WINDOW AREA

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Dear Colleague:

As the Nurses' Health Study enters its 32nd year, I am more excited than ever about the contributions the study is making to our understanding of the many issues surrounding women's health. As always, these many developments are possible only because of your continued involvement.

The hundreds of research articles that have been published using Nurses' Health Study data are a tribute to the great value of your participation. This information helps shape national health guidelines and recommendations. Going forward, we are continuing to focus on how to decrease the risk of cancer, heart disease and other major chronic diseases in women. In addition, we are increasing our efforts to address issues of great importance to older women, such as how to maintain cognitive function and maximize quality of life. As such, your ongoing involvement remains critical to help current and future generations of women live healthier lives.

The attached questionnaire continues our biennial follow-up. As always, your answers will be kept strictly confidential and used for medical statistical purposes only. Your prompt reply is greatly appreciated.

As an original member of the Nurses' Health Study you are an indispensable colleague in our research. Whether you are retired or still working and 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 want to hear from you!**

It is with our deepest gratitude that we thank you again for the ongoing commitment and care that you have generously provided as we continue to learn about women's health.

Best Regards,

Susan Hankinson, RN, Sc.D.
Principal Investigator

Do we have your correct address and name?

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

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!

3/8" spine perf

INSTRUCTIONS

Please use an ordinary 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.**

18. Since June 2006, have you had any of these clinician-diagnosed illnesses?

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

	YEAR OF DIAGNOSIS: BEFORE JUNE 1 2006	JUNE '06 TO MAY 2008	AFTER JUNE 1 2008	
Fibrocystic/other benign breast disease	●	○	○	1
Confirmed by breast biopsy? (N) No ● Yes				a
Breast cancer	○	●	○	2
Cancer of the uterus (endometrium) (Y)	○	○	○	3

18

- **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 2008 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 (617-424-4100).

3/8" spine perf

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

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

3. Do you currently smoke cigarettes? (3)

○ No ○ Yes → **How many/day?** ○ 1–4 ○ 5–14 ○ 15–24 ○ 25–34 ○ 35–44 ○ 45+ (3a)

4. Have you had your uterus removed? (4)

○ No ○ Yes → **Date of surgery:** ○ Before June 1, 2006 ○ After June 1, 2006 (4a)

5. Have you ever had either of your ovaries surgically removed? (5)

○ No ○ Yes → **a) How many ovaries do you have remaining?** (5a)

○ None ○ One

6. Do you usually use a cane or walker? (6)

○ No ○ Yes

7. Do you have difficulty with your balance? (7)

○ No ○ Yes

8. Number of times you have fallen to the ground in the past year: (8)

○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 or more

9. Can you rise from a chair 5 times in a row, without using your arms? (9)

○ No ○ Yes

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

3/8" spine perf

10. *Since June 2006,* have you used Evista (raloxifene) or Nolvadex (tamoxifen)? T 10

○ Yes → a) **How many months have you used <u>each</u> drug during the 24-month period between June 2006 and June 2008?** a

Evista: E
○ Not Used ○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months ○ Used <u>only</u> after 6/2008

Nolvadex: N
○ Not Used ○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–24 months ○ Used <u>only</u> after 6/2008

○ No

b) **Are you <u>currently</u> using Evista or Nolvadex?** b
○ No, not currently ○ Yes, Evista ○ Yes, Nolvadex

11. 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.) 11 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

12. Since June 2006, have you used <u>prescription</u> female hormones? 12

○ Yes → a) **How many months did you use hormones since June 2006?** a
○ 1–4 months ○ 5–9 ○ 10–14 ○ 15–19 ○ 20–25 ○ 26–30 ○ 31–35 ○ 36+ months

○ No

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

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

Combined:
○ Prempro (beige) ○ 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) **If you used oral conjugated estrogen (e.g., Premarin) what dose did you usually take?** d
○ .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

e) **What was your pattern of hormone use (Days per Month)?** e
Oral or Patch Estrogen:
Days per Month ○ Not used ○ <1 day/mo. ○ 1–8 days ○ 9–18 ○ 19–26 ○ 27+ days/mo. 1

Progesterone:
Days per Month ○ Not used ○ <1 day/mo. ○ 1–8 days ○ 9–18 ○ 19–26 ○ 27+ days/mo. 2

13. Do you have a hearing problem? 13
○ No ○ Mild ○ Moderate ○ Marked, no hearing aid ○ Severe, use a hearing aid

14. In the past 12 months, have you had ringing, roaring, or buzzing in your ears? 14
○ Never ○ Once/month or less ○ 2–3 times/month
○ About once/week ○ Several days/week ○ Almost every day or daily

3/8" spine perf

15. 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

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

	No	Yes
Upper endoscopy	N	Y
(Virtual) CT Colonoscopy?	N	Y
Colonoscopy?	N	Y
Sigmoidoscopy?	N	Y

Initial reason(s) you had Colonoscopy or Sigmoidoscopy?

