

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

		YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 2002	JUNE '02 TO MAY 2004	AFTER JUNE 1 2004	
Fibrocystic/other benign breast disease	(Y)	○	○	○	1
Confirmed by breast biopsy? (N) No (Y) Yes					a
Breast cancer	(Y)	○	○	○	2
Cancer of the uterus (endometrium)	(Y)	○	○	○	3
Cancer of the ovary	(Y)	○	○	○	4
Colon or rectal polyp (benign)	(Y)	○	○	○	5
Cancer of the colon or rectum	(Y)	○	○	○	6
Cancer of the lung	(Y)	○	○	○	7
Melanoma	(Y)	○	○	○	8
Basal cell skin cancer	(Y)	○	○	○	9
Squamous cell skin cancer	(Y)	○	○	○	10
Chronic lymphocytic leukemia	(Y)	○	○	○	11
Other cancer	(Y)	○	○	○	12
Specify site of other cancer →					
Diabetes mellitus	(Y)	○	○	○	13
Elevated cholesterol	(Y)	○	○	○	14
High blood pressure	(Y)	○	○	○	15
Myocardial infarction (heart attack)	(Y)	○	○	○	16
Hospitalized for MI? (N) No (Y) Yes					a
Angina pectoris					17
Confirmed by angiogram? (N) No (Y) Yes		○	○	○	a
Coronary bypass, angioplasty, or stent	(Y)	○	○	○	18
Congestive heart failure	(Y)	○	○	○	19
Stroke (CVA)	(Y)	○	○	○	20
TIA (Transient ischemic attack)	(Y)	○	○	○	21
Peripheral artery disease or claudication of legs (not varicose veins)	(Y)	○	○	○	22
Confirmed by angiogram/surgery? (N) No (Y) Yes					a
Carotid surgery (Endarterectomy)	(Y)	○	○	○	23

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

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20. (Continued)
Since June 2002, have you had any of these clinician-diagnosed illnesses?

MARK "YES" BUBBLE AND YEAR OF DIAGNOSIS BUBBLE FOR EACH ILLNESS YOU HAVE HAD DIAGNOSED.

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

		YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 2002	JUNE '02 TO MAY 2004	AFTER JUNE 1 2004	
Pulmonary embolus	Y	○	○	○	24
Atrial fibrillation	Y	○	○	○	25
Osteoporosis	Y	○	○	○	26
Hip replacement	Y	○	○	○	27
Fractures: **Wrist or Colles' Fracture**	Y	○	○	○	28
Hip fracture	Y	○	○	○	29
Graves' Disease/Hyperthyroidism	Y	○	○	○	30
Glaucoma	Y	○	○	○	31
Macular degeneration of retina	Y	○	○	○	32
Cataract—1st Diagnosis (Dx)	Y	○	○	○	33
Cataract extraction	Y	○	○	○	34
Asthma, Doctor diagnosed	Y	○	○	○	35
Emphysema or Chronic bronchitis, Dr. Dx	Y	○	○	○	36
Parkinson's Disease	Y	○	○	○	37
Alzheimer's Disease	Y	○	○	○	38
Ulcerative colitis/Crohn's	Y	○	○	○	39
Kidney stones	Y	○	○	○	40
Pernicious Anemia/B12 deficiency	Y	○	○	○	41
Multiple Sclerosis	Y	○	○	○	42
SLE (systemic lupus)	Y	○	○	○	43
Rheumatoid Arthritis, clinician Dx	Y	○	○	○	44
Gout	Y	○	○	○	45
Depression, clinician Dx	Y	○	○	○	46
Other major illness or surgery since June 2002	Y	○	○	○	47

Please specify: **Date:**

3/8" spine perf

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

21. Have you ***ever*** had any of these clinician-diagnosed illnesses or procedures?

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	1996 or BEFORE	1997–2001	2002	2003	2004+
Amyotrophic Lateral Sclerosis (A.L.S.) (Y)	○	○	○	○	○
Seizure (1 or more)/Epilepsy (Y)	○	○	○	○	○
Chronic Renal Failure (Y)	○	○	○	○	○
Barrett's esophagus (Y)	○	○	○	○	○
Shingles (Y)	○	○	○	○	○
Increased eye pressure in either eye (over 25 mm/Hg) (Y)	○	○	○	○	○
Pneumonia, x-ray confirmed (Y)	○	○	○	○	○
Osteoarthritis (Y)	○	○	○	○	○
Splenectomy (Y)	○	○	○	○	○
ICD-Implantable Cardiac Defibrillator (Y)	○	○	○	○	○

