

Date: <input type="text" value=""/> - <input type="text" value=""/> - <input type="text" value=""/> (M/D/Y) Contacted By: <input type="text" value=""/>	<b>- Affix label here-</b> Clinical Center/ID: _____ First Name _____ M.I. _____ Last Name _____
Contact Type: <input type="checkbox"/> <sub>1</sub> Phone <input type="checkbox"/> <sub>2</sub> Mail <input type="checkbox"/> <sub>3</sub> Visit <input type="checkbox"/> <sub>8</sub> Other	Visit Type: <input type="checkbox"/> <sub>1</sub> Screening # <input type="text" value=""/> <input type="checkbox"/> <sub>4</sub> Non-Routine Form Administration <input type="checkbox"/> <sub>1</sub> Self <input type="checkbox"/> <sub>2</sub> Group <input type="checkbox"/> <sub>4</sub> Assistance
<b>OFFICE USE ONLY</b>	

Public reporting for this collection of information is estimated to average 25 minutes, including the time for reviewing instructions, gathering needed information and completing and reviewing the questionnaire. 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 Office, 6701 Rockledge Drive, MSC 7730, Bethesda, MD 20892-7730, ATTN: PRA (0925-xxxx). Do not return the completed form to this address.

**We would like some information from you so that we can find out if you can take part in the study. Please print the information in the space provided and follow instructions for filling in the ovals.**

**These first questions will just help us stay in touch with you.**

1. What is your full name?

\_\_\_\_\_

(Mrs., Ms., Miss)                      First                      Middle Initial                      Last

2. What is your current mailing address?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City    State    Zip

3. What is your home phone number?

Home: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

4. Do you have a work number?

No     Yes



4.1. May we call you at work?

No     Yes

↓

4.2 What is your work number ?

Work:(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_



**Go to the next page.**

5. Is there any other number where you can often be reached?

Other: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \_\_\_\_\_  
Whose phone number is this?

6. When are the best times to call you?

		At home	At work	Other
_____	_____	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>8</sub>
day of week	time(s)			
_____	_____	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>8</sub>
day of week	time(s)			
_____	_____	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>8</sub>
day of week	time(s)			

7. What is your birth date? (Put month first, then day, and then year.)

____ ____	____ ____	____ ____
Month	Day	Year

<b>Office Use</b>
7.1.
____ 47-49
____ 50-79
____ <47, 80+

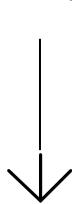
7.1. What is your age now? \_\_\_\_ years old

8. Do you think you will be living in this area for the next three years?

<sub>0</sub> No    <sub>1</sub> Yes

9. Are you now in any other research study?

<sub>0</sub> No    <sub>1</sub> Yes



9.1. What is the name of that study? _____ _____ _____
--

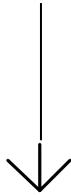
<b>Office Use</b>
9.2.
<input type="checkbox"/> <sub>0</sub> No
<input type="checkbox"/> <sub>1</sub> Yes

10. Did a doctor ever say that you had breast cancer?

<sub>0</sub> No    <sub>1</sub> Yes

11. Did a doctor ever say that you had colon, rectum, bowel, or intestinal cancer?

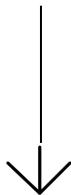
<sub>0</sub> No    <sub>1</sub> Yes



11.1. Were you first told that you had this cancer in the last 10 years? <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes
--

12. Did a doctor ever say that you had endometrial cancer (cancer of the lining of the uterus or womb)?

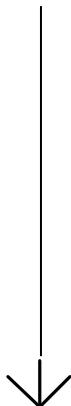
<sub>0</sub> No    <sub>1</sub> Yes



12.1. Were you told that you had this cancer in the last 10 years? <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes
--

13. Did a doctor ever say that you had skin cancer?

<sub>0</sub> No    <sub>1</sub> Yes



13.1. Was the skin cancer melanoma? <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes ↓	
<table border="1"> <tr> <td>                             13.2. Were you told that you had melanoma in the last 10 years?  <input type="checkbox"/><sub>0</sub> No    <input type="checkbox"/><sub>1</sub> Yes                         </td> </tr> </table>	13.2. Were you told that you had melanoma in the last 10 years? <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes
13.2. Were you told that you had melanoma in the last 10 years? <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes	

14. In the past 10 years, did a doctor ever say that you had any other cancers?

<sub>0</sub> No    <sub>1</sub> Yes

**The next question asks about your background. This information will help us describe in general ways, the women who are interested in the study.**

15. How would you describe your racial or ethnic group? If you are of mixed blood, which group do you identify with most?

