

NATIONAL INSTITUTES OF HEALTH AND AARP



FOLLOW-UP QUESTIONNAIRE

Please complete the questionnaire and return it in the postage-paid envelope to:

NIH-AARP Diet and Health Study
649 N. Horners Lane
Rockville, MD 20850-1299

By completing and returning this questionnaire, you are consenting to continue to participate in this study.

BEFORE TURNING THE PAGE, PLEASE READ BOX A AND BOX B.

BOX A

If the person whose name appears on the accompanying letter is deceased, please fill in the circle to the left, provide the state where they died and the date of death below, **AND STOP HERE**. Please return the blank questionnaire in the postage-paid envelope. Thank you for your help.

State where they died: _____ Date of death: _____ / _____ / _____
MONTH / YEAR

BOX B

Whenever possible, we would like this questionnaire filled out **BY** the person whose name appears on the accompanying letter. If that person is unable to fill out this questionnaire, please fill in the circle to the left and indicate your relationship to the person by marking one response below, then answer the questions **ABOUT THAT PERSON**.

Spouse Child Sibling Non-related caregiver Other

GENERAL INSTRUCTIONS

- Answer each question as best you can. The questions deal with health activities and other health-related information. Many of the questions ask for an estimate of your behavior, such as how often you took certain vitamins or how much time you spent on certain activities; you do not need to know exactly how often you took the vitamins or the exact amount of time you spent on the activities to answer the questions. A guess is better than leaving a blank.
- Be certain to completely blacken in each of your answers.
- Do not make any stray marks on this form.
- When answering the question please fill in the appropriate circle completely, do not check, 'x', dot, or half fill-in the circle. Please see below for examples of a correct mark and incorrect marks.

CORRECT MARK: ● **INCORRECT MARKS:** ☑ ✕ ◐ ◑

STATEMENT OF CONFIDENTIALITY

Collection of this information is authorized by The Public Health Service Act, Section 412 (42 USC 285 a-1). Rights of study participants are protected by The Privacy Act of 1974. Participation is voluntary, and there are no penalties for not participating or withdrawing from the study at any time. Refusal to participate will not affect your benefits in any way. The information collected in this study will be held in professional confidence. Names and other identifiers will be separated from information provided and will not appear in any report of the study. Information provided will be combined for all study participants and reported as statistical summaries.

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN

Public reporting burden for this collection of information is estimated to average 35 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0423). Do not return the completed form to this address.

The following questions ask about your use of cigarettes.

11. During your entire lifetime, did you smoke a total of 100 cigarettes (5 packs) or more?

- Yes
 No → GO TO QUESTION 15

12. Do you currently smoke cigarettes?

- Yes → GO TO QUESTION 14
 No

13. How long ago did you stop smoking?

- Less than 1 year ago 5 to 9 years ago
 1 to 4 years ago 10 or more years ago

14. Think back to the ages listed in the table below. For each age range, mark the circle that **best** describes the number of cigarettes per day, on average, that you smoked. There are 20 cigarettes in a pack. (MARK ONLY ONE RESPONSE PER AGE CATEGORY UP TO YOUR CURRENT AGE.)

On average, how many cigarettes per day did you smoke at the following ages?	AVERAGE NUMBER OF CIGARETTES PER DAY SMOKED (MARK ONLY ONE RESPONSE FOR EACH AGE CATEGORY.)							
	None	Less than 1 cigarette per day	1 to 10 cigarettes per day	11 to 20 cigarettes per day	21 to 30 cigarettes per day	31 to 40 cigarettes per day	41 to 60 cigarettes per day	More than 60 cigarettes (3 packs) per day
Less than 15 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15 to 19 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 to 24 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25 to 29 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30 to 39 years old	<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 to 49 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50 to 59 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
60 to 69 years old	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
70 years old and older	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next set of questions asks about your use of medications.

