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 _____
Spouse'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. **Congestive heart failure?**	☐	☐ →	Year first diagnosed: _ _ _ _	☐	☐
4f. **High blood pressure?**	☐	☐ →	Year first diagnosed: _ _ _ _		
4g. **Diabetes** (sugar disease)**?**	☐	☐ →	Year first diagnosed: _ _ _ _		
4h. **Macular degeneration?**	☐	☐ →	Year first diagnosed: _ _ _ _		
4i. **Parkinson's disease?**	☐	☐ →	Year first diagnosed: _ _ _ _		
4j. **Broken hip?**	☐	☐ →	Year first diagnosed: _ _ _ _		

IF YOU BROKE YOUR HIP:

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?**

	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. **Female hormones** (containing estrogen)**?**	☐	☐
6f. **Prescription medicine to treat depression?**	☐	☐

7. **In the past month, how often have you been feeling down, depressed or hopeless?**
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

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

IF YES:

8a. Have you ever had a ***benign*** breast biopsy or aspiration (that is, a breast biopsy or aspiration that did ***NOT*** result in a diagnosis of cancer)? No ☐ Yes ☐

IF YES:

8b. When was your ***first*** benign breast biopsy or aspiration? _ _ _ _ (year)

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

IF YES:

9a. Was your breast cancer detected by a routine breast cancer screening? No ☐ Yes ☐

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

11. **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:

11a. Have both your ovaries been removed completely? No ☐ Yes ☐ Not Sure ☐

11b. When was the *last* time you had surgery on your ovaries? _ _ _ _ (year)

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

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

14. **In the last year, have you lost more than 10 pounds unintentionally?** (that is, not due to dieting or exercise) No ☐ Yes ☐

15. **The following questions ask about your memory.**

	NO	YES
15a. **Have you recently experienced any change in your ability to remember things?** . . .	☐	☐
15b. **Do you have more trouble than usual remembering recent events?**	☐	☐
15c. **Do you have more trouble than usual remembering a short list of items, such as a shopping list?**	☐	☐
15d. **Do you have any difficulty understanding or following spoken instructions?**	☐	☐
15e. **Do you have more trouble than usual following a group conversation or a plot in a TV program *due to your memory*?**	☐	☐
15f. **Do you have trouble finding your way around familiar streets?**	☐	☐

16. **Do you have a hearing problem?** ☐ Not at all ☐ Mild ☐ Moderate ☐ Severe

IF YES:

16a. How old were you when you first noticed the problem? _____ years old

16b. Do you wear a hearing aid? ☐ No ☐ Yes

17. **In the past month, how many hours of actual sleep did you get most nights?** _____hours

18. **In the past month, how would you rate your sleep quality overall?**

☐ Very good ☐ Fairly good ☐ Fairly bad ☐ Very bad

19. **In the past month, how often have you taken medicine to help you sleep?** (prescribed or over-the-counter)

☐ Not in the past month ☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 or more times a week

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

21. **In the past year, 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. If you didn't do a particular type of exercise, please write '0'.)

21a. **Strenuous exercise** (heart beats rapidly)**?** (Examples: running, jogging, vigorous bicycling, vigorous swimming, vigorous gym aerobics) _____ (# of hours per week)

21b. **Moderate exercise** (not exhausting)**?** (Examples: fast walking, doubles tennis, moderate bicycling, moderate swimming, moderate gym aerobics, dancing) _____ (# of hours per week)

21c. **Mild exercise?** (Examples: gentle yoga, bowling, golf, light gardening, easy walking) _____ (# of hours per week)

22. **About how much do you usually *walk outdoors* in a week** (including walking to work, shopping, or to other activities)**?** (Please include outdoor walking you reported in the question above. If you do not walk outdoors, please write '0'.)

_____ miles OR
_____ blocks OR
_____ minutes
(per week)

23. **What is your usual walking pace?** ☐ Slow ☐ Average ☐ Brisk ☐ Unable to walk

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

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

25. **In the past year, have you had any falls to the ground?** No ☐ Yes ☐→ Number of falls: _____

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

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

Thank You!