1st Follow-Up (1987)

IOWA WOMEN'S HEALTH STUDY
UNIVERSITY OF MINNESOTA AND UNIVERSITY OF IOWA

MARKING DIRECTIONS

- Use a pencil only (Do NOT use pen).
- Darken completely the circle of the answer you choose.
- Erase cleanly any answer you wish to change.
- Make no stray marks of any kind.
- Written responses must stay within spaces provided.

ADDRESS LABEL

DO NOT WRITE IN THIS AREA

1. Mark one of the following three circles:

○ A. INDIVIDUAL LISTED ON THE ADDRESS LABEL NO LONGER LIVES AT THE GIVEN ADDRESS AND/OR I DO NOT KNOW THE INDIVIDUAL LISTED ABOVE.

○ B. INDIVIDUAL ON ADDRESS LABEL IS DECEASED.

Date of death: Month ____ 19 Year ____ State Where Death Occurred: ____

○ C. NEITHER A OR B APPLIES.

2. Please correct any incorrect information on the label.

CORRECT NAME

CORRECT STREET ADDRESS

CORRECT CITY, STATE, ZIP

THE REST OF THIS QUESTIONNAIRE IS TO BE COMPLETED ONLY BY THE INDIVIDUAL ON THE ADDRESS LABEL. (If you are not the individual on the label, please STOP here and return the questionnaire in the postage-paid envelope.)

3. In general, would you say your current health is:

○ EXCELLENT ○ FAIR
○ GOOD ○ POOR

We are interested in medical conditions you have developed since our last questionnaire. Since February 1, 1986, were you diagnosed for the first time by a doctor as having:

4. SUGAR DIABETES

○ NO ○ YES

If "Yes", please mark the month and year of diagnosis.

○ Jan. ○ May ○ Sep. ○ 1986
○ Feb. ○ Jun. ○ Oct. ○ 1987
○ Mar. ○ Jul. ○ Nov.
○ Apr. ○ Aug. ○ Dec.

Since February 1, 1986, were you diagnosed for the first time by a doctor as having:

5. HEART DISEASE OR ANGINA

○ NO ○ YES

If "Yes", please mark the month and year of diagnosis.

○ Jan. ○ May ○ Sep. ○ 1986
○ Feb. ○ Jun. ○ Oct. ○ 1987
○ Mar. ○ Jul. ○ Nov.
○ Apr. ○ Aug. ○ Dec.

6. HEART ATTACK

○ NO ○ YES

If "Yes", please mark the month and year of diagnosis.

○ Jan. ○ May ○ Sep. ○ 1986
○ Feb. ○ Jun. ○ Oct. ○ 1987
○ Mar. ○ Jul. ○ Nov.
○ Apr. ○ Aug. ○ Dec.

7. STROKE

○ NO ○ YES

If "Yes", please mark the month and year of diagnosis.

○ Jan. ○ May ○ Sep. ○ 1986
○ Feb. ○ Jun. ○ Oct. ○ 1987
○ Mar. ○ Jul. ○ Nov.
○ Apr. ○ Aug. ○ Dec.

8. HIGH BLOOD PRESSURE (HYPERTENSION)

○ NO ○ YES

If "Yes", please mark the month and year of diagnosis.

○ Jan. ○ May ○ Sep. ○ 1986
○ Feb. ○ Jun. ○ Oct. ○ 1987
○ Mar. ○ Jul. ○ Nov.
○ Apr. ○ Aug. ○ Dec.

9. BENIGN (NON-CANCEROUS) LUMPS OR CYSTS IN BREAST

○ NO ○ YES

If "Yes", please mark the month and year of diagnosis.

○ Jan. ○ May ○ Sep. ○ 1986
○ Feb. ○ Jun. ○ Oct. ○ 1987
○ Mar. ○ Jul. ○ Nov.
○ Apr. ○ Aug. ○ Dec.

10. BREAST CANCER

○ NO ○ YES

If "Yes", please mark the month and year of diagnosis.

○ Jan. ○ May ○ Sep. ○ 1986
○ Feb. ○ Jun. ○ Oct. ○ 1987
○ Mar. ○ Jul. ○ Nov.
○ Apr. ○ Aug. ○ Dec.

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(0) (1) (9) ○ 86 ○ 87 ○ 9 (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)
(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (0) (1) (2) (3) (4) (5) (6) (7) (8) (9)

Since February 1, 1986, were you diagnosed for the first time by a doctor as having:

11. CANCER OTHER THAN BREAST CANCER — Please specify type, and month and year of diagnosis.

○ NO ○ YES

Type

○ Jan. ○ May ○ Sep. ○ 1986
○ Feb. ○ Jun. ○ Oct. ○ 1987
○ Mar. ○ Jul. ○ Nov.
○ Apr. ○ Aug. ○ Dec.

12. Have you suffered a fracture (broken bone) since February 1, 1986, which required treatment by a doctor?

○ NO → (Go to Question 13)
○ YES → If yes, which of the following fractures?

○ NO ○ YES UPPER ARM
○ NO ○ YES FOREARM
○ NO ○ YES WRIST
○ NO ○ YES RIBS
○ NO ○ YES HIP
○ NO ○ YES OTHER

13. Are you currently using pills which contain ESTROGENS OR OTHER FEMALE HORMONES? (For example, for the change of life [menopause], after surgery, or for any other reason?)

○ NO ○ YES

14. May we have your permission to contact your physician(s) for verification of your medical history?

○ NO → (Go to Question 15)
○ YES

If "Yes," please sign below:

Signature

Please list the name, address and phone number of your usual doctor and any others from whom you've received treatment. Begin with the most recent and list only three.

1. Doctor: _____
   Address: _____
   City: _____ State: _____
   ZIP: _____ Telephone: (_____) _____
   Area Code

2. Doctor: _____
   Address: _____
   City: _____ State: _____
   ZIP: _____ Telephone: (_____) _____
   Area Code

3. Doctor: _____
   Address: _____
   City: _____ State: _____
   ZIP: _____ Telephone: (_____) _____
   Area Code

15. Which of the following best describes your national origin or ancestry? (Please mark only one.)

○ ASIAN
○ AFRO-AMERICAN
○ AMERICAN INDIAN
○ DUTCH
○ ENGLISH, SCOTTISH, WELSH
○ GERMAN
○ IRISH
○ NORWEGIAN
○ SWEDISH
○ SOUTHERN EUROPEAN (ITALIAN, GREEK, ETC.)
○ EASTERN EUROPEAN (POLISH, RUSSIAN, CZECH, ETC.)
○ OTHER CENTRAL OR WESTERN EUROPEAN
○ OTHER

If "other" please specify in write-in box only.

16. What is your current weight? (Without clothes and to the nearest pound)

Pounds

17. We plan to conduct a brief study this winter on diet that would require completion of several food questionnaires. Would you be interested in participating?

○ NO

○ YES

If your winter address is different from the one indicated on front of this questionnaire, please give your winter address.

WINTER STREET ADDRESS

WINTER CITY, STATE, ZIP

FROM (DATE) — TO (DATE)

THANK YOU FOR YOUR TIME AND COOPERATION. If you have any additional comments, you may include them in the space provided below. Please place the completed questionnaire in the postage-paid envelope provided, seal it, and mail it to us.

COMMENTS

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11. ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

16. ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