Black Women's Health Study 2007

PLEASE USE A BLUE OR BLACK BALLPOINT PEN

1. Please write in your age and date of birth.

Age ____ ____

Month ____ ____ / Day ____ ____ / 1 9 ____ ____ Year

(example: June = 06)

2. Since March 2005, have you had a:
(Fill in all circles that apply.)

- ○ Physical exam
- ○ Pap smear
- ○ Sigmoidoscopy
- ○ Blood sugar test
- ○ Mammogram
- ○ Colonoscopy
- ○ Eye exam
- ○ Breast biopsy
- ○ Dental cleaning

3. When was the last time you had a:

Pelvic (GYN) exam?	**Pelvic ultrasound?**
○ Never had one	○ Never had one
○ <5 years ago	○ <5 years ago
○ 5-9 years ago	○ 5-9 years ago
○ 10 or more years ago	○ 10 or more years ago

4. Since March 2005, how many times have you given birth to:

A single child ____ Twins or triplets ____

5. Have you ever tried for 12 or more months to become pregnant without success?

○ No ○ Yes

a. How old were you at that time? ____ ____ Age

b. What was the cause?
(Fill in all circles that apply.)

- ○ Don't know
- ○ Not investigated
- ○ Partner (male factor)
- ○ Ovulatory problem
- ○ Tubal blockage
- ○ Endometriosis
- ○ Cervical mucus factors
- ○ Other

6. Since March 2005, have you used birth control pills?

○ No ○ Yes If **yes**, how many months? ____ ____ Months

7. Since March 2005, have you taken female hormones (like estrogen) for menopause?

○ No ○ Yes If **yes**, how many months? ____ ____ Months

Name of medication(s):

8. Women whose periods have stopped permanently (for at least 12 months) are considered to have gone through menopause, even if they have not had any symptoms (hot flashes, etc.). Which of the following best describes your current situation?

- ○ I still have my usual menstrual periods
- ○ I am currently going through menopause
- ○ My menstrual periods have stopped permanently
- ○ My periods stopped but I have periods now due to use of female hormones
- ○ I don't know if my periods have stopped because I began taking female hormones when I still had periods
- ○ Uncertain (Please describe):

→ Age periods stopped: ____ ____

→ Reason periods stopped:

- ○ Natural menopause
- ○ Chemotherapy/radiation
- ○ Surgery
- ○ Other:

9. Have you had a hysterectomy (womb removed)?
(Fill in all circles that apply.)

- ○ No
- ○ Yes, both ovaries removed
- ○ Yes, and kept ovaries
- ○ Yes, one ovary only removed

10. Please write in your current weight. ____ ____ ____ Pounds

11. How many brothers and sisters (half or full) did you grow up with? ____ ____

a. How many were older than you? ____ ____

12. During the past year, how many hours each week did you spend (on average)**:**

	None	less than 1 hr	1-2 hrs	3-4 hrs	5-6 hrs	7-9 hrs	10 or more hrs
Walking for exercise	○	○	○	○	○	○	○
Vigorous exercise (e.g., jogging, aerobics)	○	○	○	○	○	○	○

13. Since March 2005, if you were diagnosed for the first time with any of the following conditions, please fill in the circle for yes and write in the year it was first diagnosed. *(e.g. 2005 = 05)*

	Yes	Year
1. Diabetes (sugar, sugar diabetes)	○	
2. Breast cancer	○	
3. Lung cancer	○	
4. Colon cancer	○	
5. Rectal cancer	○	
6. Uterine cancer (not including cervical cancer)	○	
7. Other type of cancer. (Please write in the type)	○	
8. Heart attack	○	
9. Stroke	○	
10. Coronary bypass surgery, angioplasty, or stent	○	
11. Angina (chest pain)	○	
12. Blood clot (lungs or legs)	○	
13. Hypertension (high blood pressure)	○	
14. High cholesterol	○	
15. Fibroids in womb	○	
15a. Confirmed by ultrasound	○	
15b. Confirmed by surgery (e.g. hysterectomy)	○	
16. Lupus (not discoid)	○	
17. Multiple sclerosis	○	
18. Osteoarthritis	○	
19. Rheumatoid arthritis	○	
20. Asthma	○	
21. Sarcoidosis	○	
22. Colon or rectal polyp (benign)	○	
23. Depression treated with medication	○	
24. Glaucoma	○	
25. Cataracts	○	
26. Other serious illness	○	

14. Have you EVER been diagnosed with any of the following conditions? *Please fill in the circle for yes and write in the year it was first diagnosed.*

	Yes	Year
1. Congestive heart failure (CHF)	○	
2. End stage renal disease	○	
3. Endometriosis (confirmed by laparoscopy)	○	
4. Mono (infectious mononucleosis)	○	

15. Do you take any of the following medications or vitamins at least 3 days a week?
(Fill in the circle for YES, leave blank for NO.)

- ○ Aspirin for prevention of heart disease
- ○ Pills to lower cholesterol. Name:
- ○ Injections for diabetes
- ○ Pills for diabetes. Name:
- ○ Diuretics (water pills) for high blood pressure or other reasons. Name:
- ○ Other blood pressure pills. Name:
- ○ Inhalers or pills for asthma. Name:
- ○ Multi-Vitamins
- ○ Folic acid by itself
- ○ Calcium with Vitamin D
- ○ Calcium by itself
- ○ Vitamin D by itself

Please list all other medications or supplements that you currently take at least 3 days a week:

16. How many cigarettes do you currently smoke each day?

a. Do you smoke menthol cigarettes? ○ No ○ Yes

17. How many alcoholic beverages do you drink each week?

18. As an adult, how many teeth have you lost due to tooth decay or gum disease?

19. Do you have use of a car on a regular basis? ○ No ○ Yes

Today's Date Month / Day / Year

Your email address:

@

Your telephone number:

( ) -

○ Home
○ Work
○ Cell

( ) -

○ Home
○ Work
○ Cell

Any comments?

Please go to the next page

Has your name or address changed?
If yes, please make the changes below:

First Name: **MI** **Last Name:**

Number and Street Address

City **State** **Zip Code** -

Please check to see that all pages are completed, place the questionnaire in the prepaid envelope provided and mail to us.

Thank you for your time and cooperation.

This research project is covered by a Certificate of Confidentiality issued by the US Department of Health and Human Services. The certificate protects against the release of information collected during the course of this study.