1992

HEALTH PROFESSIONALS FOLLOW-UP STUDY

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1. Current weight (lbs.)

2. Current Marital Status: ○ Married ○ Divorced/Separated ○ Widowed ○ Never Married

3. Living Arrangement: ○ Alone ○ With Wife ○ With other Family ○ Nursing Home ○ Other

4. Work Status: ○ Full-time ○ Part-time ○ Retired ○ Disabled

5a. Do you currently smoke cigarettes? ○ No ○ Yes →

a. Please mark the average number of cigarettes per day:
○ 1-4 cigarettes ○ 5-14 cigarettes ○ 15-24 cigarettes
○ 25-34 cigarettes ○ 35-44 cigarettes ○ 45 or more cigarettes

5b. Do you currently smoke a pipe or cigar daily? ○ Neither ○ Pipe ○ Cigar

6. Are you: ○ Naturally right-handed ○ Naturally left-handed ○ Forced to change ○ Ambidextrous

7. In the past 30 years, how many times have you donated blood?
○ Never ○ 5 or less ○ 6-9 ○ 10-19 ○ 20-29 ○ 30-59 ○ 60-89 ○ 90 or more

8. Please indicate the times of day that you usually eat *(mark all that apply)*:
○ Before breakfast ○ Breakfast ○ Between breakfast and lunch ○ Lunch
○ Between lunch and dinner ○ Dinner ○ Between dinner and bed time ○ After going to bed

9. How often do you eat:
Brown gravy from beef, pork or lamb drippings: ○ Never ○ 1-3/month ○ 1/week ○ 2-3/week ○ 4-5/week
Other gravy (e.g., chicken, turkey or storebought): ○ Never ○ 1-3/month ○ 1/week ○ 2-3/week ○ 4-5/week

10. How many teeth have you lost since January 1, 1990? ○ None ○ 1 ○ 2 ○ 3 ○ 4 ○ 5-9 ○ 10+

11. Did either of your parents or siblings have...(mark if yes)

	LUNG CANCER	COLON OR RECTAL CANCER	PROSTATE CANCER	DIABETES	MELANOMA	HYPERTENSION	DEMENTIA BEFORE AGE 70	ALCOHOL PROBLEM
Mother	○	○	○	○	○	○	○	○
Father	○	○	○	○	○	○	○	○
Sibling	○	○	○	○	○	○	○	○

12. In the past 2 years, have you had
... a physical exam? ○ No ○ Yes, for symptoms ○ Yes, for routine screenings
... a blood cholesterol check? ○ No ○ Yes, for symptoms ○ Yes, for routine screenings
... a rectal exam? ○ No ○ Yes, for symptoms ○ Yes, for routine screenings
... an eye exam? ○ No ○ Yes, for symptoms ○ Yes, for routine screenings

13. Have you ever had a colonoscopy or sigmoidoscopy? ○ No ○ Yes →

a. Did you have colonoscopy or sigmoidoscopy since January 1, 1990? ○ No ○ Yes

b. Why did you have the colonoscopy or sigmoidoscopy *(mark all that apply)*?
○ Bleeding in stool ○ Family history of colon cancer
○ Positive test for occult fecal blood ○ Diarrhea or constipation
○ Abdominal pain ○ Routine screening (no symptoms) or follow-up

14. What is your current usual blood pressure?
Systolic: ○ Unknown ○ <105mm Hg ○ 105-114 ○ 115-124 ○ 125-134 ○ 135-144 ○ 145-154 ○ 155-164 ○ 165-174 ○ 175+
Diastolic: ○ Unknown ○ <65mm Hg ○ 65-74 ○ 75-79 ○ 80-84 ○ 85-89 ○ 90-94 ○ 95-104 ○ 105+

15. What is your normal walking pace? ○ Easy (<2 mph) ○ Normal, average (2 to 2.9 mph) ○ Brisk pace (3 to 3.9 mph) ○ Very brisk, striding (4 mph or faster)

16. Do you have difficulty with your balance? ○ No ○ Yes

17. Do you have difficulty climbing a flight of stairs or walking eight blocks due to a physical impairment? ○ No ○ Yes

18. How many flights of stairs (not steps) do you climb daily?
○ No flights ○ 1-2 flights ○ 3-4 flights ○ 5-9 flights ○ 10-14 flights ○ 15 or more flights

