18. **Did your biological father ever have cancer?** No ☐ Yes ☐ Don't know ☐

IF YES: (Report only the *first* cancer.)

18a. Father: Type of cancer:_____ Age at diagnosis:_____

19. **Did your biological mother have cancer?** No ☐ Yes ☐ Don't know ☐

IF YES: (Report only the *first* cancer.)

19a. Mother: Type of cancer:_____ Age at diagnosis:_____

20. **Did any of your biological sisters have cancer?** No ☐ Yes ☐ No biological sisters ☐

IF YES: (Report only the *first* cancer for each sister who had cancer.)

20a. Sister 1: Type of cancer:_____ Age at diagnosis:_____

20b. Sister 2: Type of cancer:_____ Age at diagnosis:_____

20c. Sister 3: Type of cancer:_____ Age at diagnosis:_____

21. **Did any of your biological brothers have cancer?** No ☐ Yes ☐ No biological brothers ☐

IF YES: (Report only the *first* cancer for each brother who had cancer.)

21a. Brother 1: Type of cancer:_____ Age at diagnosis:_____

21b. Brother 2: Type of cancer:_____ Age at diagnosis:_____

21c. Brother 3: Type of cancer:_____ Age at diagnosis:_____

22. **Do you live in any of the following residential settings?**

Nursing home ☐ Assisted living facility ☐ Senior/retirement housing ☐ None of these ☐

23. **Do you live part of the year at an address *different* from the one printed on the front of this questionnaire?** No ☐ Yes ☐

IF YES: Please give your 2nd address below.

2nd address: _____ Apt. #_____

_____

Telephone (_____)_____

Which months are you usually at this 2nd address? _____

Thank You!

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?** **Were you hospitalized?**

	NO	YES		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. **Psoriasis?**	☐	☐ →	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. **Prescription medicine to prevent or treat osteoporosis?**	☐	☐
6f. **Female hormones** (containing estrogen)**?**	☐	☐
6g. **Multivitamins?**	☐	☐
6h. **Calcium pills or chews** (including Tums and Rolaids)**?**	☐	☐
6i. **Vitamin D?**	☐	☐

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

8. **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:

8a. Have both your ovaries been removed completely? No ☐ Yes ☐ Not Sure ☐

8b. When was the *last* time you had surgery on your ovaries? _ _ _ _ (year)

9. **Have you ever had a biopsy or aspiration of the breast?** No ☐ Yes ☐

IF YES:

9a. Have you ever had a ***benign*** breast biopsy or aspiration (that is, a breast biopsy or aspiration that did ***NOT*** result in a dignosis of cancer)? No ☐ Yes ☐

IF YES:

9b. When was your ***first*** benign breast biopsy or aspiration? _ _ _ _ (year)

10. **Did you report breast cancer on page 1 of this questionnaire?** No ☐ Yes ☐

IF YES:

10a. Was your breast cancer detected by a routine breast cancer screening? No ☐ Yes ☐

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

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

13. **What is your current height?** _____feet _____inches

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

IF YES:

14a. How many cigarettes do you usually smoke each day? _____cigarettes per day

15. **About how much do you usually walk outdoors in a week** (including walking to work or to other activities)**?** (If you are not sure, please try to estimate.) _____miles OR _____blocks OR _____minutes (per week)

16. **Do you usually use a cane, walker, or wheelchair/scooter?** (Check all that apply.)

☐ No ☐ Cane ☐ Walker ☐ Wheelchair/scooter ☐ Unable to walk

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

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