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

17. Have you ***ever*** had any of these clinician-diagnosed illnesses?

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"		YEAR OF FIRST DIAGNOSIS: 1997 or BEFORE	1998–2001	2002–2005	2006–2007	2008+
Lou Gehrig's disease/ Amyotrophic Lateral Sclerosis	Y	○	○	○	○	○
Multiple sclerosis	Y	○	○	○	○	○
Pernicious anemia/B12 deficiency	Y	○	○	○	○	○
Shingles	Y	○	○	○	○	○
Increased eye pressure in either eye (over 25 mm/Hg)	Y	○	○	○	○	○
Osteoarthritis	Y	○	○	○	○	○
Sleep apnea	Y	○	○	○	○	○
Psoriasis	Y	○	○	○	○	○
Psoriatic arthritis	Y	○	○	○	○	○
Pneumonia, x-ray confirmed	Y	○	○	○	○	○
Asthma, Dr. Diagnosed	Y	○	○	○	○	○
Emphysema or Chronic bronchitis, Dr Dx	Y	○	○	○	○	○
Gastric or Duodenal ulcer	Y	○	○	○	○	○
Hyperparathyroidism	Y	○	○	○	○	○

3/8" spine perf

18. Since June 2006, 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 2006	JUNE '06 TO MAY 2008	AFTER JUNE 1 2008	
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 (e.g., liver, pancreas, etc.) →					
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	(Y)	○	○	○	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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18. (Continued)
Since June 2006, have you had any of these clinician-diagnosed illnesses?

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

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

		YEAR OF DIAGNOSIS			
		BEFORE JUNE 1 2006	JUNE '06 TO MAY 2008	AFTER JUNE 1 2008	
Pulmonary embolus	Y	○	○	○	24
Atrial fibrillation	Y	○	○	○	25
ICD-Implantable Defibrillator	Y	○	○	○	26
Osteoporosis	Y	○	○	○	27
Hip replacement	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
Alzheimer's disease	Y	○	○	○	35
Parkinson's disease	Y	○	○	○	36
Ulcerative colitis/Crohn's	Y	○	○	○	37
Barrett's esophagus	Y	○	○	○	38
Kidney stones	Y	○	○	○	39
SLE (systemic lupus)	Y	○	○	○	40
Rheumatoid arthritis, clinician Dx	Y	○	○	○	41
Gout	Y	○	○	○	42
Depression, clinician Dx	Y	○	○	○	43
Other major illness or surgery since June 2006	Y	○	○	○	44

Please specify: Date:

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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

19. Regular Medication *(Mark if used regularly in past 2 years)*

19

Analgesics

○ 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 or less/tablet)
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 or more/tablet)
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

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

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

Other Regular Medications

○ Thiazide diuretic ○ Lasix ○ Potassium

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

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

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

○ Angiotensin receptor blocker [e.g., valsartan (Diovan), losartan (Cozaar), irgesartan (Avapro)]

○ Other anti-hypertensive (e.g., clonidine, doxazosin)

○ Coumadin ○ Plavix ○ Digoxin ○ Antiarrhythmic

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

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

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

○ Insulin ○ Metformin

○ Other oral hypoglycemic medication

○ SSRIs (Celexa, Lexapro, Prozac, Paxil, Zoloft, Luvox)

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

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

○ Prilosec, Nexium, Prevacid (lansoprazole), Protonix, Aciphex

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

○ Aricept ○ Namenda

○ Fosamax, Actonel, or other bisphosphonate

○ Ambien, Sonata or Lunesta

○ Other prescription sleep meds. (e.g., Trazodone, Rozerem)

○ Other regular medications (no need to specify)

3/8" spine perf

20. During the past 4 years, what is the TOTAL amount of time you used antibiotics? (Exclude skin creams, mouthwash or isoniazid.) 20

○ None ○ Less than 15 days ○ 15 days to 2 months ○ 2 to 4 months
○ 4 months to 2 years ○ 2 to 3 years ○ Over 3 years

