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 ______________
Husband's name ______________

2. When you enrolled in our study you gave the names of the following two people whom we could write to if we were unable to contact 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 **No** or **Yes** for every question. **IF YES**, please give the date of *first* diagnosis.)

	NO	YES		Month	Year
3a. **Breast cancer?**	☐	☐ →	Date of diagnosis:	________	_ _ _ _
3b. **Cancer of the uterus** (womb)?	☐	☐ →	Date of diagnosis:	________	_ _ _ _
3c. **Cancer of the ovary?**	☐	☐ →	Date of diagnosis:	________	_ _ _ _
3d. **Colon or rectum cancer?**	☐	☐ →	Date of diagnosis:	________	_ _ _ _
3e. **Melanoma?**	☐	☐ →	Date of diagnosis:	________	_ _ _ _
3f. **Lymphoma or Leukemia?**	☐	☐ →	Date of diagnosis:	________	_ _ _ _
3g. **Other cancer?**	☐	☐ →	Date of diagnosis:	________	_ _ _ _
		→	Type of cancer:	________________	
3h. **Hysterectomy** (uterus removed)?	☐	☐ →	Date of surgery:	________	_ _ _ _
3i. **Fibroid(s) of the uterus?**	☐	☐ →	Date of diagnosis:	________	_ _ _ _
		→	Did they cause heavy bleeding or pain ? No ☐ Yes ☐		

DC 06/03/2019

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

	NO	YES	
4a. **Heart attack or myocardial infarction?**	☐	☐ →	Years diagnosed: _ _ _ _, _ _ _ _, _ _ _ _
		→	Were you ever hospitalized for this? No ☐ Yes ☐
4b. **Angina?**	☐	☐ →	Year first diagnosed: _ _ _ _
4c. **Stroke?**	☐	☐ →	Years diagnosed: _ _ _ _, _ _ _ _, _ _ _ _
4d. **TIA** (small stroke or mini-stroke)?	☐	☐ →	Years diagnosed: _ _ _ _, _ _ _ _, _ _ _ _
4e. **High blood pressure?**	☐	☐ →	Year first diagnosed: _ _ _ _
4f. **Diabetes** (sugar disease)?	☐	☐ →	Year first diagnosed: _ _ _ _
4g. **Thyroid disorder?**	☐	☐ →	Year first diagnosed: _ _ _ _
4h. **Bone fracture since age 35?**	☐	☐ →	1. Month/Year: _ _ / _ _ _ _ Bone:__________
IF BONE FRACTURE:			2. Month/Year: _ _ / _ _ _ _ Bone:__________

4i. How did the fracture(s) happen? (Check all that apply.) ☐ slipped or tripped
☐ fell on ice/snow ☐ fell from standing on a chair or ladder ☐ fell down stairs
☐ motor vehicle accident ☐ Other: ______________________________

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

	NO	YES	
5a. **Coronary Bypass surgery?**	☐	☐ →	Which Years? _ _ _ _, _ _ _ _
5b. **Balloon or other angioplasty?**	☐	☐ →	Which Years? _ _ _ _, _ _ _ _, _ _ _ _
5c. **Carotid artery surgery?**	☐	☐ →	Which Years? _ _ _ _, _ _ _ _

6. **Have you ever taken any of the following medicines?** (**IF YES,** how old were you when you *first* started taking this medicine? How many years did you use it?)

	NO	YES		
6a. **Insulin?**	☐	☐ →	Age started: ______	
6b. **Blood pressure medicine?**	☐	☐ →	Age started: ______	
6c. **Medicine to lower your cholesterol?**	☐	☐ →	Age started: ______	
6d. **Tamoxifen** (Nolvadex)?	☐	☐ →	Age started: ______	# of years used: _____
6e. **Fosamax, Actonel or Didronel?**	☐	☐ →	Age started: ______	# of years used: _____
6f. **Evista** (Raloxifene)?	☐	☐ →	Age started: ______	# of years used: _____
6g. **Miacalcin** (Calcitonin)?	☐	☐ →	Age started: ______	# of years used: _____
6h. **Calcium pills or chews?**	☐	☐ →	Age started: ______	# of years used: _____

7. **How much do you currently weigh?** _______ pounds

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 ☐

IF NO MENSTRUAL PERIOD IN PAST SIX MONTHS:

8a. How old were you when you had your *last* menstrual period? _______ (age)

9. **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 10.

