

Form 148 - OS Follow-Up Questionnaire (Observational Study - Year 8)

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
- Darken the oval completely next to the answer you choose.
- Erase cleanly any marks you wish to change.
- Do not make any stray marks on this form.



CORRECT MARK

INCORRECT MARKS

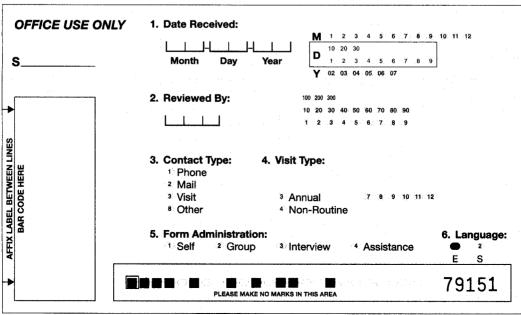
• For questions where you write in a number, write the number in the box provided. Then mark the corresponding oval to the right.

Example: If you weigh 159 pounds:

115191

100 200 300 400 500 600 700 10 20 30 40 50 60 70 80 90

Public reporting for this collection of information is estimated to average 10 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 (0925-0414). Do not return the completed form to this address.



This questionnaire asks you about factors that may affect your health. These include weight changes, physical activity and exercise, use of coffee, tea, and soft drinks, use of female hormones, and recent medical conditions.

Th	e following questions are about you	r weight. (Give	e your best guess.)	100 200	300 40	0 500	600	700	
1.	What is your <u>current</u> weight?		pounds	10 20 1 2	30 4	5 5		70 84	9 9
2.	In the past year, what was your higher	and waight?		100 200 10 20					0 94
۷.	In the past year, what was your high	iesi weigni?	pounds	1 2	3 4	. 5	6	7 8	9
				100 200	300 40	0 500	600	700	
3.	In the past year, what was your low	est weight?	pounds	10 20	30 4	50	60	70 84	3 90
				1 2	3 4	5	6	7 8	9
	ollowing questions are about your uports.	sual physical a	activity and exercise. T	his inc	lude	S V	vall	king	,
4.	Think about the walking you do out			outside	the	ho	me	;	
	for more than 10 minutes without st	opping? (Marl	k only one.)						
	Rarely or never 1-3 times each month								
	² 1 time each week ³ 2-3 times each week	1							
	4 4-6 times each week 5 7 or more times each week								
	4.1. When you walk outside the for how many minutes do	ne home for mo	re than 10 minutes withoutle?	out stop	ping	<u>,</u>			
	Less than	20-39	40-59	1 hour					

Go to the next page.

9 Don't know

20 min.

4.2. What is your usual speed?

min.

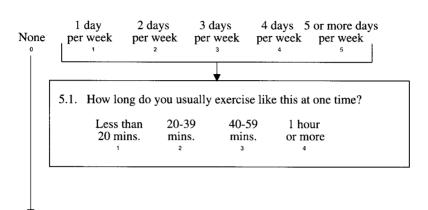
² Causal strolling or walking (less than 2 miles an hour)

Average or normal (2-3 miles an hour)
 Fairly fast (3-4 miles an hour)
 Very fast (more than 4 miles an hour)

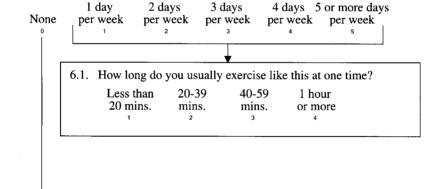
min.

or more

5. Not including walking outside the home, how often <u>each week</u> (7 days), do you usually do STRENUOUS OR VERY HARD EXERCISE (you work up a sweat and your heart beats fast)? For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.



6. Not including walking outside the home, how often <u>each week</u> (7 days) do you usually do MODERATE EXERCISE (not exhausting)? For example, biking outdoors, use of an exercise machine (like a stationary bike or treadmill), calisthenics, easy swimming, popular and folk dancing.



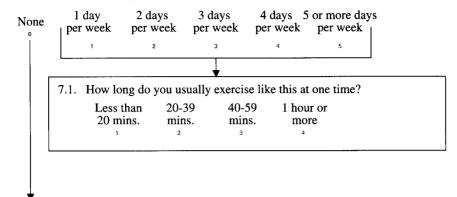
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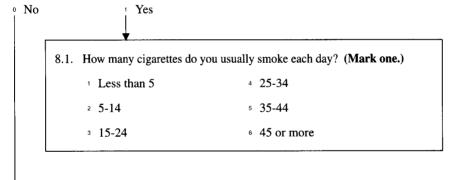
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7. Not including walking outside the home, how often <u>each week</u> (7 days), do you usually do MILD EXERCISE? For example, slow dancing, bowling, golf.



8. Do you smoke cigarettes now?



- 9. In the past year, have you taken any of the following prescription weight loss medications for at least 2 months? (Mark all that apply.)
 - 9.1. Meridia (Sibutramine)NoYes9.2. Xenical (Orlistat)NoYes
 - 9.3. Phentermine (Fastin)

 No Yes
 - 9.4. Other prescription weight No Yes loss medication

(Specify:

The following questions are about coffee, tea, and soft drinks you may drink.