15. During the past 12 months , about how often did you usually take the following medications listed below? (MARK ONLY ONE RESPONSE PER MEDICATION.)	USE OF MEDICATIONS				
	Did not take in the past 12 months	1 to 3 times per month	1 to 2 times per week	3 to 6 times per week	7 or more times per week
Aspirin (for example, Bayer, Bufferin, Anacin, baby aspirin, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acetaminophen (for example, Tylenol, Panadol, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anti-Inflammatory pain relievers (for example, Ibuprofen, Advil, Motrin, Aleve, Anaprox, Clinoril, Relafen, Piroxicam, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vioxx, Celebrex, or Bextra	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cholesterol-lowering medications (for example, Mevacor, Zocor, Lescol, Pravachol, Crestor, Lipitor, other statins)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. During the <u>past 20 years</u> , for how many total years did you take the following medications at least once per week? (MARK ONLY ONE RESPONSE PER MEDICATION.)	USE OF MEDICATIONS				
	Did not take at least once per week	Less than 2 years	2 to 5 years	6 to 10 years	11 or more years
Aspirin (for example, Bayer, Bufferin, Anacin, baby aspirin, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Acetaminophen (for example, Tylenol, Panadol, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anti-Inflammatory pain relievers (for example, Ibuprofen, Advil, Motrin, Aleve, Anaprox, Clinoril, Relafen, Piroxicam, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vioxx, Celebrex, or Bextra	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cholesterol-lowering medications (for example, Mevacor, Zocor, Lescol, Pravachol, Crestor, Lipitor, other statins)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next set of questions asks about your lifetime use of vitamin and mineral supplements.

17a. Please mark your use of multivitamins. (MARK ONLY ONE RESPONSE.)	USE OF VITAMIN AND MINERAL SUPPLEMENTS					
	Never used	Past use only	CURRENT USE			
Less than 2 years			2 to 4 years	5 to 9 years	10 or more years	
Multivitamins	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17b. Excluding multivitamins, please mark your use of the following <u>single</u> supplements. (MARK ONLY ONE RESPONSE PER SUPPLEMENT.)						
Vitamin A	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beta-Carotene	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vitamin C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vitamin E	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Calcium (including Tums)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Zinc	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Selenium	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fish oil	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next set of questions asks about your use of vitamin and mineral supplements in the past 12 months.

18. Thinking about the past 12 months, did you take any vitamin or mineral supplements?

- No → GO TO QUESTION 22 ON PAGE 7
- Yes, 1 pill or less per month → GO TO QUESTION 22 ON PAGE 7
- Yes, more than 1 pill per month

19. <u>During the past 12 months</u> , how often did you take the following multivitamins?	USE OF MULTIVITAMINS (MARK ONLY ONE RESPONSE PER MULTIVITAMIN.)				
	Did not take in the past 12 months	Less than 1 time per week	1 to 3 times per week	4 to 6 times per week	Every day
Stress-tab type	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Therapeutic or Theragran type	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
One-a-Day type	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Centrum, all types	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. During the past 12 months, which of the following supplements did you take more than once per month? (DO NOT INCLUDE VITAMINS AND MINERALS CONTAINED IN THE MULTIVITAMINS YOU REPORTED TAKING IN QUESTION 19.) (MARK ALL THAT APPLY.)

- | | | | |
|--|----------------------------------|---------------------------------------|--|
| <input type="radio"/> Iron | <input type="radio"/> Ginseng | <input type="radio"/> DHEA | <input type="radio"/> Ginkgo Biloba |
| <input type="radio"/> Metamucil/Citrucel | <input type="radio"/> Magnesium | <input type="radio"/> St. John's Wort | <input type="radio"/> Garlic supplements |
| <input type="radio"/> Echinacea | <input type="radio"/> Melatonin | <input type="radio"/> Saw Palmetto | <input type="radio"/> Lycopene |
| <input type="radio"/> Coenzyme Q10 | <input type="radio"/> Folic Acid | <input type="radio"/> Lutein | <input type="radio"/> None of these |

21. During the past 12 months, how often did you take the following single supplements, and what was the total amount of each single supplement you usually took in one day? (PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE.)

