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:	________	

DC 2/8/2021

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. **Chronic Obstructive Pulmonary Disease?**	☐	☐ →	Year first diagnosed: ____		
4g. **High blood pressure?**.	☐	☐ →	Year first diagnosed: ____		
4h. **Diabetes** (sugar disease)**?**	☐	☐ →	Year first diagnosed: ____		
4i. **Macular degeneration?**	☐	☐ →	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. **Anticoagulant medications or blood thinners** (Coumadin, Pradaxa, Eliquis, Xarelto)**?** . .	☐	☐
6f. **Low-dose aspirin** (baby aspirin, 81mg daily aspirin)**?**	☐	☐
6g. **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. **Has a healthcare provider ever told you that you had, or likely had, COVID-19?** No ☐ Yes ☐

IF YES:

8a. Date the healthcare provider told you that you had, or likely had, COVID-19: _ _ / _ _/ _ _ (MM/ DD/ YY)

8b. Were you hospitalized? No ☐ Yes ☐→ Date you were hospitalized: _ _ / _ _/ _ _ (MM/ DD/ YY)

9. **Which of the following COVID-19 symptoms have you had in 2020?** (Mark all that apply.)

☐ No symptoms ☐ Fever ☐ Cough ☐ Shortness of breath ☐ Sore throat ☐ Fatigue

☐ Loss of taste or smell ☐ Other:________________________________

10. **Did you ever have a nasal swab or saliva test for active COVID-19 infection?** No ☐ Yes ☐

IF YES:

10a. Was your swab/saliva test ever positive? No ☐ Yes ☐→ Date of **<u>1st</u>** positive: _ _ / _ _/ _ _ (MM/ DD/ YY)

10b. Was your swab/saliva test ever negative? No ☐ Yes ☐→ Date of **<u>most</u> <u>recent</u>** negative test: _ _ / _ _/ _ _ (MM/ DD/ YY)

11. **Did you ever have an antibody (blood) test for COVID-19?** No ☐ Yes ☐

IF YES:

11a. Was your antibody test ever positive? No ☐ Yes ☐→ Date of **<u>1st</u>** positive: _ _ / _ _/ _ _ (MM/ DD/ YY)

11b. Was your antibody test ever negative? No ☐ Yes ☐→ Date of **<u>most</u> <u>recent</u>** negative test: _ _ / _ _/ _ _ (MM/ DD/ YY)

12. **Between March and June 2020 (during the 1st stay-at-home order), about how many times per week did you go outside the home?** (for example, to stores or parks) ________ (times per week)

13. **Between March and June 2020 (during the 1st stay-at-home order), about how much did you usually *walk outdoors* in a week** (including walking to work, shopping, or to other activities)**?** (If you did not walk outdoors, please write ‘0’.)

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

14. **Since the *<u>end</u>* of the 1st stay-at-home order, 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’.)

14a. **Strenuous exercise** (heart beats rapidly)**?** (Examples: running, jogging, vigorous bicycling, vigorous swimming, vigorous gym aerobics) ________ (# of hours per week)

14b. **Moderate exercise** (not exhausting)**?** (Examples: fast walking, doubles tennis, moderate bicycling, moderate swimming, moderate gym aerobics, dancing) ________ (# of hours per week)

14c. **Mild exercise?** (Examples: gentle yoga, bowling, golf, light gardening, easy walking) ________ (# of hours per week)

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

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

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

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

	NO	YES
17a. **Have you recently experienced any change in your ability to remember things?** . . .	☐	☐
17b. **Do you have more trouble than usual remembering recent events?**	☐	☐
17c. **Do you have more trouble than usual remembering a short list of items, such as a shopping list?**	☐	☐
17d. **Do you have any difficulty understanding or following spoken instructions?**	☐	☐
17e. **Do you have more trouble than usual following a group conversation or a plot in a TV program *due to your memory*?**	☐	☐
17f. **Do you have trouble finding your way around familiar streets?**	☐	☐

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

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

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

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

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

21. **In the past month, how lonely were you?**

☐ Not lonely ☐ Slightly lonely ☐ Moderately lonely ☐ Very lonely ☐ Extremely lonely

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

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

24. **How much do you currently weigh?** ______ pounds

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

26. **How many alcoholic drinks do you currently consume in a week?**

(By one drink, we mean 12 oz of beer, 5 oz of wine, or 1½ ounces of liquor) _______ drinks per week

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

IF YES:

27a. How old were you when you first noticed the problem? ______ years old

27b. Do you wear a hearing aid? ☐ No ☐ Yes

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

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

Thank You!