19. During the past year what was your average total time per week at each activity?

	AVERAGE TOTAL TIME PER WEEK												
	NONE	1-4 Min.	5-19 Min.	20-39 Min.	40-60 Min.	1.5 Hrs.	2-3 Hrs.	4-6 Hrs.	7-10 Hrs.	11-20 Hrs.	21-30 Hrs.	31-40 Hrs.	40+ Hrs.
Sitting at work	○	○	○	○	○	○	○	○	○	○	○	○	○
Sitting or driving in a car, bus or train	○	○	○	○	○	○	○	○	○	○	○	○	○
Sitting or lying watching TV or VCR	○	○	○	○	○	○	○	○	○	○	○	○	○
Sitting at home reading	○	○	○	○	○	○	○	○	○	○	○	○	○
Other sitting at home (e.g., at desk or eating)	○	○	○	○	○	○	○	○	○	○	○	○	○
Walking or hiking outdoors (including walking at golf)	○	○	○	○	○	○	○	○	○	○	○	○	○
Jogging (slower than 10 minutes/mile)	○	○	○	○	○	○	○	○	○	○	○	○	○
Running (10 minutes/mile or faster)	○	○	○	○	○	○	○	○	○	○	○	○	○
Bicycling (including stationary machine)	○	○	○	○	○	○	○	○	○	○	○	○	○
Lap swimming	○	○	○	○	○	○	○	○	○	○	○	○	○
Tennis	○	○	○	○	○	○	○	○	○	○	○	○	○
Squash or Racquetball	○	○	○	○	○	○	○	○	○	○	○	○	○
Calisthenics, Rowing or other Aerobics	○	○	○	○	○	○	○	○	○	○	○	○	○
Weightlifting or Nautilus	○	○	○	○	○	○	○	○	○	○	○	○	○
Heavy outdoor work (e.g., digging, chopping)	○	○	○	○	○	○	○	○	○	○	○	○	○

Please continue on page 2 →

ID #

20. Is this your date of birth?

○ No ➡ IF NO, please indicate your date of birth. MONTH | DAY | YEAR

○ Yes

21. Do you currently take a multi-vitamin?

○ No

○ Yes ➡

a. How many do you take per week?
○ 2 or fewer ○ 6 to 9
○ 3 to 5 ○ 10 or more

b. What specific brand do you usually use?
Please specify exact BRAND and TYPE.

22. Not counting multi-vitamins, do you take any of the following supplements?

SUPPLEMENT	AMOUNT PER DAY
Vitamin A?	
○ Yes, seasonal use only	○ less than 8,000 IU per day
○ Yes, most months	○ 8,000-12,000 IU
	○ 13,000-22,000 IU ○ amount unknown
○ No	○ 23,000 IU or more
Vitamin C?	○ less than 400 mg per day
○ Yes, seasonal use only	○ 400-700 mg
○ Yes, most months	○ 750-1250 mg ○ amount unknown
○ No	○ 1,300 mg or more
Vitamin B-6?	○ less than 10 mg day
○ Yes ➡	○ 10-39 mg
	○ 40-79 mg ○ amount unknown
○ No	○ 80 mg or more
Vitamin E?	○ less than 100 IU per day
○ Yes ➡	○ 100-250 IU
	○ 300-500 IU ○ amount unknown
○ No	○ 600 IU or more
Calcium (including dolomite, Tums, etc.)	**(mg of elemental calcium)**
	○ less than 400 mg per day
○ Yes ➡	○ 400-800 mg
	○ 900-1,200 mg ○ amount unknown
○ No	○ 1,300 mg or more
Selenium?	
	○ less than 80 mcg per day
○ Yes ➡	○ 80-130 mcg
	○ 140-250 mcg ○ amount unknown
○ No	○ 260 mcg or more
Niacin?	○ less than 50 mg per day
○ Yes ➡	○ 100-300 mg
	○ 400-800 mg ○ amount unknown
○ No	○ 900 or more
Zinc?	○ less than 25 per day
○ Yes ➡	○ 25-74 mg
	○ 75-100 mg ○ amount unknown
○ No	○ 101 mg or more
Fish oil?	○ less than 2,500 mg per day
○ Yes ➡	○ 2,500-4,999 mg
	○ 5,000 to 9,999 mg ○ amount unknown
○ No	○ 10,000 mg or more