22. In the past two years have you had . . .

(If yes, mark all that apply)

	No	Yes, for Screening	Yes, for Symptoms
A physical exam?	(N)	(Y)	(Y)
Exam by eye doctor?	(N)	(Y)	(Y)
Mammogram?	(N)	(Y)	(Y)
Fasting blood sugar	(N)	(Y)	(Y)

23. Did you have a colonoscopy or sigmoidoscopy since ***June 1, 2002?***

○ No ○ Yes →

Initial reason(s) you had Colonoscopy or Sigmoidoscopy?

- ○ Visible blood
- ○ Occult fecal blood
- ○ Diarrhea/constipation
- ○ Barium enema
- ○ Prior polyps
- ○ Abdominal pain
- ○ Family history of colon cancer
- ○ Follow-up of (virtual) CT colonoscopy
- ○ Asymptomatic or routine screening

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24. Indicate <u>each year</u> in which you have had the following procedures:
(Mark all that apply)

	YEAR(S) OF PROCEDURES						
	Never	1993 or earlier	'94–'95	'96–'97	'98–'99	'00–'01	'02+
Sigmoidoscopy?	○	○	○	○	○	○	○
Colonoscopy?	○	○	○	○	○	○	○
Upper endscopy (esophagus/stomach)	○	○	○	○	○	○	○

25. Your Blood Cholesterol (if checked within 5 years):

○ Unknown/Not checked within 5 years ○ <140 mg/dl ○ 140–159 ○ 160–179 ○ 180–199 ○ 200–219
○ 220–239 ○ 240–269 ○ 270–299 ○ 300–329 ○ 330+ mg/dl

26. Current usual blood pressure (if checked within 2 years):

Systolic: ○ Unknown/Not checked within 2 years ○ <105 mmHg ○ 105–114 ○ 115–124 ○ 125–134
○ 135–144 ○ 145–154 ○ 155–164 ○ 165–174 ○ 175+

Diastolic: ○ Unknown/Not checked within 2 years ○ <65 mmHg ○ 65–74 ○ 75–84 ○ 85–89
○ 90–94 ○ 95–104 ○ 105+

27. In the past two years, did you <u>forgo</u> any of the following for *financial reasons*?
(Mark all that apply)

○ Medical care ○ Medical screening ○ Dental care
○ Eye care ○ Mental health care ○ None of these

28. Have you ever had gastrointestinal bleeding that required hospitalization or a transfusion?

○ Yes → **a) What was the site of the bleeding?** ***(Mark all that apply)*** ○ Esophagus ○ Stomach ○ Duodenum ○ Colon/rectum ○ Other ○ Site unknown

○ No

b) What year(s) did this happen? ***(Mark all that apply)*** ○ Before 1990 ○ '90–'91 ○ '92–'93 ○ '94–'95 ○ '96–'97 ○ '98–'99 ○ 2000-'01 ○ 2002+

29. For each of the following periods of your life, please add up the TOTAL amount of time you used antibiotics. (Exclude skin creams, mouthwash or Isoniazid.)
(Mark one answer for each age range)

	Total Time Using Antibiotics							
	None	Less than 15 days	15 days to 2 Months	2–4 Months	4 Mos–2 Years	2–3 Years	3–5 Years	5+ Years
Age 20–39	○	○	○	○	○	○	○	○
Age 40–59	○	○	○	○	○	○	○	○
Age 60 to the present	○	○	○	○	○	○	○	○

a) What was the most common reason that you used an antibiotic?