	USE OF SINGLE SUPPLEMENTS (MARK ONLY ONE RESPONSE PER SUPPLEMENT.)						TOTAL AMOUNT YOU USUALLY TOOK IN ONE DAY (MARK ONLY ONE RESPONSE PER SUPPLEMENT.)				
	Did not take in the past 12 months	Less than 1 time per week	1 to 3 times per week	4 to 6 times per week	Every day		Less than 8,000 IU	8,000 to 12,000 IU	13,000 to 22,000 IU	More than 22,000 IU	Don't know
Vitamin A	<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"/>	<input type="radio"/>
Beta-Carotene	<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"/>	<input type="radio"/>
Vitamin C	<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"/>	<input type="radio"/>
Vitamin E	<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"/>	<input type="radio"/>
Calcium (including Tums)	<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"/>	<input type="radio"/>
Zinc	<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"/>	<input type="radio"/>
Selenium	<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"/>	<input type="radio"/>
Fish oil	<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"/>	<input type="radio"/>

26. Have you ever been told by a doctor that you had any of the following conditions? If yes, mark one circle to indicate year first diagnosed.

CONDITION	No	YES-YEAR CONDITION WAS FIRST DIAGNOSED (MARK ONLY ONE RESPONSE PER CONDITION.)			
		Before 1985	1985-1994	1995-1999	2000 to Present
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart attack, angina, or coronary artery disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TIA (Transient Ischemic Attack)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart-rhythm disturbance, like atrial fibrillation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulmonary embolus (blood clot in lungs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emphysema or chronic bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoarthritis of the hip or knee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis of the spine or hip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip fracture	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Macular degeneration of the eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Renal disease requiring dialysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colon or rectal polyps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach ulcer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Duodenal ulcer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parkinson's disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Multiple sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amyotrophic lateral sclerosis (ALS) or Lou Gehrig's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benign Breast Disease detected by biopsy (FEMALES ONLY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Benign Prostatic Hyperplasia (BPH) (MALES ONLY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. Have you <u>ever</u> had any of the following procedures performed? (MARK ONLY ONE RESPONSE FOR EACH PROCEDURE.)	No	YES - YEAR FIRST PERFORMED. (MARK ONLY ONE RESPONSE PER PROCEDURE.)			
		Before 1985	1985-1994	1995-1999	2000 to Present
Coronary artery bypass or angioplasty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gallbladder removal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cataract extraction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vasectomy (MALES ONLY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

28. During the <u>past 20 years</u> , how many times did you purposely lose each of the following amounts of weight? (DO NOT INCLUDE ANY WEIGHT LOSS DUE TO ILLNESS.)	NUMBER OF TIMES				
	Never	1 to 2 times	3 to 4 times	5 to 6 times	7 or more times
5 to 9 pounds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 to 19 pounds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 to 49 pounds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
50 or more pounds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. Currently, would you say your overall health is: (MARK ONLY ONE RESPONSE.)

- Excellent
 Very good
 Good
 Fair
 Poor

The following questions ask about routine screening tests you may have had (not for symptoms).

30. When did you last have a colonoscopy or sigmoidoscopy (a test where a tube is inserted into your rectum to view your bowel for signs of cancer and other health problems)? (MARK ONLY ONE RESPONSE.)

- Never had one
 Less than 1 year ago
 1 year to less than 2 years ago
 2 years to less than 5 years ago
 5 years to less than 10 years ago
 10 or more years ago
 Had one, but not sure when
 Not sure if had one

**IF YOU ARE FEMALE,
GO TO QUESTION 33 ON PAGE 10.**

31. When did you last have a rectal examination of your prostate? (MARK ONLY ONE RESPONSE.)

- Never had one
 Less than 1 year ago
 1 year to less than 2 years ago
 2 years to less than 5 years ago
 5 or more years ago
 Had one, but not sure when
 Not sure if had one

32. When did you last have a PSA test (a test that screens your blood for indications of prostate cancer)? (MARK ONLY ONE RESPONSE.)

- Never had one
 Less than 1 year ago
 1 year to less than 2 years ago
 2 years to less than 5 years ago
 5 or more years ago
 Had one, but not sure when
 Not sure if had one

IF YOU ARE MALE, GO TO PAGE 12.

