



IOWA WOMEN'S HEALTH STUDY

UNIVERSITY OF MINNESOTA AND UNIVERSITY OF IOWA

3rd Follow-Up
(1992)

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. Determine which one of the following three statements applies and mark the appropriate circle.

- The individual listed on the address label is alive.
- Individual on address label is deceased.

Date of Death: State Where Death Occurred:

Month	Year	
<input type="text"/>	19 <input type="text"/>	<input type="text"/>

- I do not know whether the individual on address label is alive or dead.

2. Please correct any incorrect information on the label.

_____ CORRECT NAME

_____ CORRECT STREET ADDRESS

_____ CORRECT CITY, STATE ZIP

FOR OFFICE USE ONLY

0 1

0 1 2 3 4 5 6 7 8 9

86 87 88 89 90 91 92

0 1 2 3 4 5

0 1 2 3 4 5 6 7 8 9

We request that the rest of this questionnaire be completed by the individual on the label. If someone else completes the questionnaire for the named individual, please darken this circle.



The remaining questions inquire about the individual on the label. If you are not that individual, answer the questions as if you were.

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

- EXCELLENT
- GOOD
- FAIR
- POOR

4. Compared to other people your own age, would you say your memory is:

- EXCELLENT
- GOOD
- FAIR
- POOR
- VERY POOR

5. Which of these statements fits you best?

(Mark one.)

- I cannot work (or keep house) at all now because of my health.
- I have to limit some of the work or other things that I do.
- I am not limited in any of my activities.

6. Which of these things are you healthy enough to do without help?

A. Heavy work around the house like shoveling snow or washing walls, windows, and floors?

- NO
- YES

B. Walk a half mile?

- NO
- YES

C. Go out to a movie, to church or a meeting, or to visit friends?

- NO
- YES

D. Walk up and down a flight of stairs?

- NO
- YES

E. Prepare most of your own meals?

- NO
- YES

We are interested in medical conditions you have developed since July, 1989.

7. Since July 1989, have you suffered a fracture (broken bone), which required treatment by a doctor?

NO → **GO TO ITEM 8**

YES → If yes, which of the following fractures? (Mark NO or YES for each type.)

- NO YES UPPER ARM
- NO YES FOREARM
- NO YES WRIST
- NO YES RIBS

(Mark NO or YES for each type.)

- NO YES HIP
- NO YES VERTEBRA (Part of the Spine)
- NO YES OTHER

8. Since July 1989, were you diagnosed for the first time by a doctor as having:

- NO YES SUGAR DIABETES
- NO YES HEART DISEASE OR ANGINA
- NO YES HEART ATTACK
- NO YES STROKE
- NO YES HIGH BLOOD PRESSURE (HYPERTENSION)
- NO YES BREAST CANCER
- NO YES CANCER OTHER THAN BREAST CANCER

↓
If yes, please specify the type of cancer:

TYPE

9. Has your uterus (womb) been surgically removed?

- NO
- YES
- DON'T KNOW

10. Have your ovaries been surgically removed?

- NO
- YES - ONE OVARY
- YES - BOTH OVARIES
- DON'T KNOW

<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9	FOR OFFICE USE ONLY
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------

11. Please indicate, by filling in the circle, (either "no", "yes", or "not sure") if a physician has told you that you have any of the following conditions. In addition, please give your approximate age at diagnosis. It is very important that you mark an answer for each of the following questions, even if you have never had that condition.

HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE . . .

NO	YES	NOT SURE	IF "YES" AGE AT FIRST DIAGNOSIS	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Years Old	RHEUMATOID ARTHRITIS
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Years Old	OSTEOARTHRITIS
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Years Old	MIGRAINE HEADACHES
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Years Old	CATARACTS (EYE)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Years Old	GLAUCOMA (EYE)
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Years Old	PARKINSON'S DISEASE
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Years Old	CORONARY BYPASS SURGERY
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Years Old	BALLOON ANGIOPLASTY (DILATION) OF THE CORONARY ARTERIES

12. How many months of the year do you live in Iowa?

- 10-12 months 4-6 months
 7-9 months Less than 4 months

13. What is your current marital status?

- Never married Separated or divorced
 Currently married Widowed

14. Are you a twin?

- NO
 YES →
 Is your twin a male or female?
 Male
 Female

 Are you and your twin:
 Identical (monozygotic)
 Fraternal (dizygotic)
 Not sure

GO TO ITEM 15, NEXT PAGE

FOR OFFICE USE ONLY

RA	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
OA	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MH	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
C	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
G	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PD	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CB	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
BA	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Some of the following questions ask you to provide a number in a set of blank boxes and fill in related circles. For example, 95 pounds is:

0 9 5

Pounds

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

First write the number in the boxes. Then follow the arrow to the appropriate circle and darken. If you cannot follow how to darken the correct circles, please simply write the numbers in the boxes and we will do the rest.