- <sub>1</sub> American Indian or Alaskan Native
- <sub>2</sub> Asian or Pacific Islander (ancestry is Chinese, Indo-Chinese, Korean, Japanese, Pacific Islander, Vietnamese)
- <sub>3</sub> Black or African-American (not of Hispanic origin)
- <sub>4</sub> Hispanic/Latino (ancestry is Mexican, Cuban, Puerto Rican, Central American, or South American)
- <sub>5</sub> White (not of Hispanic origin)
- <sub>8</sub> Other (**Specify**): \_\_\_\_\_

16. How did you hear about the study? (**Mark one. If you heard in more than one way, mark the one that made you decide to contact us.**)

- |   |   |
|---|---|
| <input type="checkbox"/> <sub>1</sub> Mailed letter | <input type="checkbox"/> <sub>5</sub> Newspaper or Magazine           |
| <input type="checkbox"/> <sub>2</sub> Brochure      | <input type="checkbox"/> <sub>6</sub> Meeting                         |
| <input type="checkbox"/> <sub>3</sub> T.V.          | <input type="checkbox"/> <sub>7</sub> Friend/Relative                 |
| <input type="checkbox"/> <sub>4</sub> Radio         | <input type="checkbox"/> <sub>8</sub> Other ( <b>Specify</b> ): _____ |

<b>Office Use</b> <b>16.1.</b> <b>RSC</b> <input type="checkbox"/>
---

Now we want to ask you some questions about hormones and your menstrual history.

17. Did you ever use any female hormones like estrogen (Premarin) or progesterone (Provera)? These might be pills, skin patches, implants, creams, suppositories, shots, or birth control pills. **(This does not include birth control pills you used before you were 50 years old.)**

<sub>0</sub> No    <sub>1</sub> Yes  
↓

17.1. Are you taking female hormones now?

<sub>0</sub> No →    17.2. Have you taken female hormones in the last 3 months?  
<sub>0</sub> No    <sub>1</sub> Yes

<sub>1</sub> Yes  
↓

17.3. Have you ever had an osteoporosis-related fracture or broken bone? (Osteoporosis is a condition where bones become brittle and weak as a woman ages.)

<sub>0</sub> No    <sub>1</sub> Yes  
↓

17.4. Did a doctor give you hormones to treat the fracture or broken bone?  
<sub>0</sub> No    <sub>1</sub> Yes

18. Did you ever have a hysterectomy? (This is an operation to take out your uterus or womb.)

<sub>0</sub> No    <sub>1</sub> Yes  
↓

18.1. Was your hysterectomy within the last 3 months?  
<sub>0</sub> No    <sub>1</sub> Yes

18.2. How old were you when you had your hysterectomy?

Less than 30	30-34	35-39	40-44	45-49	50-54	55-59	60 or older
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>	<input type="checkbox"/> <sub>8</sub>

Go to the next page.

19. When was the last time you had any menstrual bleeding or spotting? (**Your best guess.**)

- <sub>1</sub> Still having menstrual bleeding  
<sub>2</sub> Within the last 6 months  
<sub>3</sub> 7 to 12 months ago  
<sub>4</sub> Over 12 months ago

**These questions are about your diet and your health.**

20. How many of your meals are prepared away from your home each week, that is, meals that you eat in a restaurant, or as "take-out," or at friends' or relatives' houses?

- <sub>0</sub> Less than 10 meals each week  
<sub>1</sub> 10 or more meals each week

21. Are you following a special diet for malabsorption, celiac sprue (sometimes this is called a gluten-free diet), ulcerative colitis, or Crohn's disease that is prescribed by a doctor? (**We know that these may be unfamiliar words. If you have not been told to follow one of these diets, mark No.**)

- <sub>0</sub> No      <sub>1</sub> Yes

22. Are you following a special low-fiber or low-residue diet (low in fruits, vegetables, and grains) that was prescribed for you by your doctor?

- <sub>0</sub> No      <sub>1</sub> Yes

23. Did a doctor ever say that you had sugar diabetes or high blood sugar when you were not pregnant?

<sub>0</sub> No      <sub>1</sub> Yes



23.1. How old were you when you were first told you had sugar diabetes? (**Don't include diabetes you had only when pregnant.**)

Less than 20	20-29	30-39	40-49	50-59	60-69	70 or older
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>	<input type="checkbox"/> <sub>6</sub>	<input type="checkbox"/> <sub>7</sub>

23.2. Were you ever hospitalized for a diabetic coma?

<sub>0</sub> No      <sub>1</sub> Yes

23.3. Did a doctor ever tell you to keep a special diet for your diabetes?

<sub>0</sub> No      <sub>1</sub> Yes

23.4. Did you ever take insulin shots?

<sub>0</sub> No      <sub>1</sub> Yes

↓

23.5. Are you using insulin now?

<sub>0</sub> No      <sub>1</sub> Yes

↓

23.6. Did you ever take pills for your diabetes to lower your blood sugar?

<sub>0</sub> No      <sub>1</sub> Yes

23.7. Do you have sugar diabetes or high blood sugar now?

<sub>0</sub> No      <sub>1</sub> Yes



24. Did a doctor ever say that you had a blood clot in your legs? This is sometimes called deep vein thrombosis or DVT. This does not include varicose veins or phlebitis.