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

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

21. Have you ever had gastrointestinal bleeding that required hospitalization or a transfusion? 21

○ Yes → **a) What was the site of the bleeding? *(Mark all that apply.)*** a
○ No ○ Esophagus ○ Stomach ○ Duodenum
○ Colon/rectum ○ Other ○ Site unknown

b) What year(s) did this happen? *(Mark all that apply.)* b
○ Before 1990 ○ '90–'93 ○ '94–'97 ○ '98–'99
○ 2000–'01 ○ 2002–'03 ○ 2004–'05 ○ 2006+

22. Have you ever been diagnosed with diverticulosis or diverticulitis of the colon or rectum? 22

○ Yes → **a) Have you ever had diverticulitis that required antibiotics or hospitalization?** a
○ No ○ No ○ Yes → **Year(s)?**
○ Before 1990 ○ '90–'91 ○ '92–'93 ○ '94–'95 ○ '96–'97 ○ '98–'99
○ 2000–'01 ○ 2002–'03 ○ 2004–'05 ○ 2006–'07 ○ 2008+

b) Have you ever had diverticular bleeding that required hospitalization? b
○ No ○ Yes → **Year(s)?**
○ Before 1990 ○ '90–'91 ○ '92–'93 ○ '94–'95 ○ '96–'97 ○ '98–'99
○ 2000–'01 ○ 2002–'03 ○ 2004–'05 ○ 2006–'07 ○ 2008+

23. In the last year, how often have you had heartburn or acid-reflux? 23

○ None in the past year ○ Less than once a month ○ About once a month ○ About once a week
○ Several times a week ○ Daily

24. During the past 4 weeks, have you had any hot flashes or night sweats? 24

○ No ○ Yes → **If yes, were they *(mark one):*** ○ Mild ○ Moderate ○ Severe

25. At the beginning of menopause, did you have hot flashes or night sweats? (If you took estrogen, consider the time period before starting treatment.) 25

○ Yes → **a) Were they *(mark one):*** ○ Mild ○ Moderate ○ Severe a
○ No **b) How long did these symptoms last?** ○ Less than 5 years ○ 5–9 years ○ 10 years or longer b

26. On average, how often in the past year have you experienced any amount of accidental bowel leakage? 26

a) Liquid stool: ○ Never ○ Less than 1/month ○ 1–3/month ○ About once/week a
○ Several times/week ○ Nearly daily

b) Solid stool: ○ Never ○ Less than 1/month ○ 1–3/month ○ About once/week b
○ Several times/week ○ Nearly daily

27. During the last 12 months, how often have you leaked or lost control of your urine? 27

○ 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

28. Do you ever use any kind of pad for protection against leaking urine or stool? 28

○ Yes ○ No

3/8" spine perf

Family Disease History

29. 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?						29
○ No						
Mother (Y) →	○	○	○	○	○	
Daughter (Y) →	○	○	○	○	○	O
Breast Cancer?						
○ No						
One Sister (Y) →	○	○	○	○	○	
Additional Sister (Y) →	○	○	○	○	○	
Daughter (Y) →	○	○	○	○	○	B
Colon or Rectal Cancer?						
○ No						
One Sibling (Y) →	○	○	○	○	○	
Additional Sibling (Y) →	○	○	○	○	○	
Offspring (Y) →	○	○	○	○	○	C
Pancreatic Cancer?						
○ No						
Parent (Y) →	○	○	○	○	○	
Sibling (Y) →	○	○	○	○	○	P
Melanoma?						
○ No						
Parent (Y) →	○	○	○	○	○	
Sibling (Y) →	○	○	○	○	○	
Offspring (Y) →	○	○	○	○	○	M
Cancer of the Uterus? (exclude fibroids and cervical cancer)						
○ No						
Mother (Y) →	○	○	○	○	○	
Sister (Y) →	○	○	○	○	○	
Offspring (Y) →	○	○	○	○	○	U
Kidney Cancer?						
○ No						
Parent (Y) →	○	○	○	○	○	
Sibling (Y) →	○	○	○	○	○	K
Myocardial Infarction?						
○ No						
Brother (Y) →	○	○	○	○	○	
Sister (Y) →	○	○	○	○	○	
Offspring (Y) →	○	○	○	○	○	MI

3/8" spine perf

Family Disease History

29. (Continued)
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	
Stroke (CVA)?							
○ No	Mother (Y) →	○	○	○	○	○	
	Father (Y) →	○	○	○	○	○	
	Sibling (Y) →	○	○	○	○	○	S
Multiple Sclerosis (MS)?							
○ No	Mother (Y) →	○	○	○	○	○	
	Father (Y) →	○	○	○	○	○	
	Sibling (Y) →	○	○	○	○	○	
	Offspring (Y) →	○	○	○	○	○	M
Parkinson's Disease?							
○ No	Mother (Y) →	○	○	○	○	○	
	Father (Y) →	○	○	○	○	○	
	Sibling (Y) →	○	○	○	○	○	P
Rheumatoid Arthritis or Lupus (SLE)?							
○ No	Parent (Y) →	○	○	○	○	○	
	Sibling (Y) →	○	○	○	○	○	
	Offspring (Y) →	○	○	○	○	○	R

