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)
(____) _____ (cell)
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?**	☐	☐→	Date of diagnosis: _____	__ __ __ __
3g. **Leukemia?**	☐	☐→	Date of diagnosis: _____	__ __ __ __
3h. **Lung cancer?**	☐	☐→	Date of diagnosis: _____	__ __ __ __
3i. **Other cancer?**	☐	☐→	Date of diagnosis: _____	__ __ __ __
		→	Type of cancer: _____	__ __ __ __

4. **Did a doctor ever tell you that you had any of the medical problems listed below?**

	NO	YES		Were you hospitalized? NO	YES
4a. **Heart attack or myocardial infarction?**	☐	☐ →	Years diagnosed: _ _ _ _, _ _ _ _	☐	☐
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. **Parkinson's disease?**	☐	☐ →	Year first diagnosed: _ _ _ _		
4i. **Broken hip?**	☐	☐ →	Year first diagnosed: _ _ _ _		
4j. **Broken wrist?**	☐	☐ →	Year first diagnosed: _ _ _ _		

IF YOU BROKE YOUR HIP OR WRIST:

4k. How did the fracture(s) happen? (Check all that apply.) ☐ slipped ☐ tripped
☐ fell on ice/snow ☐ fell from standing position ☐ fell down stairs
☐ motor vehicle accident ☐ Other: _____

5. **Did you ever have any of the following procedures?**

	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?**

	NO	YES		
6a. **Insulin?**	☐	☐ →	Age started: _____	
6b. **Pills for diabetes?**	☐	☐ →	Age started: _____	
6c. **Blood pressure medicine?**	☐	☐ →	Age started: _____	
6d. **Medicine to lower your cholesterol?**	☐	☐ →	Age started: _____	
6e. **Fosamax, Actonel, Didronel or Boniva?**	☐	☐ →	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: _____
6i. **Multivitamins?**	☐	☐ →	Age started: _____	# of years used: _____

7. **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:

7a. How old were you when you had your last menstrual period? _____ (age)

8. **Have you had a hysterectomy** (uterus removed)**?** No ☐ Yes ☐ → Date of surgery: _____

9. **Have you had fibroids of the uterus?** No ☐ Yes ☐ → Date of surgery: _____

IF YOU HAD FIBROIDS:

9a. Did they cause heavy bleeding or pain ? No ☐ Yes, heavy bleeding ☐ Yes, pain ☐

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 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? _ _ _ _ (year)

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

IF YOU USED PILLS OR PATCHES: (Do not complete for creams or vaginal rings.)

11a. How old were you when you *first* used these female hormone pills or patches? _____ (age)

11b. Altogether, for about how many years did you use hormone pills or patches? _____ (# of years)

11c. Are you still using hormone pills or patches? No ☐ Yes ☐

IF NO LONGER USING HORMONE PILLS OR PATCHES:

11d. How old were you when you last used hormone pills or patches? _____ (age)

11e. 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:

11f. How old were you when you first took estrogen ***by itself***? _____ (age)

11g. Altogether, for about how many years did you take estrogen ***by itself***? _____ (# of years)

11h. Did you ever take estrogen and progesterone ***together*** in ***one pill or patch*** (such as Prempro, Premphase, or Combipatch)? No ☐ Yes ☐ Not Sure ☐

11i. Did you ever take ***both*** estrogen (such as Premarin) and progesterone (such as Provera) in ***separate pills or patches***? No ☐ Yes ☐ Not Sure ☐

IF YOU TOOK PROGESTERONE IN A SEPARATE PILL:

11j. How many days per month did you use the ***progesterone*** pill or patch? _____(# days/mo)

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

13. **Did any of these biological relatives ever have cancer?**

	NO	YES
13a. **Did your biological father ever have cancer?**	☐	☐ → Type of cancer: _____
13b. **Did your biological mother ever have cancer?**	☐	☐ → Type of cancer: _____
13c. **Did any of your brothers ever have cancer?**	☐	☐ → Type of cancer: _____
13d. **Did any of your sisters have *breast* cancer?**	☐	☐ → **Age at diagnosis:** _____
13e. **Did any of your sisters have some other cancer?**	☐	☐ → Type of cancer: _____
13f. **Did any of your daughters have *breast* cancer?**	☐	☐ → **Age at diagnosis:** _____
13g. **Did any of your children have some other cancer?**	☐	☐ → Type of cancer: _____

14. **Over the past year, about how many times per week on average did you take aspirin?** (Include Anacin, Bufferin, Alka Seltzer and other drugs which contain aspirin.)

☐ Less than once per week ☐ 1-2 times per week ☐ 3 or more times per week

IF YOU TOOK ASPIRIN:

14a. What type of aspirin did you take? ☐ Low dose (baby) aspirin ☐ Regular strength or greater

15. **At any time in the past year, did you take any of the following medications *three or more times in one week*? (IF YES,** for how many months in the past year did you take it three or more times per week?)

	NO	YES
15a. **Tylenol** (Acetaminophen, Excedrin)?	☐	☐ → Months of use in past year: ☐ Less than 6 months ☐ 6-12 months
15b. **Advil** (Motrin, Ibuprofen)?	☐	☐ → Months of use in past year: ☐ Less than 6 months ☐ 6-12 months
15c. **Aleve** (Naproxen)?	☐	☐ → Months of use in past year: ☐ Less than 6 months ☐ 6-12 months
15d. **Celebrex** or **Bextra**?	☐	☐ → Months of use in past year: ☐ Less than 6 months ☐ 6-12 months

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

IF YES:

16a. How many cigarettes do you usually smoke each day? _____ (# cigarettes per day)

17. **Over your *entire life*, how many times have you had a severe sunburn, with considerable pain or blistering?**

☐ Never
☐ 1-4 times
☐ 5-10 times
☐ More than 10 times but less than yearly
☐ One or more times per year

THANK YOU!