○ Respiratory infection ○ UTI ○ Acne/Rosacea
○ Chronic bronchitis ○ Dental ○ Other

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30. Regular Medication *(mark if used regularly in past 2 years)*

30

○ Acetaminophen (e.g., Tylenol)
Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days → **Total tablets per week:** ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets

○ "Baby" or low dose aspirin (100 mg/tablet or less)
Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days → **Total tablets per week:** ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets

○ Aspirin or aspirin-containing products (325mg/tablet or more)
Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days → **Total tablets per week:** ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets

○ Ibuprofen (e.g., Advil, Motrin, Nuprin)
Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days → **Total tablets per week:** ○ 1–2 ○ 3–5 ○ 6–14 ○ 15+ tablets

○ Celebrex or Vioxx (COX-2 inhibitors)
Days per week: ○ 1 ○ 2–3 ○ 4–5 ○ 6+ days

○ Other anti-inflammatory analgesics, 2+ times/week (e.g., Aleve, Naprosyn, Relafen, Ketoprofen, Anaprox)

○ Thiazide diuretic ○ Lasix ○ Potassium

○ Calcium blocker (e.g., Calan, Procardia, Cardizem)

○ Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)

○ ACE Inhibitors (e.g., Capoten, Vasotec, Zestril)

○ Other antihypertensive (e.g., losartan, doxazosin)

○ Coumadin ○ Digoxin ○ Antiarrhythmic

"Statin" cholesterol-lowering drug: ○ Mevacor (lovastatin) ○ Zocor (simvastatin) ○ Crestor ○ Pravachol (pravastatin) ○ Lipitor (atorvastatin) ○ Lescol

○ Other cholesterol-lowering drug [e.g., niacin, Lopid (gemfibrozil), Tricor (fenofibrate), Questran (cholestyramine), Colestin, Zetia]

○ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)

○ Insulin ○ Oral hypoglycemic medication

○ SSRI's (e.g., Prozac, Zoloft, Paxil, Celexa)

○ Other antidepressants (e.g., Elavil, Tofranil, Pamelor)

○ Minor tranquilizers (e.g., Valium, Xanax, Ativan, Librium)

○ Prilosec, Nexium, Prevacid (lansoprazole), Protonix, Aciphex
Years used: ○ 0–2 yrs ○ 3–5 yrs ○ 6–9 yrs ○ 10+ yrs

○ H2 blocker (e.g., Pepcid, Tagamet, Zantac, Axid)

○ Aricept ○ Namenda

○ Fosamax, Actonel, or other bisphosphonate

○ No regular medication

○ Other regular medications (no need to specify)

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31. Have any of the following biological relatives had...

		Relative's Age at First Diagnosis (Do not count half siblings.)					
		Before Age 50	Age 50 to 59	Age 60 to 69	Age 70+	Age Unknown	
Ovarian Cancer? ○ No	Mother (Y)	○	○	○	○	○	
	Sister (Y)	○	○	○	○	○	
	Daughter (Y)	○	○	○	○	○	O
Breast Cancer? ○ No	Mother (Y)	○	○	○	○	○	
	One Sister (Y)	○	○	○	○	○	
	Additional Sister (Y)	○	○	○	○	○	
	Daughter (Y)	○	○	○	○	○	B
Colon or Rectal Cancer? ○ No	Parent (Y)	○	○	○	○	○	
	One Sibling (Y)	○	○	○	○	○	
	Additional Sibling (Y)	○	○	○	○	○	
	Offspring (Y)	○	○	○	○	○	C

32. Have your parents or any siblings had dementia?

Mother: ○ No ○ Yes → **Age diagnosed?** ○ < age 55 ○ age 55–64 ○ 65+

Father: ○ No ○ Yes → **Age diagnosed?** ○ < age 55 ○ age 55–64 ○ 65+

Sibling: ○ No ○ Yes → **Age diagnosed?** ○ < age 55 ○ age 55–64 ○ 65+

33. Do you currently take a multi-vitamin? (Please report <u>other</u> individual vitamins in question 34)

○ Yes → **a) How many do you take per week?** ○ 2 or less ○ 3–5 ○ 6–9 ○ 10 or more

○ No

34. Do you take any of the following separate preparations on a regular basis? DO NOT REPORT CONTENTS OF MULTI-VITAMINS MENTIONED ABOVE.

○ Vitamin C ○ Vitamin D ○ Vitamin E ○ B-Complex ○ Zinc ○ Iron
○ Vitamin A ○ Calcium ○ Beta Carotene ○ Selenium ○ Folic Acid ○ Niacin

35. In a typical week <u>during the past year</u>, on how many days did you consume an alcoholic beverage of any type?

○ No days ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 days ○ 6 days ○ 7 days

36. In a typical month <u>during the past year</u>, what was the largest number of drinks of beer, wine and/or liquor you may have had in one day?