<sub>0</sub> No      <sub>1</sub> Yes



24.1. Did you have a blood clot in your leg in the last 6 months?

<sub>0</sub> No      <sub>1</sub> Yes

24.2. Did this blood clot occur within one month after a serious accident, fracture, injury, or operation?

<sub>0</sub> No      <sub>1</sub> Yes



**Go to the next page.**

25. Did a doctor ever say that you had a blood clot in your lung? This is sometimes called a pulmonary embolus or PE.

<sub>0</sub> No    <sub>1</sub> Yes



<p>25.1. Did you have a blood clot in your lung in the last 6 months?</p> <p><input type="checkbox"/><sub>0</sub> No    <input type="checkbox"/><sub>1</sub> Yes</p> <p>25.2 Did this blood clot occur within one month after a serious accident, fracture, injury, or operation?</p> <p><input type="checkbox"/><sub>0</sub> No    <input type="checkbox"/><sub>1</sub> Yes</p>
--

26. Did a doctor ever say that you had a stroke?

<sub>0</sub> No    <sub>1</sub> Yes



<p>26.1. Did you have a stroke in the last 6 months?</p> <p><input type="checkbox"/><sub>0</sub> No    <input type="checkbox"/><sub>1</sub> Yes</p>
---

<p><b>Office Use</b></p> <p>26.1.</p> <p>____ FE</p>
--

27. Did a doctor ever say that you had a small stroke that lasted less than 24 hours? This is sometimes called a TIA or transient ischemic attack.

<sub>0</sub> No    <sub>1</sub> Yes



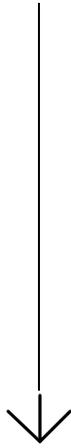
<p>27.1. Did you have a TIA in the last 6 months?</p> <p><input type="checkbox"/><sub>0</sub> No    <input type="checkbox"/><sub>1</sub> Yes</p>
--

<p><b>Office Use</b></p> <p>27.1.</p> <p>____ FE</p>
--

**Go to the next page.**

28. Did a doctor ever say that you had a heart attack? This is sometimes called a coronary, MI, or myocardial infarction.

<sub>0</sub> No    <sub>1</sub> Yes  
↓



28.1 How old were you when you had your <u>first</u> heart attack? ( <b>Your best guess.</b> )				
Less than 40	40-49	50-59	60-69	70 or older
<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
28.2. Did you have a heart attack in the last 6 months?				
<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes				

Office Use 28.2. ____ FE
--------------------------------

29. Did a doctor ever say that you had any of the following health problems? (**Please answer No or Yes for each problem listed.**)

	No	Yes
29.1. Sickle cell anemia?	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>
29.2. Heart failure?	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>
29.3. Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)?	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>
29.4. Bleeding problem?	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>

Office Use 29. 2. ____ CP 3. ____ CP 4. ____ CP
---

30. Have you lost 15 or more pounds in the last 6 months without trying?

<sub>0</sub> No    <sub>1</sub> Yes

31. Are you on kidney dialysis or a kidney machine for kidney or renal failure?

<sub>0</sub> No    <sub>1</sub> Yes

32. Do you have any other long-term or chronic illness?

<sub>0</sub> No    <sub>1</sub> Yes



Office Use  
32.  
\_\_\_\_CP

↓

33. Are there any reasons, like serious emotional problems, mental illness, or too much stress, that would make it hard for you to be in a research study?

<sub>0</sub> No    <sub>1</sub> Yes

34. Will you be able to come to our clinic?

<sub>0</sub> No →

<sub>1</sub> Yes

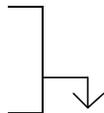
34.1. What kind of help would you need in order to come to our clinic?

- <sub>0</sub> Transportation
- <sub>1</sub> Child care
- <sub>0</sub> Adult Care
- <sub>1</sub> Other (Specify): \_\_\_\_\_

Office Use  
34.1  
\_\_\_\_TE

35. Do you think you might be interested in the Dietary Change part of the study?

<sub>0</sub> No    <sub>1</sub> Yes  
<sub>9</sub> Don't know



↓  
  
<sub>0</sub> No    <sub>1</sub> Yes

**Go to the next page.**

36. Do you think you might be interested in the Hormone Replacement part of the study?

- <sub>0</sub> No
- <sub>1</sub> Yes
- <sub>9</sub> Don't know/need more information

36.1. If you join the hormone part of the study, you may be placed into the hormone or no-hormone (placebo) group. Would you consider taking only the hormone pills given to you by Clinical Center staff if you join the hormone part of the study?

- <sub>0</sub> No
- <sub>1</sub> Yes
- <sub>9</sub> Don't know

**Go to Question 37.**

36.2. If you are currently on hormones, are you interested in talking to your doctor about the Hormone Replacement part of the Study?

- <sub>0</sub> No
- <sub>1</sub> Yes
- <sub>9</sub> Don't know
- <sub>2</sub> Not on hormones

**Go to Question 37.**

36.3. Would you like us to send information about the Hormone Replacement part of the study to your doctor?

- <sub>0</sub> No
- <sub>1</sub> Yes

**Go to Question 37.**

What is the name and address of your primary doctor or gynecologist?

Doctor's Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

37. What is the date you finished this form?

-  -   
 Month      Day      Year