15. Have you ever received blood or had a blood transfusion?

NO → GO TO ITEM 17

YES

DON'T KNOW → GO TO ITEM 17

16a. How old were you when you received your first blood transfusion?

Years Old

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

b. Since July 1989, have you received blood or had a blood transfusion?

NO

YES

DON'T KNOW

17. 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

18. How often do you take aspirin? Examples of aspirin include: Bufferin, Anacin, enteric-coated aspirin, Ecotrin, and Excedrin. (Do not include acetaminophen, Tylenol, ibuprofen, Advil.)

Never

Less than 1 per week

1 per week

2-5 per week

6+ per week

19. How often do you take other nonsteroidal anti-inflammatory drugs or arthritis medicines? Examples include: ibuprofen, Advil, Nuprin, Motrin, Naprosyn, Feldene, Clinoril. (Do not include aspirin, acetaminophen, Tylenol, prednisone, cortisone, Deltasone)

Never

2-5 per week

Less than 1 per week

6+ per week

1 per week

The following questions ask about your weight in the past when you weren't pregnant.

Think first about when you were 18-39 years old. If it helps, remember the places you lived when you were 18-39, who you knew, etc.

20. Between the ages of 18-39, what was the MOST you weighed (excluding pregnancy)?

Pounds

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

21. Between the ages of 18-39, what was the LEAST you weighed?

Pounds

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

22. Between the ages of 18-39, about how many different times did you LOSE each of the following amounts of weight on purpose (excluding pregnancy or illness)? (Please darken one circle for each row, even if the answer is zero.)

	0 times	1-2 times	3-4 times	5-6 times	7+ times
50+ lbs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 to 49 lbs. .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 to 19 lbs. .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 to 9 lbs. ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

23. Between the ages of 18-39, about how many different times did you lose 20 or more pounds when you weren't trying to (for example, because of illness)?

- 0 times 5-6 times
 1-2 times 7+ times
 3-4 times

Think now about when you were 40-54 years old.

24. Between the ages of 40-54, what was the MOST you weighed?

Pounds

25. Between the ages of 40-54, what was the LEAST you weighed?

Pounds

26. Between 40-54, about how many different times did you LOSE each of the following amounts of weight on purpose (excluding pregnancy or illness)?

	0 times	1-2 times	3-4 times	5-6 times	7+ times
50+ lbs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 to 49 lbs. .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 to 19 lbs. .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 to 9 lbs. ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. Between 40-54, about how many different times did you lose 20 or more pounds when you weren't trying to (for example, because of illness)?

- 0 times 5-6 times
 1-2 times 7+ times
 3-4 times

Next think about the time since you were 55 years old.

28. Between the age of 55 and now, what was the MOST you weighed?

Pounds

29. Between the age of 55 and now, what was the LEAST you weighed?

Pounds

30. Between age 55 and now, about how many different times did you LOSE each of the following amounts of weight on purpose (excluding illness)?

	0 times	1-2 times	3-4 times	5-6 times	7+ times
50+ lbs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 to 49 lbs. .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 to 19 lbs. .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 to 9 lbs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

31. Between age 55 and now, about how many different times did you lose 20 or more pounds when you weren't trying to (for example, because of illness)?

- 0 times
- 1-2 times
- 3-4 times
- 5-6 times
- 7+ times

32. What is your current weight? (without clothes, to the nearest pound)

Pounds

33. Please darken the circles indicating the number of times since age 18 that you lost 20 or more pounds due to each of the following:

I lost 20 or more pounds by ...