○ None ○ 1–2 ○ 3–5 ○ 6–9 ○ 10–14 ○ 15 or more

37. How many squamous or basal cell carcinoma lesions have you ever had <u>removed</u> by surgery, cryotherapy or other means? (Include only new primary cancers. Exclude melanoma and benign lesions like moles or actinic keratoses.)

○ Never had squamous or basal cell carcinoma ○ 1 ○ 2–4 ○ 5–10 ○ 11+

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38. Following are questions about your physical activity at various times in your life and at various intensity levels. For each age range below, please estimate the *average* amount of time that you spent in these activities.
We recognize that this is a difficult task, but we ask that you *average* your activity over seasons and years during the given age categories.

a) Walking to and from School or Work

Average hours per WEEK

	None	0.5	1–2	3–4	5–6	7–10	11+
Grades 7–8	○	○	○	○	○	○	○
Grades 9–12	○	○	○	○	○	○	○
Ages 18–22	○	○	○	○	○	○	○
Ages 23–29	○	○	○	○	○	○	○
Ages 30–34	○	○	○	○	○	○	○

b) TV Watching

Average hours per WEEK

	None	1	2–5	6–10	11–20	21–40	41–60	61–90	91+
Grades 7–8	○	○	○	○	○	○	○	○	○
Grades 9–12	○	○	○	○	○	○	○	○	○
Ages 18–22	○	○	○	○	○	○	○	○	○
Ages 23–29	○	○	○	○	○	○	○	○	○
Ages 30–34	○	○	○	○	○	○	○	○	○

c) Strenuous Recreational Activity

Causing increased breathing, heart-rate, or sweating (e.g., running, aerobics, lap swimming)

Average hours per WEEK

	None	0.5	1–2	3–4	5–6	7–10	11+
Grades 7–8	○	○	○	○	○	○	○
Grades 9–12	○	○	○	○	○	○	○
Ages 18–22	○	○	○	○	○	○	○
Ages 23–29	○	○	○	○	○	○	○
Ages 30–34	○	○	○	○	○	○	○

d) Moderate Recreational Activity

e.g., hiking, walking for exercise, casual cycling, yard work (do not count activities already reported)

Average hours per WEEK

	None	0.5	1–2	3–4	5–6	7–10	11+
Grades 7–8	○	○	○	○	○	○	○
Grades 9–12	○	○	○	○	○	○	○
Ages 18–22	○	○	○	○	○	○	○
Ages 23–29	○	○	○	○	○	○	○
Ages 30–34	○	○	○	○	○	○	○

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39. 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 for exercise or walking to work	○	○	○	○	○	○	○	○	○	○
Jogging (slower than 10 minutes/mile)	○	○	○	○	○	○	○	○	○	○
Running (10 minutes/mile or faster)	○	○	○	○	○	○	○	○	○	○
Bicycling (include stationary machine)	○	○	○	○	○	○	○	○	○	○
Tennis, squash, racquetball	○	○	○	○	○	○	○	○	○	○
Lap swimming	○	○	○	○	○	○	○	○	○	○
Other aerobic exercise (aerobic dance, ski or stair machine, etc.)	○	○	○	○	○	○	○	○	○	○
Lower intensity exercise (yoga, stretching, toning)	○	○	○	○	○	○	○	○	○	○
Other vigorous activities (e.g., lawn mowing)	○	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises (Include free weights or machines such as Nautilus) — **Arm weights**	○	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises (Include free weights or machines such as Nautilus) — **Leg weights**	○	○	○	○	○	○	○	○	○	○

40. DURING THE PAST YEAR, on average, how many HOURS PER WEEK did you spend:

	TIME PER WEEK								
	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? (hours per week)	○	○	○	○	○	○	○	○	○
Standing or walking around at home? (hours/week)	○	○	○	○	○	○	○	○	○
Sitting at work or away from home or while driving? (hours/week)	○	○	○	○	○	○	○	○	○
Sitting at home while watching TV/VCR? (hours/week)	○	○	○	○	○	○	○	○	○
Other sitting at home (e.g., reading, meal times, at desk)? (hours/week)	○	○	○	○	○	○	○	○	○

41. What is your usual walking pace outdoors?

○ Easy, casual (less than 2 mph) ○ Normal, average (2–2.9 mph) ○ Brisk pace (3–3.9 mph)
○ Very brisk/striding (4 mph or faster) ○ Unable to walk

42. How many flights of stairs (not steps) do you climb daily?

○ No flights ○ 1–2 flights ○ 3–4 flights ○ 5–9 flights ○ 10–14 flights ○ 15 or more flights

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43. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
(Mark one response on each line.)

