IOWA WOMEN’S HEALTH STUDY
UNIVERSITY OF MINNESOTA AND UNIVERSITY OF IOWA

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

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

   Date of death:
   Date: _______ _______
   State Where Death Occurred:

2. Please correct any incorrect information on the label.

   CORRECT NAME:

   CORRECT STREET ADDRESS:

   CORRECT CITY, STATE, ZIP:

3. In general, would you say your current health is:
   ○ EXCELLENT
   ○ GOOD
   ○ FAIR
   ○ POOR

4. 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.

5. Which of these things are you still 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

We are interested in medical conditions you have developed since our first questionnaire in February 1986.

6. Have you suffered a fracture (broken bone) since February 1, 1986, which required treatment by a doctor?
   ○ NO   → (Go to Question 7)
   ○ 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
      ○ NO    ○ YES HIP
      ○ NO    ○ YES VERTEBRA (Part of the Spine)
      ○ NO    ○ YES OTHER

FOR OFFICE USE ONLY

0 1 2 3 4 5 6 7 8 9 86 87 88 89
7. Since February 1, 1986, 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  BENIGN (Non-Cancerous) LUMPS OR CYSTS IN THE BREAST
   ○ NO  ○ YES  BREAST CANCER
   ○ NO  ○ YES  CANCER OTHER THAN BREAST CANCER

   If yes, please specify the type of cancer:
   TYPE

8. Have you ever had a mammogram (radiographic examination of your breast) in a screening examination to detect breast cancer?
   ○ NO  → (Go to Question 9)
   ○ YES  → If YES, how many mammograms have you ever had?
     ○ 1
     ○ 2
     ○ 3
     ○ 4
     ○ 5 or more

   When was your last mammogram?
     ○ In the past 12 months
     ○ 1–2 years ago
     ○ 3–5 years ago
     ○ 6–10 years ago
     ○ More than 10 years ago

9. 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

10. What is your current weight? (Without clothes and to the nearest pound)
    Pounds

11. Drinking water may be related to your health.
   A. What is your main source of drinking water at home?
      ○ Municipal (City) Water System
      ○ Rural Water System (includes Country Water System)
      ○ Private Well
      ○ Bottled water purchased from a store or dealer
      ○ Other
      ○ Don't know
   B. How long have you been drinking the type of water that you indicated above?
      ○ Less than one year
      ○ 1–5 years
      ○ 6–10 years
      ○ 11–20 years
      ○ More than 20 years
      ○ Don't know

12. Since February 1, 1986, did you:
   A. Receive a blood transfusion (that is, receive whole blood donated from someone else after you had surgery, an accident, or lost blood for any other reason)?
      ○ NO
      ○ YES
      ○ DON'T KNOW
   B. Receive any other blood products such as blood plasma or gamma globulin, given into your vein or injected?
      ○ NO
      ○ YES
      ○ DON'T KNOW
   C. Receive any other fluid intravenously (given into your veins)?
      ○ NO
      ○ YES
      ○ DON'T KNOW

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.

   COMMENTS

   FOR OFFICE USE ONLY

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

3021-Date Recognition Corp. - 54321