IF YES:

9a. Have both your ovaries been removed completely? No ☐ Yes ☐ Not Sure ☐

9b. When was the *last* time you had surgery on your ovaries? __ __ __ __ (year)

10. **Have you ever used female hormone pills or patches to prevent symptoms of menopause, effects of hysterectomy, osteoporosis, or heart disease?** (Exclude hormones taken for infertility or birth control.) No ☐ Yes ☐ Not Sure ☐

IF NO OR NOT SURE, GO TO NEXT PAGE.

IF YES:

10a. How old were you when you *first* took these female hormones? _______ (age)

10b. Altogether, for about how many years did you take these hormones? _______ (# of years)

10c. Are you still taking these hormones? No ☐ Yes ☐

IF NO LONGER TAKING HORMONES:

10d. How old were you when you *last* took hormones? _______ (age)

10e. Have you ever taken estrogen *by itself* (such as Premarin or Estrace), without taking progesterone during the same month or cycle? No ☐ Yes ☐ Not Sure ☐

IF YES:

10f. How old were you when you *first* took estrogen *by itself*? _______ (age)

10g. Altogether, for about how many years did you take estrogen *by itself*? _____ (# of years)

10h. Did you ever take progesterone *together with* estrogen? No ☐ Yes ☐ Not Sure ☐

IF YES:

10i. What preparation did you take the longest? ☐ Prempro ☐ Provera ☐ Other: _______

10j. How many days per month did you take this preparation? _______ (# days per month)

PLEASE TURN THIS PAGE OVER →

DC 06/03/2019

11. Did any of these biological relatives ever have cancer? (**IF YES,** please give the type of cancer.)

	NO	YES	
11a. **Did your biological father ever have cancer?**	☐	☐ →	Type of cancer: ______
11b. **Did your biological mother ever have cancer?**	☐	☐ →	Type of cancer: ______
11c. **Did any of your brothers ever have cancer?**	☐	☐ →	Type of cancer: ______
11d. **Did any of your sisters ever have cancer?**	☐	☐ →	Type of cancer: ______
11e. **Did any of your sisters have *breast* cancer?**	☐	☐ →	Age at diagnosis: ______

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

IF NO, GO TO QUESTION 13.

IF YES:

12a. Why are you taking aspirin? ☐ Arthritis ☐ Headache / Pain ☐ Prevention of heart disease ☐ Other, please specify: ______

13. Have you taken any of the following medications *three or more times per week* for a period of *six months or longer?* (**IF YES,** how old were you when you started taking this medicine 3 or more times per week? How many years did you take it?)

	NO	YES		
13a. **Tylenol** (Acetaminophen, Excedrin)? .	☐	☐ →	Age started: ______	# of years used: ______
13b. **Advil** (Motrin, Ibuprofen)?	☐	☐ →	Age started: ______	# of years used: ______
13c. **Aleve** (Anaprox, Naproxen)?	☐	☐ →	Age started: ______	# of years used: ______
13d. **Celebrex** (Celecoxib)?	☐	☐ →	Age started: ______	# of years used: ______
13e. **Vioxx** (Rofecoxib)?	☐	☐ →	Age started: ______	# of years used: ______

IF YOU TOOK ANY OF THESE MEDICATIONS:

13f. Why did you take this medication? ☐ Arthritis ☐ Headache / Pain ☐ Other, please specify: ______

14. Have you ever (at any age) smoked cigarettes on a regular basis, meaning at least one cigarette a day on average? No ☐ Yes ☐

IF YES:

14a. At about what age did you start smoking regularly? ______ (age)

14b. How many cigarettes do/did you usually smoke each day? ______ (# of cigarettes per day)

14c. Do you still smoke? No ☐ Yes ☐

IF NO LONGER SMOKING:

14d. How old were you when you stopped smoking? ______ (age)