NYU WOMEN'S HEALTH STUDY FOLLOW-UP QUESTIONNAIRE

1. Below is your name, address and telephone number as it appears in our records. **Please print corrections if necessary in the spaces provided, and fill in the additional information requested.**

Name_____
Address _____ Apt. #_____
_____

Phone
(____)_____ (home)
(____)_____ (work)

Date of birth _____

When is the best time to call you? _____ **Husband's name** _____

2. When you enrolled in our study you gave the names of the following two people whom we could contact if we were unable to reach you. **Please correct this information if needed, or provide new names and addresses.** (At least one address should be *different* from yours).

Name_____
Address _____ Apt. #_____
_____
Telephone (____) _____

Name_____
Address _____ Apt. #_____
_____
Telephone (____) _____

3. **Have you ever had any of the following conditions?** (Please check Yes or No. **IF YES,** please give the date of *first* diagnosis or surgery.)

		No	Yes		Month	Year
3a.	**Breast cancer?**	☐	☐→	Date of diagnosis:	_____	19 ____
3b.	**Cancer of the uterus** (womb)?.....	☐	☐→	Date of diagnosis:	_____	19 ____
3c.	**Cancer of the ovary?**	☐	☐→	Date of diagnosis:	_____	19 ____
3d.	**Colon or rectum cancer?**.....	☐	☐→	Date of diagnosis:	_____	19 ____
3e.	**Melanoma?**	☐	☐→	Date of diagnosis:	_____	19 ____
3f.	**Lymphoma or Leukemia?**.....	☐	☐→	Date of diagnosis:	_____	19 ____
3g.	**Other cancer?**.....	☐	☐→	Date of diagnosis:	_____	19 ____
			↳	Type of cancer:	_____	
3h.	**Hysterectomy** (uterus removed)?	☐	☐→	Date of surgery:	_____	19 ____
3i.	**Bone fracture since age 35?**	☐	☐→	1. Year: 19 _____, Bone:	_____	
				2. Year: 19 _____, Bone:	_____	

4. **Did a doctor ever tell you that you had any of the medical problems listed below?** (Please check Yes or No. **IF YES,** when did a doctor tell you that you had this problem?)

		No	Yes	
4a.	**Heart attack or myocardial infarction?**	☐	☐→	Years diagnosed: 19____, 19____, 19____
4b.	**Angina?**	☐	☐→	Year first diagnosed: 19____
4c.	**Heart failure?**	☐	☐→	Year first diagnosed: 19____
4d.	**Stroke?**	☐	☐→	Years diagnosed: 19____, 19____, 19____
4e.	**TIA** (small stroke)?	☐	☐→	Years diagnosed: 19____, 19____, 19____
4f.	**High blood pressure?**	☐	☐→	Year first diagnosed: 19____
4g.	**Diabetes** (sugar disease)?	☐	☐→	Year first diagnosed: 19____
4h.	**Other heart or blood vessel problem?** (Please list all other conditions.)	☐	☐→	What problem? 1. _____ 2. _____

5. **Did you ever have any of the following procedures?** (**IF YES,** when?)

		No	Yes	
5a.	**Coronary Bypass surgery?**	☐	☐→	When? 19____, 19____
5b.	**Balloon or other angioplasty?**	☐	☐→	When? 19____, 19____, 19____
5c.	**Carotid artery surgery?**	☐	☐→	When? 19____, 19____
5d.	**Other blood vessel surgery?**	☐	☐→	Type of surgery:_____ Year: 19____

6. **Have you ever taken any of the following medicines?** (**IF YES,** when did you *first* start taking this medicine?)