Your Siblings

30. Do you have any siblings (living or deceased) whose age compared to yours is: ***(Mark all that apply.)*** 30

- ○ No siblings (only child)
- ○ Less than 2 years older than you
- ○ 2 to 5 years older than you
- ○ 5+ years older than you
- ○ Less than 2 years younger than you
- ○ 2 to 5 years younger than you
- ○ 5+ years younger than you

31. What is your *current* status? 31

○ Married ○ Widowed ○ Divorced ○ Separated ○ Never married ○ Domestic Partnership

32. Your living arrangement: ***(Mark all that apply.)*** 32

○ Alone ○ With spouse or partner ○ With other family ○ Nursing home ○ Assisted living facility ○ Other

33. What is your *current* work status: ***(Mark all that apply.)*** 33

- ○ Retired
- ○ Homemaker
- ○ Full-time non-nursing employment
- ○ Part-time non-nursing employment
- ○ Nursing full-time
- ○ Nursing part-time
- ○ Disabled

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34. Blood Cholesterol (most recent, within last 5 years): 34

○ 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

35. Current usual blood pressure (if checked within 2 years): 35

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

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

36. Your resting pulse rate: (please take after sitting for 5 min.) 36

○ Unsure
○ <55/min ○ 55–59 ○ 60–64 ○ 65–69 ○ 70–74
○ 75–79 ○ 80–84 ○ 85–89 ○ 90–99 ○ 100 or more

37. How many hours <u>each week</u> do you participate in any groups such as a social or work group, church-connected group, self-help group, charity, public service or community group? 37

○ None ○ 1 to 2 hours ○ 3 to 5 hours ○ 6 to 10 hours ○ 11 to 15 hours ○ 16 or more hours

38. How often do you go to religious meetings or services? 38

○ More than once a week ○ Once a week ○ 1 to 3 times per month
○ Less than once per month ○ Never or almost never

39. Apart from your children, how many relatives do you have with whom you feel close? 39

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

40. How many close friends do you have? 40

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

41. Is there any one special person you know that you feel very close to; someone you feel you can share confidences and feelings with? 41

○ Yes → **a)** How often do you see or talk with this person? a
○ No ○ Daily ○ Weekly ○ Monthly ○ Several times/year ○ Once/year or less

42. Can you count on anyone to provide you with emotional support (talking over problems or helping you make a difficult decision)? 42

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

43. How many people can you count on to provide you with emotional support? 43

○ None ○ One ○ Two ○ Three or more

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44. 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**	○	○	○	○	○	○	○	○	○	○

45. DURING THE PAST YEAR, on average, how many <u>HOURS PER WEEK</u> 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? (hrs./week)	○	○	○	○	○	○	○	○	○
Standing or walking around at home? (hrs./week)	○	○	○	○	○	○	○	○	○
Sitting at work or away from home or while driving? (hrs./week)	○	○	○	○	○	○	○	○	○
Sitting at home while watching TV/VCR? (hrs./week)	○	○	○	○	○	○	○	○	○
Other sitting at home (e.g., reading, meal times, at desk)? (hrs./week)	○	○	○	○	○	○	○	○	○

46. 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

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

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

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48. 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	○	○	○

49. Please mark Yes or No for each of the following statements:

Shops, stores and markets are within easy walking distance of my home.	○ Yes	○ No
There are sidewalks on most of the streets in my neighborhood.	○ Yes	○ No
The crime rate in my neighborhood makes it unsafe to go on walks at night.	○ Yes	○ No
My neighborhood has free or low cost recreation facilities, such as parks, walking trails, bike paths, rec. centers, playgrounds, public swimming pools, etc.	○ Yes	○ No
I walk around my neighborhood twice a week or more for leisure or exercise.	○ Yes	○ No

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50. How often do you deliberately take a nap during the day? 50

○ Never ○ Less than once a week ○ Several times a week ○ Daily ○ More than once per day