10. <u>During the past 3 months</u>, how often did you drink these beverages: (Mark one for each beverage.) (For coffee, large or doubles count as 2 cups.)

_				•						
	Never or less than 1 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 or more per day	
10.1. Caffeinated coffee, either instant or paper-filtered drip (cups)	1.	: 2 °	(3)	.4,	.5	6 :	7	8	9	
10.2. Other caffeinated coffee, such as perked, espresso, or latté (cups)	3	2	3	.4.	.5 .	6	7	.8	9.	
10.3. Decaf coffee, either instant or paper-filtered drip (cups)	/ .j /):	2	3	4	5	6	. 7.	8	9	
10.4. Other decaf coffee, such as perked, espresso, or latté (cups)		2	3	4	5	6	7	. 8	9	
10.5. Regular tea (not decaf) (cups)	1	2	3	4	5	6	7	8	9	
10.6. Decaf tea (cups)	1	2	.3.	4	5	6	7	8	9	
10.7. Soft drinks with caffeine (such as Coke®, Diet Pepsi®, Dr. Pepper®, Mountain Dew®) (12 oz. can)	1	2	, 3 ·	4-	5_	6	7	8	9	
10.8. Soft drinks without caffeine (such as Sprite®, 7-Up®, Diet Sprite®) (12 oz. can)		(2)	3	: 13 · · · · · · · · · · · · · · · · · ·	5 (i		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	8	: 9	

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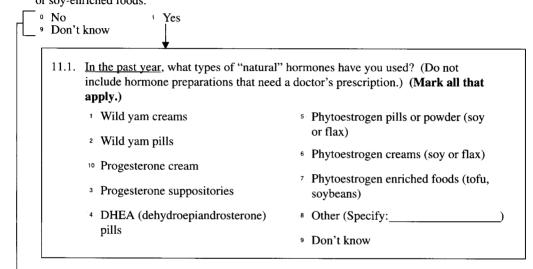


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The next set of questions are about female hormones (estrogen or progesterone) you might have used <u>during the past year</u>. Women's use of hormones has been changing—these questions help us understand patterns of use.

Question 11 is about natural hormones you can get without a doctor's prescription.

11. In the past year, did you use any "natural" hormones that you can get without a doctor's prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, skin cream, or soy-enriched foods.



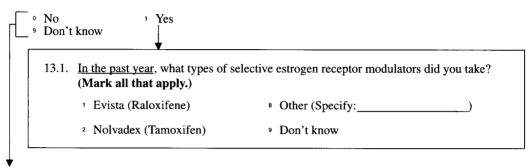
The next questions (12-13) are about medications you get with a doctor's prescription.

12. <u>In the past year</u>, have you used any treatments for **osteoporosis** or other bone conditions that you get <u>with</u> a doctor's prescription? Examples are Fosamax, Miacalcin, and Actonel. (**Do not include use of selective estrogen receptor modulators (SERMs) such as Evista (Raloxifene) which are covered in Question 13.)**

12.1. Which one(s)? (Mark all that apply.)	
¹ Alendronate (Fosamax)	⁵ Zolendronate
² Calcitonin (Miacalcin)	⁶ Parathyroid hormone (PTH) (Forteo)
³ Risedronate (Actonel)	8 Other (Specify:
⁴ Pamidronate (Aredia)	9 Don't know

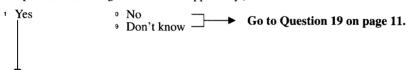
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13. In the past year, did you use any non-estrogen prescription treatments for hormone replacement? These may be prescribed to prevent osteoporosis and breast cancer and are sometimes called "designer estrogens" or selective estrogen receptor modulators (SERMs). Examples are Evista (Raloxifene) and Nolvadex (Tamoxifen).



The next questions (14-18) are about other female hormones you get with a doctor's prescription.

14. <u>In the past year</u>, did you use any female hormones (ESTROGEN or PROGESTERONE [also called PROGESTIN]) that were prescribed by a doctor? (This may have been in the form of a pill, skin patch, shot, or vaginal cream or suppository.)



Go to the next page.

15. <u>In the past year</u>, did you use female hormones PILLS or PATCHES prescribed by a doctor which contained <u>both</u> ESTROGEN and PROGESTERONE (PROGESTIN) COMBINED in the <u>same</u> pill, patch, or package (for example, Prempro, Premphase)? (**Do not include the use of two separate estrogen and progesterone pills used at the same time.**)

One of the past year, did you use female hormones PILLS or PATCHES prescribed by a doctor which contained by a docto

t know	¹ Yes	
		months did you use <u>COMBINED</u> female hormone ntained both ESTROGEN and PROGESTERONE?
1		³ 7-10 months ⁴ 11-12 months
15.2. V	Which combination did you	use the longest?
:	3 Premphase	5 FemHRT 6 Ortho-Prefest 8 Other (Specify:)
	15.1. <u>I</u> F	15.1. In the past year, how many PILLS or PATCH which con 1 Less than 1 month 2 1-6 months 15.2. Which combination did you

16. <u>In the past year</u>, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and TESTOSTERONE COMBINED in the same pill (for example, Estratest)?