		No	Yes	
6a.	**Blood pressure medicine?**	☐	☐→	Year first taken: 19____
6b.	**Medicine to lower your cholesterol?**	☐	☐→	Year first taken: 19____
6c.	**Insulin?**	☐	☐→	Year first taken: 19____

7. **Do you regularly take aspirin three or more times per week?** (Include Anacin, Bufferin, Alka Seltzer and other drugs which contain aspirin.) No ☐ Yes ☐

8. **Have you had at least one menstrual period in the past six months?** (Do not count bleeding which was brought on by hormones.) No ☐ Yes ☐

9. **What was the date of your last menstrual period?** (If you don't remember the month, just write the year.) _____ (month) 19 _____ (year)

10. **Have you ever had an ovary removed?** (This can be done either as a separate procedure or at the same time as a hysterectomy.) No ☐ Yes ☐ Not Sure ☐

IF NO OR NOT SURE, GO TO QUESTION 11.

IF YES:

10a. Have both your ovaries been removed completely? No ☐ Yes ☐ Not Sure ☐

10b. When was the *last* time you had surgery on your ovaries? 19 _____ (Year)

11. **Have you ever taken female hormones to prevent symptoms of menopause, effects of hysterectomy, osteoporosis, or heart disease?** (Exclude hormones taken for infertility.) No ☐ Yes ☐ Not Sure ☐

IF NO OR NOT SURE, GO TO QUESTION 12.

IF YES:

11a. How old were you when you *first* took these hormones? _____ (age)

11b. Altogether, for about how many years did you take these hormones? _____ (# of years)

11c. Are you still taking these hormones? No ☐ Yes ☐

IF NO LONGER TAKING HORMONES:

11d. How old were you when you *last* took these hormones? _____ (age)

12. **Do you currently smoke cigarettes?** No ☐ Yes ☐

IF NO, GO TO QUESTION 13.

IF YES:

12a. How many cigarettes do you usually smoke each day? _____ (# cigarettes per day)

13. **How much do you currently weigh?** _____ pounds

14. **In what country were you born?** _____ (Please **print** country.)

15. **Did your parent, brother, or sister ever have cancer of the colon or rectum?** No ☐ Yes ☐

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16. **In what year was your biological mother born?** _____ (year)

17. **How many children did your biological mother give birth to BEFORE you were born?** (Please include stillbirths.) _____ (number)

18. **AROUND 1985,** (when the study began), **how many hours did you usually sleep per night?** _____ (# of hours per night)

19. **AROUND 1985, did you usually sleep with a light on** (including a TV), **or with a bright light shining into your room?** No ☐ Yes ☐

20. **AROUND 1985, did you work outside the home?** No ☐ Yes ☐

IF NO, GO TO QUESTION 21.

IF YES:

20a. How many hours per week did you work outside the home in 1985? _____ (# of hours per week)

20b. Which of the following categories best describes the type of physical activity required by your primary job? _____ (choose 1, 2, or 3)

(1) Mainly sitting with some arm movements. (Examples: typist, bus driver, lawyer.)

(2) Sitting or standing with some walking. (Examples: cashier, teacher, lab technician.)

(3) Walking, with some lifting or carrying of materials. (Examples: mail carrier, waitress, nurse.)

21. **AROUND 1985, approximately how many hours per week did you spend doing the following types of work?** (If you didn't do this type of work, please write '0'.)

21a. **Heavy work in or around the home?** (Examples: scrubbing floors, grocery shopping, vacuuming, caring for young children; digging, raking, shoveling.) _____ (# of hours per week)

21b. **Lighter work in or around the home** (not including activities where you sit)**?** (Examples: preparing food, doing dishes, ironing, dusting, sweeping, doing laundry; weeding, watering.) _____ (# of hours per week)

22. **AROUND 1985, approximately how many hours per week did you spend in the following types of exercise?** (Please only include activities you did on a regular basis throughout the entire year. If you didn't do a particular type of exercise, please write '0'.)

22a. **Strenuous exercise (heart beats rapidly)?** (Examples: running, jogging, squash, vigorous gym aerobics, vigorous swimming, vigorous long distance bicycling.) _____ (# of hours per week)

22b. **Moderate exercise (not exhausting)?** (Examples: fast walking, tennis, easy bicycling, volleyball, easy swimming, easy gym aerobics.) _____ (# of hours per week)

22c. **Mild exercise (minimal effort)?** (Examples: yoga, fishing, bowling, golf, easy walking.) _____ (# of hours per week)