51. What is the chance of your dozing off in each of the following situations? 51

	CHANCE OF DOZING			
	No Chance of Dozing	Slight Chance of Dozing	Moderate Chance of Dozing	High Chance of Dozing
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting inactive in a public place (e.g., a theater or a meeting)	○	○	○	○
As a passenger in a car for an hour without a break	○	○	○	○
Lying down to rest in the afternoon when circumstances permit	○	○	○	○
Sitting and talking to someone	○	○	○	○
Sitting quietly after a lunch without alcohol	○	○	○	○
In a car, while stopped for a few minutes in traffic	○	○	○	○

52. On average, over a 24 hour period, do you sleep: 52

○ <5 hours ○ 5 hrs ○ 6 hrs ○ 7 hrs ○ 8 hrs ○ 9 hrs ○ 10+ hours

53. Do you feel that your sleep duration is adequate? 53

○ No → **What is the major reason that your sleep duration is *inadequate*? *(Mark one answer.)*** a
- ○ Work/family activities or schedule
- ○ Leisure/social activities: reading/TV/computer, etc.
- ○ Medical problem (e.g., pain, breathing difficulties)
- ○ Just can't get to or stay asleep (worrying or insomnia)

○ Yes

54. Do you snore? 54

○ Every night ○ Most nights ○ A few nights a week ○ Occasionally ○ Almost never ○ Don't know

55. On average, how often are your daily activities affected because you are sleepy during the day? 55

○ Almost every day ○ 1–3 days/week ○ 4–6 days/week ○ Rarely ○ Never

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

	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.	○	○	○	○	○

57. How have you felt during the *past month*? *(Please mark Yes or No on each question.)*

Are you basically satisfied with your life?	○ Yes	○ No
Have you dropped many of your activities and interests?	○ Yes	○ No
Do you feel that your life is empty?	○ Yes	○ No
Do you often get bored?	○ Yes	○ No
Are you in good spirits most of the time?	○ Yes	○ No
Are you afraid that something bad is going to happen to you?	○ Yes	○ No
Do you feel happy most of the time?	○ Yes	○ No
Do you often feel helpless?	○ Yes	○ No
Do you prefer to stay at home, rather than going out and doing new things?	○ Yes	○ No
Do you feel you have more problems with memory than most?	○ Yes	○ No
Do you think it is wonderful to be alive now?	○ Yes	○ No
Do you feel pretty worthless the way you are now?	○ Yes	○ No
Do you feel full of energy?	○ Yes	○ No
Do you feel that your situation is hopeless?	○ Yes	○ No
Do you think that most people are better off than you are?	○ Yes	○ No

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58. The following question asks about your eating habits in the past year. People sometimes have difficulty controlling their intake of certain foods such as sweets, starches, salty snacks, fatty foods, sugary drinks, and others.

In the past 12 MONTHS, how often were each of these statements true for you?	Never	Once per Month	2-4 Times per Month	2-3 Times per Week	4+ Times per Week
I find myself consuming certain foods even though I am no longer hungry.	○	○	○	○	○
I worry about cutting down on certain foods.	○	○	○	○	○
I feel sluggish or fatigued from overeating.	○	○	○	○	○
I have spent time dealing with negative feelings from overeating certain foods, instead of spending time in important activities such as time with family, friends, work, or recreation.	○	○	○	○	○
I have had physical withdrawal symptoms such as agitation and anxiety when I cut down on certain foods. (Do NOT include caffeinated drinks: coffee, tea, cola, energy drinks, etc.)	○	○	○	○	○
My behavior with respect to food and eating causes me significant distress.	○	○	○	○	○
Issues related to food and eating decrease my ability to function effectively (daily routine, job/school, social or family activities, health difficulties).	○	○	○	○	○

IN THE PAST 12 MONTHS…	No	Yes
I kept consuming the same types or amounts of food despite significant emotional and/or physical problems related to my eating.	○	○
Eating the same amount of food does not reduce negative emotions or increase pleasurable feelings the way it used to.	○	○

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59. Since June 2004, did you receive an influenza vaccination? 59

○ Yes → **a) In which winter flu seasons?** ***(Mark all that apply.)***
○ No ○ 2004/2005 ○ 2005/2006 ○ 2006/2007 ○ 2007/2008 ○ 2008/2009 a

60. Do you currently take a multi-vitamin? 60

○ Yes → **a) How many do you take per week?**
○ No ○ 2 or less ○ 3–5 ○ 6–9 ○ 10 or more a

61. 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: 61

Name: _____

Address: _____

_____

Phone or E-Mail: _____

62. Did you need any help from someone else to complete this questionnaire? 62

○ 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 below 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. Susan Hankinson
Nurses' Health Study
181 Longwood Ave.
Boston, MA 02115-5804

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

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