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	○	○	○
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
Lifting or carrying groceries	○	○	○
Climbing *several* flights of stairs	○	○	○
Climbing *one* flight of stairs	○	○	○
Bending, kneeling, or stooping	○	○	○
Walking *more than a mile*	○	○	○
Walking *several blocks*	○	○	○
Walking *one* block	○	○	○
Bathing or dressing yourself	○	○	○

44. What is your *current* status?
○ Married ○ Widowed ○ Divorced ○ Separated ○ Never married ○ Domestic Partnership

45. Your living arrangement: *(Mark all that apply)*
○ Alone ○ With spouse or partner ○ With other family ○ Nursing home ○ Assisted living facility ○ Other

46. What is your *current* work status? *(Mark all that apply)*
○ Retired ○ Full-time non-nursing employment ○ Nursing full-time
○ Homemaker ○ Part-time non-nursing employment ○ Nursing part-time

47. How many hours <u>each week</u> do you participate in any groups such as social or work group, church-connected group, self-help group, charity, public service or community group?
○ None ○ 1 to 2 hours ○ 3 to 5 hours ○ 6 to 10 hours ○ 11 to 15 hours ○ 16 or more hours

48. How often do you go to religious meetings or services?
○ More than once a week ○ Once a week ○ 1 to 3 times per month
○ Less than once per month ○ Never or almost never

49. Apart from your children, how many relatives do you have with whom you feel close?
○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 9 ○ 10 or more

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50. How many close friends do you have?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 to 9 ○ 10 or more

51. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with?

○ Yes → **a)** How often do you see or talk with this person?
○ Daily ○ Weekly ○ Monthly ○ Several times/year ○ Once/year or less

○ No

52. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)?

○ None of the time ○ A little of the time ○ Some of the time ○ Most of the time ○ All of the time

53. How many people can you count on to provide you with emotional support?

○ None ○ One ○ Two ○ Three or more

54. Outside of your employment, do you provide regular care to any of the following? *(Mark one response on each line. For people to whom you do not provide regular care, mark "Zero Hours.")*

	HOURS PER WEEK					
	Zero Hrs.	1–8 Hrs.	9–20 Hrs.	21–35 Hrs.	36–72 Hrs.	73+ Hrs.
Your grandchildren	○	○	○	○	○	○
Disabled or ill spouse/partner	○	○	○	○	○	○
Disabled or ill parent or other person	○	○	○	○	○	○

55. Below is a list of some of the ways you may have felt or behaved during the *past month*. Please indicate how often you have felt this way.

During the past month... *(Mark one answer per line)*	Rarely or none of the time	Some or a little of the time	Occasionally or a moderate amount of time	All of the time
I was bothered by things that usually don't bother me	○	○	○	○
I had trouble keeping my mind on what I was doing	○	○	○	○
I felt depressed	○	○	○	○
I felt that everything I did was an effort	○	○	○	○
I felt hopeful about the future	○	○	○	○
I felt fearful	○	○	○	○
My sleep was restless	○	○	○	○
I was happy	○	○	○	○
I felt lonely	○	○	○	○
I could not "get going"	○	○	○	○

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56. <u>In your lifetime</u>, have you ever had two weeks or longer when nearly every day you felt sad, blue, or depressed for most of the day? 56

○ No ○ Yes

57. Below is a list of statements which people have used to describe themselves. Please mark the response that indicates how you generally feel. 57

	Almost never	Sometimes	Often	Almost always
I feel nervous and restless	○	○	○	○
I feel satisfied with myself	○	○	○	○
I wish I could be as happy as others seem to be	○	○	○	○
I feel like a failure	○	○	○	○
I worry too much over something that really doesn't matter	○	○	○	○
I lack self-confidence	○	○	○	○
I feel secure	○	○	○	○
I feel inadequate	○	○	○	○
I am a steady person	○	○	○	○
I get in a state of tension or turmoil as I think over my recent concerns and interests	○	○	○	○