_	1 Yes	O No Don't know	Go to Question 17 on the next page.
	16.1.	In the past year, how many months did which contained both ESTROGEN and	you use <u>COMBINED</u> female hormone pills TESTOSTERONE?
		Less than 1 month 1-6 months	7-10 months11-12 months
	16.2.	In the past year, what type of COMBIN did you use the longest?	NED ESTROGEN and TESTOSTERONE pills
		Estratest 2 Estratest HS	Other (Specify:) Don't know

Go to the next page.



- 17. <u>In the past year</u>, did you use any ESTROGEN pill, patch, cream, or shots (other than the combinations described in Ouestions 15 and 16)?
 - Yes

 One No

 Don't know

 Go to Question 18 on the next page.

17.1.	Did you	use an estro	gen	pill?
	º No	¹ Yes —	•	17.2



17.3. What kind did you take? (Mark the one used the

For how many months did you use the estrogen pills?

longest if you used more than one kind.)

1 Premarin or conjugated equine estrogens
2 Estrace or estradiol

Ogen or estropripate
Estratab or esterified estrogens
Other (Specify:

9 Don't know

17.4. Did you use an estrogen <u>patch</u>?

	↓	
17.6.	Did you use an estrogen	cream?

Less than 1 month 3 7-10 months

17.5. For how many months did you use the patch?

² 1-6 months ⁴ 11-12 months

17.7. For how many months did you use the cream?

1 Less than 1 month 3 7-10 months 2 1-6 months 4 11-12 months

17.8. Did you have estrogen shots?

¹ Yes →

17.9.	For how many months did you have the shots

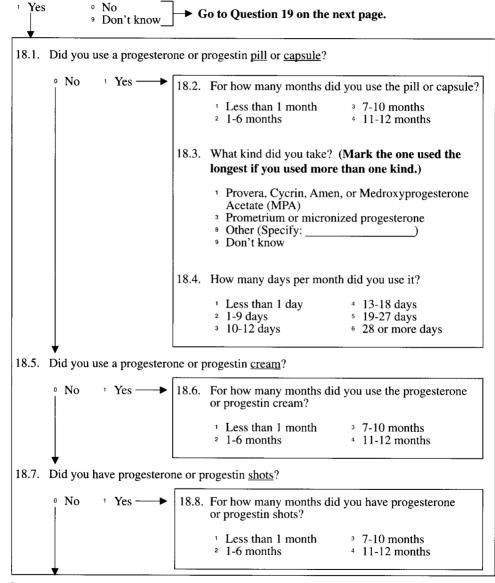
Less than 1 month
 1-6 months
 3 7-10 months
 4 11-12 months

Go to the next page.

o No

Question 18 is about products that contain the hormone PROGESTERONE (progestin) alone.

18. <u>In the past year</u>, did you use any PROGESTERONE or PROGESTIN pill, cream, or shots (other than the combinations described in Question 15)?



Go to the next page.



Question 19 is about your medical conditions in the past year

Question 15 is about your medical conditions in the past year.	
19. In the past year, has a doctor told you that you have any of the following cond	itions?

(Please mark one response for each condition.)

(Please	mark <u>one</u> response for each condition.)	No	Yes
19.1.	Cataract(s)	0	1.
19.2.	Macular degeneration of the retina	0	1
19.3.	Asthma	0	í
19.4.	Emphysema or chronic bronchitis	0	1
19.5.	Heart failure or congestive heart failure	0	1
19.6.	Angina (chest pains from the heart)	0	1
19.7.	Atrial fibrillation	0	1
19.8.	Kidney or bladder stones (renal or urinary calculi)	0	1
19.9.	Dialysis for kidney or renal failure	0	1
19.10.	Stomach or duodenal ulcer	0	1
19.11.	Diverticulitis	0	1
19.12.	Pancreatitis (inflamed pancreas)	0	1
19.13.	Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)	0	1
19.14.	Overactive thyroid	0	1
19.15.	Underactive thyroid	0	1
19.16.	Alzheimer's disease	0	1
19.17.	Multiple sclerosis	0 -	1
19.18.	Parkinson's disease	0	1

Lou Gehrig's disease)

19.19. Amyotropic Lateral Sclerosis (ALS, motor neuron disease, or

20. Has any member of your family (mother, father, full-blooded sister or brother) been diagnosed with Alzheimer's disease or senile dementia?

No Pon't know	¹ Yes — 2 0.	1. Who? (Please	mark all that apply.)	
		¹ Mother	3 Any brother	
		² Father	4 Any sister	

The last question is about your current living situation.

- 21. What is your current marital status? (Mark one that best describes you.)
 - Never married

4 Presently married

² Divorced or separated

⁵ Living in a marriage-like relationship

3 Widowed

Thank you. Please take a few minutes to review for any questions you may have missed. Feel ree to write any comments here.				
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4				
		30.2.		
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