NYU WOMEN'S HEALTH STUDY FOLLOW-UP QUESTIONNAIRE

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

Name _____
Address _____ Apt.# ____
_____
Phone
Home # (____) _____
Cell # (____) _____
Email _____
Your 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 rectal cancer?**	☐	☐ →	Date of diagnosis: _____	__ __	__ __
3e. **Basal or squamous cell skin cancer?**	☐	☐ →	Date of diagnosis: _____	__ __	__ __
3f. **Melanoma?**	☐	☐ →	Date of diagnosis: _____	__ __	__ __
3g. **Lymphoma?**	☐	☐ →	Date of diagnosis: _____	__ __	__ __
3h. **Leukemia?**	☐	☐ →	Date of diagnosis: _____	__ __	__ __
3i. **Lung cancer?**	☐	☐ →	Date of diagnosis: _____	__ __	__ __
3j. **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: _ _ _ _		

IF YOU BROKE YOUR HIP:

4j. 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?**

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

6. **Are you currently taking any of the following medicines?**

	NO	YES
6a. **Insulin?**	☐	☐
6b. **Pills for diabetes?**	☐	☐
6c. **Blood pressure medicine?**	☐	☐
6d. **Medicine to lower your cholesterol?**	☐	☐
6e. **Fosamax** (Alendronate)**, Actonel, Reclast or Boniva?**	☐	☐
6f. **Evista** (Raloxifene)**?**	☐	☐
6g. **Miacalcin or Fortical** (Calcitonin)**?**	☐	☐
6h. **Forteo?**	☐	☐
6i. **Calcium pills or chews** (including Tums and Rolaids)**?**	☐	☐
6j. **Multivitamins?**	☐	☐

7. **Have you ever taken Vitamin D** (in calcium supplements or separately)**?** No ☐ Yes ☐

IF YES:

7a. At what age did you start taking Vitamin D? _____ (age)
7b. Are you still taking Vitamin D? No ☐ Yes ☐
7c. How many years altogether did you take Vitamin D? _____ years

8. **Have you had a tubal ligation** (tubes tied)**?** No ☐ Yes ☐ → Year of procedure: _ _ _ _

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

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 had a biopsy or aspiration of the breast?** No ☐ Yes ☐

IF YES:

11a. Have you had a breast biopsy or aspiration that did NOT result in a diagnosis of breast cancer?
No ☐ Yes ☐ → Year of ***first*** biopsy or aspiration: _ _ _ _

12. **Have you ever had a colonoscopy or sigmoidoscopy?** No ☐ Yes ☐

IF YES:

12a. In what year did you have the ***first*** colonoscopy/sigmoidoscopy? _ _ _ _ (year)
12b. Why was the colonoscopy or sigmoidoscopy done? ☐ routine screening ☐ Other: _____

13. **Have you ever had colon or rectal polyp(s) removed?** No ☐ Yes ☐ → Years: _ _ _ _, _ _ _ _

14. **Do you currently use female hormones (pills or patches) to prevent symptoms of menopause, effects of hysterectomy, or osteoporosis?** No ☐ Yes ☐

IF YES:

14a. Which of the following are you taking?

☐ ***Estrogen by itself*** (such as Premarin, Estrace or Ogen), without taking progesterone during the same month or cycle

☐ Estrogen and progesterone ***together*** in ***one pill or patch*** (such as Prempro, Premphase, or Combipatch)

☐ ***Both*** estrogen (such as Premarin) and progesterone (such as Provera) in ***separate pills or patches***

☐ Not sure

IF YOU TAKE PROGESTERONE IN A SEPARATE PILL:

14b. How many days per month do you use the ***progesterone*** pill or patch? _____ (#days/mo)

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

16. **What did you weigh at birth?** ☐ Less than 5.5 lbs ☐ 5.5 - 9 lbs ☐ more than 9 lbs ☐ Not Sure

17. **Did your biological mother have breast cancer?** No ☐ Yes ☐→ Age at diagnosis: _____

18. **Did any of your biological sister(s) have breast cancer?** No ☐ Yes ☐ No biological sisters ☐

IF YES:

18a. Number of sisters with breast cancer: _____ 18b. Age(s) at diagnosis: _____, _____, _____

19. **Did any of your biological daughter(s) have breast cancer?** No ☐ Yes ☐ No biological daughters ☐

IF YES:

19a. Number of daughters with breast cancer: _____ 19b. Age(s) at diagnosis: _____, _____, _____

20. **Are you a twin?** No ☐ Yes ☐→ What type? ☐ Identical ☐ Fraternal ☐ Not sure

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

IF YES:

21a. How many cigarettes do you usually smoke each day? _____ (# cigarettes per day)

22. **Before age 18, did you live with an adult who smoked *in the house*?** No ☐ Yes ☐

23. **During the past year, how often *on average* did you take aspirin?** (Include Anacin, Bufferin, Alka Seltzer, aspirin-containing Excedrin, and other drugs which contain aspirin.)

☐ Did not take ☐ Less than once per week ☐ 1-2 times per week ☐ 3 or more times per week

IF YOU TOOK ASPIRIN:

23a. What type of aspirin did you take? ☐ Low dose (baby) aspirin ☐ Regular strength or greater

24. **During the past year, how often *on average* did you take the following?**

24a. **Tylenol or Excedrin** (Acetaminophen)**?**

☐ Did not take ☐ Less than once per week ☐ 1-2 times per week ☐ 3 or more times per week

24b. **Advil, Motrin or Nuprin** (Ibuprofen)**?**

☐ Did not take ☐ Less than once per week ☐ 1-2 times per week ☐ 3 or more times per week

24c. **Aleve** (Naproxen)**?**

☐ Did not take ☐ Less than once per week ☐ 1-2 times per week ☐ 3 or more times per week

Thank You!