	0 times	1-2 times	3-4 times	5-6 times	7+ times
a. Diet pills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. A liquid diet .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Weight loss group, without food supplied (e.g., TOPS, Weight Watchers) ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I lost 20 or more pounds by ...

	0 times	1-2 times	3-4 times	5-6 times	7+ times
d. Diet center with food provided (e.g., Nutri-System, Jenny Craig) .	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Starvation, fasting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Other low calorie diet ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Depression or stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Stomach/intestinal surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

34. How many different times in your life have you gained 20 pounds or more within a six month period, excluding pregnancy?

- 0 times
- 1-2 times
- 3-4 times
- 5-6 times
- 7+ times

35. What is the most weight you ever gained during a pregnancy?

- Never pregnant
- Less than 10 pounds
- 10-19 pounds
- 20-29 pounds
- 30-39 pounds
- 40+ pounds

36. When you eat red meat, such as beef, pork, or lamb, how "well done" is it usually prepared?

- Rare
- Medium rare
- Medium
- Medium well done
- Well done
- Do not eat red meat

37. How many times do you eat or drink during a usual day? This includes meals, snacks, and beverage breaks.

- Once
- Twice
- 3 times
- 4 times
- 5 times
- 6 times
- 7 times
- 8 times
- 9+ times

38. Have you ever in your life drunk alcoholic beverages on a regular basis?

- YES → a. How old were you when you began drinking alcoholic beverages regularly?
- NO

GO TO ITEM 39

Years Old

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

Continue in next column

b. Do you currently drink alcoholic beverages regularly?

- YES
- NO → At what age did you quit drinking alcoholic beverages?

Years Old

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

c. During the entire time you were drinking regularly, what was your average consumption of alcoholic beverages?

- Less than one per month
- 1-3 per month
- 1 per week
- 2-4 per week
- 5-6 per week
- 1 per day
- 2-3 per day
- 4-5 per day
- 6+ per day

39. Please indicate how often on average over the past year you ate or drank the following. Be sure to fill in a circle for each row.

AVERAGE USE LAST YEAR

	Never or less than once per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day
Beer (1 glass, bottle, can)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red wine (4 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White wine (4 oz. glass)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liquor, e.g., whiskey, gin, etc. (1 drink or shot)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Red meat, poultry, or fish that was cooked by frying, broiling, baking, or barbecuing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drippings from cooked red meat, poultry, or fish, either on other foods or in gravy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

40. We would like to ask you about diseases that have occurred in your family members. Fill in all appropriate circles to indicate whether your Father, Mother, a brother or a sister have had each disease. Include only blood relatives. (You may have to darken more than one circle per row. If none of these relatives have had the disease, please mark the circle "No family history".)

	No family history	Father	Mother	Brother	Sister
Diabetes mellitus (sugar diabetes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prostate cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart attack at or before age 45	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast cancer at or before age 45	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast cancer after age 45	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

41. We would like to know about your full sisters (who share the same mother and father as you) and half-sisters (who share only one parent with you), but not step-sisters.

Do/did you have any sisters (full or half)?

NO → **GO TO ITEM 42**

YES → Darken a circle to indicate how many sisters you have (or had).

1
 2
 3
 4
 5
 6
 7
 8
 9+

To help identify sisters in the Iowa Women's Health Study, would you please print the names and birthdates of your full sisters that lived in Iowa between 1985 and 1987.

LAST NAME (in 1985-1987)	FIRST NAME	MONTH / YEAR OF BIRTH
		Use numbers please
1) _____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2) _____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3) _____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4) _____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5) _____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
6) _____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
7) _____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Now please print the names and birthdates of your half-sisters (same mother or father) that lived in Iowa between 1985 and 1987.

LAST NAME (in 1985-1987)	FIRST NAME	MAIDEN NAME	MONTH / YEAR OF BIRTH
1) _____	_____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2) _____	_____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3) _____	_____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4) _____	_____	_____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

42. Do you smoke cigarettes now?

NO YES → How many per day?

Cigarettes per day

43. If we need additional information or for clarification of your answers, we may need to contact you by telephone. What is your telephone number?

Telephone: () - _____

44. Please provide the name, address and telephone number of a close friend or relative who does not live with you, but will always know your whereabouts:

Name: _____

Street: _____

City: _____ State: _____

Telephone: () - _____

Their relationship: _____

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.