58. Please indicate the extent to which you agree or disagree with the following statements. 58

	Disagree strongly	Disagree a little	Neither agree nor disagree	Agree a little	Agree strongly
In uncertain times I usually expect the best	○	○	○	○	○
If something can go wrong with me, it will	○	○	○	○	○
I'm always optimistic about my future	○	○	○	○	○
I hardly ever expect things to go my way	○	○	○	○	○
I rarely count on good things happening to me	○	○	○	○	○
Overall, I expect more good things to happen to me than bad	○	○	○	○	○

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59. In the past year, how often did you participate in each of the following activities? 59

	Daily or about every day	Several times per week	Several times per month	A few times per year	Once per year or less
Play cards	○	○	○	○	○
Play board games	○	○	○	○	○
Read books	○	○	○	○	○
Read magazines or newspapers	○	○	○	○	○
Crossword or other puzzles	○	○	○	○	○

60. Do you have an unreasonable fear of being in enclosed spaces, such as stores, elevators, etc.? 60

○ Often ○ Sometimes ○ Never

61. Do you find yourself worrying about getting some incurable illness? 61

○ Often ○ Sometimes ○ Never

62. Are you scared of heights? 62

○ Very ○ Moderately ○ Not at all

63. Do you feel panicky in crowds? 63

○ Always ○ Sometimes ○ Never

64. Do you worry unduly when relatives are late coming home? 64

○ Yes ○ No

65. Do you feel more relaxed indoors? 65

○ Definitely ○ Sometimes ○ Not particularly

66. Do you dislike going out alone? 66

○ Yes ○ No

67. Do you feel uneasy traveling on buses or trains, even if they are not crowded? 67

○ Very ○ A little ○ Not at all

68. How tall was YOUR MOTHER, without shoes on, at her maximum adult height? 68

○ Under 5 feet ○ 5' to 5'3" ○ 5'4 to 5'6" ○ 5'7" to 5'10" ○ 5'11"+ ○ Don't know

69. How tall was YOUR FATHER, without shoes on, at his maximum adult height? 69

○ Under 5 feet ○ 5' to 5'8" ○ 5'9" to 5'10" ○ 5'11" to 6' ○ 6'1" to 6'3" ○ 6'4"+ ○ Don't know

70. What was your birth order, relative to your siblings? 70

○ Only child ○ 1st born ○ 2nd ○ 3rd ○ 4th ○ 5th ○ 6th ○ 7th ○ 8th ○ 9th or later
○ Adopted

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71. Did your parents own a home at the time of your birth or infancy? (71)

○ Yes ○ No

72. Did your mother smoke cigarettes during her pregnancy with you? (72)

○ Don't know ○ No ○ Yes

73. Did your father smoke cigarettes or a pipe during the year when your mother was pregnant with you? (73)

○ Don't know ○ No ○ Yes

74. Please mark true or false for each of the following statements, as they apply to you: (74)

	True	False	
I do not like to exercise, so I rarely stick with an exercise program.	○	○	a
I make myself exercise in order not to gain weight.	○	○	b
If I eat too much, I exercise to make up for it.	○	○	c

75. Would a weight fluctuation of 5 lbs. affect the way you live your life? (75)

○ Not at all ○ Slightly ○ Moderately ○ Very much

76. Do you eat sensibly in front of others and splurge alone? (76)

○ Never ○ Rarely ○ Often ○ Always

77. Do you have feelings of guilt after overeating? (77)

○ Never ○ Rarely ○ Often ○ Always

78. 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: (78)

Name: _____

Address: _____

_____

Phone or E-Mail: _____

79. Did you need any help from someone else to complete this questionnaire? (79)

○ No ○ Yes → **What kind of help did you need?** ***(Mark all that apply)*** (a)

○ Help with vision
○ Help with writing
○ Help with memory
○ Other

○ This questionnaire was completed by someone other than the participating nurse. (Please elaborate in the blank space on the next page and include your name, telephone number and relationship to the participant.)

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Thank you!

Please check to make sure you have not accidentally skipped any pages.

Please return form in prepaid envelope to:

Dr. Graham Colditz
181 Longwood Avenue
Boston, MA 02115

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

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