THE FOLLOWING TWO PAGES ARE FOR FEMALES ONLY. IF YOU ARE MALE, GO TO PAGE 12.

33. When was your last mammogram (an x-ray of the breast to look for breast cancer)? (MARK ONLY ONE RESPONSE.)

- Never had one
- Less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 5 years ago
- 5 or more years ago
- Had one, but not sure when
- Not sure if had one

34. When did you last have an ultrasound or scan of your ovaries? (MARK ONLY ONE RESPONSE.)

- Never had one
- Less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 5 years ago
- 5 or more years ago
- Had one, but not sure when
- Not sure if had one

The next set of questions asks about your use of female hormones during or after menopause.

35. Did you ever take any female hormones, such as estrogen, progesterone, or a combination, for the treatment of menopausal symptoms (e.g., hot flashes or to prevent bone loss)?

- Yes, within the past ten years
- Yes, more than ten years ago
↳ GO TO QUESTION 49 ON PAGE 12
- No
↳ GO TO QUESTION 49 ON PAGE 12
- Not sure
↳ GO TO QUESTION 49 ON PAGE 12

36. During the past 10 years, which of the following types of female hormones did you use? (MARK ALL THAT APPLY.)

- Pills
- Patches
- Vaginal creams or suppositories
- Shots
- Not sure what type

IF YOU MARKED PILLS IN QUESTION 36, CONTINUE WITH QUESTION 37.

IF NOT, GO TO QUESTION 49 ON PAGE 12.

PILLS WITH ESTROGEN ONLY

37. Did you take hormone pills containing estrogen-only, such as Premarin, during the past 10 years?

- Yes
- No → GO TO QUESTION 41 ON PAGE 11

38. Thinking about the past 10 years, for how many years in total did you take estrogen-only hormone pills? (MARK ONLY ONE RESPONSE.)

- Less than 1 year
- 1 to 2 years
- 3 to 4 years
- 5 to 10 years

39. Are you still taking estrogen-only hormone pills?

- Yes
- No → When did you stop taking estrogen hormone pills?

YEAR

- 1994
- 1995
- 1996
- 1997
- 1998
- 1999
- 2000
- 2001
- 2002
- 2003
- 2004

40. What is the name of the estrogen-only hormone pill that you took for the longest period of time during the past 10 years? (MARK ONLY ONE RESPONSE.)

- Premarin
- Ogen
- Estrace
- Estratab or Estratest
- Another estrogen-only hormone pill
- Not sure of the name

THIS PAGE IS FOR FEMALES ONLY. IF YOU ARE MALE, GO TO PAGE 12.

PILLS WITH PROGESTERONE OR PROGESTIN ONLY

41. Did you take hormone pills containing progesterone-only or progestin-only, such as Provera, during the past 10 years?

- Yes
 No → GO TO QUESTION 45

42. Thinking about the past 10 years, for how many years in total did you take progesterone-only or progestin-only hormone pills?
(MARK ONLY ONE RESPONSE.)

- Less than 1 year
 1 to 2 years
 3 to 4 years
 5 to 10 years

43. Are you still taking progesterone-only or progestin-only hormone pills?

- Yes
 No → When did you stop taking progesterone or progestin hormone pills?

YEAR
<input type="radio"/> 1994
<input type="radio"/> 1995
<input type="radio"/> 1996
<input type="radio"/> 1997
<input type="radio"/> 1998
<input type="radio"/> 1999
<input type="radio"/> 2000
<input type="radio"/> 2001
<input type="radio"/> 2002
<input type="radio"/> 2003
<input type="radio"/> 2004

44. What is the name of the progesterone-only or progestin-only hormone pill that you took for the longest period of time during the past 10 years?
(MARK ONLY ONE RESPONSE.)

- Provera
 Medroxyprogesterone
 Cycrin
 Another progesterone-only or progestin-only hormone pill
 Not sure of the name

COMBINATION PILLS - Pills that contain both estrogen and progesterone or progestin

45. Did you take hormone pills that contained both estrogen and progesterone or progestin in the same pill, such as Prempro or Premphase, during the past 10 years?

- Yes
 No → GO TO QUESTION 49 ON PAGE 12

46. Thinking about the past 10 years, for how many years in total did you take a pill that contains both estrogen and progesterone or progestin?
(MARK ONLY ONE RESPONSE.)

- Less than 1 year
 1 to 2 years
 3 to 4 years
 5 to 10 years

47. Are you still taking a combination of estrogen and progesterone or progestin hormone pills?

- Yes
 No → When did you stop taking estrogen and progesterone or progestin hormone pills?

YEAR
<input type="radio"/> 1994
<input type="radio"/> 1995
<input type="radio"/> 1996
<input type="radio"/> 1997
<input type="radio"/> 1998
<input type="radio"/> 1999
<input type="radio"/> 2000
<input type="radio"/> 2001
<input type="radio"/> 2002
<input type="radio"/> 2003
<input type="radio"/> 2004

48. What is the name of the combination of estrogen and progesterone or progestin pill that you took for the longest period of time during the past 10 years?
(MARK ONLY ONE RESPONSE.)

- Prempro (Pink)
 Prempro (Blue)
 Premphase
 FemHRT
 Another estrogen and progesterone or progestin hormone pill
 Not sure of the name

The last set of questions asks about your Social Security number.

49. The NIH-AARP Diet and Health Study includes such a large number of participants and is so successful, that we would like to expand the objectives of the study to look at the relationship between diet and health conditions in addition to cancer. For this purpose, we would like to use your Social Security number to obtain health information from Medicare and Medicaid records. This will have no effects on any benefits you may receive. Please mark one circle in the box below to indicate whether or not you consent to the use of your Social Security number for this purpose. Most NIH-AARP Diet and Health Study participants provided their Social Security number on the questionnaire they completed about eight years ago.

I consent to the use of my Social Security number to obtain health information from Medicare and Medicaid records for the purposes of the NIH-AARP Diet and Health Study.

Yes No

50. To be sure we have your correct Social Security number, please provide your Social Security number by marking the circles below. Providing this information is voluntary. If you choose not to provide this information, there will be no effects on any benefits you may receive. We are collecting this information under the authority of the Public Health Service Act, Section 412 (42 USC 285a-1) and Section 413 (42 USC 285a-2). Please be assured that this information will be held confidential to the full extent permitted by law. This study is covered by a Certificate of Confidentiality issued by the National Institutes of Health on behalf of the Secretary of the Department of Health and Human Services. The Certificate ensures that researchers involved in this project cannot be forced to disclose your identity or any information about you collected in this study. (ENTER YOUR SOCIAL SECURITY NUMBER AND MARK ONE CIRCLE BENEATH EACH BOX.)

EXAMPLE:
If your Social Security number is 123-45-6789, your entry would be:

SOCIAL SECURITY NUMBER										
1	2	3	-	4	5	-	6	7	8	9
0	0	0		0	0		0	0	0	0
●	1	1		1	1		1	1	1	1
2	●	2		2	2		2	2	2	2
3	3	●		3	3		3	3	3	3
4	4	4		●	4		4	4	4	4
5	5	5		5	●		5	5	5	5
6	6	6		6	6		●	6	6	6
7	7	7		7	7		7	●	7	7
8	8	8		8	8		8	8	●	8
9	9	9		9	9		9	9	9	●

SOCIAL SECURITY NUMBER										
			-			-				
0	0	0		0	0		0	0	0	0
1	1	1		1	1		1	1	1	1
2	2	2		2	2		2	2	2	2
3	3	3		3	3		3	3	3	3
4	4	4		4	4		4	4	4	4
5	5	5		5	5		5	5	5	5
6	6	6		6	6		6	6	6	6
7	7	7		7	7		7	7	7	7
8	8	8		8	8		8	8	8	8
9	9	9		9	9		9	9	9	9

***Thank you very much for your valuable contribution of time and effort.
Please return the questionnaire in the postage-paid envelope provided.***