Mark if you take any of these. ➡

○ Potassium	○ Chromium	○ Copper
○ Vitamin D	○ Iron	○ Beta-Carotene
○ Magnesium	○ Iodine	○ Folic Acid
○ B-Complex	○ Lecithin	○ Brewers Yeast

23. Since January 1, 1990, have you had any of the following professionally diagnosed conditions?

Leave blank for NO, mark here for YES ➡ (Y)

	YEAR OF DIAGNOSIS: Before 1990	1990	1991	1992
High blood pressure (Y)	○	○	○	○
Diabetes mellitus (Y)	○	○	○	○
Elevated cholesterol (Y)	○	○	○	○
Elevated triglycerides (Y)	○	○	○	○
Myocardial infarction (heart attack) (Y)	○	○	○	○
Hospitalized for this MI? ○ No ○ Yes				
Angina pectoris (Y)	○	○	○	○
Confirmed by angiogram? ○ No ○ Yes				
Coronary artery bypass or angioplasty (Y)	○	○	○	○
Peripheral venous thrombosis (Y)	○	○	○	○
TIA (Transient Ischemic Attack) (Y)	○	○	○	○
Stroke (CVA) (Y)	○	○	○	○
Carotid artery surgery (Y)	○	○	○	○
Intermittent claudication (Y)	○	○	○	○
Surgery for arterial disease of the leg (e.g., femoral artery) (Y)	○	○	○	○
Pulmonary embolus (Y)	○	○	○	○
Aortic aneurysm (Y)	○	○	○	○
Heart-rhythm disturbance (Y)	○	○	○	○
Gout (Y)	○	○	○	○
Rheumatoid arthritis (Y)	○	○	○	○
Other arthritis (e.g., osteoarthritis) (Y)	○	○	○	○
Osteoporosis (Y)	○	○	○	○
Hip replacement (Y)	○	○	○	○
Vasectomy (Y)	○	○	○	○
Diverticulitis or Diverticulosis (Y)	○	○	○	○
Colon or rectal polyp (Y)	○	○	○	○
Cancer of colon or rectum (Y)	○	○	○	○
Basal cell skin cancer (Y)	○	○	○	○
Squamous cell skin cancer (Y)	○	○	○	○
Melanoma (Y)	○	○	○	○
Solar or actinic keratosis (Y)	○	○	○	○
Prostate cancer (Y)	○	○	○	○
Lymphoma or leukemia (Y)	○	○	○	○
Other cancer (Y)	○	○	○	○
Please specify site and year: ➡				
Glaucoma (Y)	○	○	○	○
Cataract extraction (Y)	○	○	○	○
Macular degeneration (Y)	○	○	○	○
Chronic renal failure (Y)	○	○	○	○
Gallstones (Y)	○	○	○	○
a. How was diagnosis made? ○ X-ray/ultra-sound ○ Other				
b. Gallstone symptoms? ○ No ○ Yes				
Gall bladder removal (Y)	○	○	○	○
Kidney stones (Y)	○	○	○	○
Gastric or duodenal ulcer (Y)	○	○	○	○
Ulcerative colitis (Y)	○	○	○	○
Periodontal disease with bone loss (Y)	○	○	○	○
Parkinson's disease (Y)	○	○	○	○
Pneumonia (Y)	○	○	○	○
Other major illness? (Y)	○	○	○	○
Diagnosis: Date				

Your TB skin test since 1987: ○ Pos ○ Neg ○ Unknown

If ever positive, conversion date: ○ Before 1987 ○ 1987+

24. Since January 1, 1990, have you had any of these fractures?

○ None ○ Hip (exclude pelvis) ○ Wrist (Colles or distal forearm) ○ Other

If hip or wrist, please specify circumstances. If a fall, include cause, impact, surface and height of fall. ➡

25. Please mark any of these professionally diagnosed diseases or clinical procedures and year of first occurrences.

Mark here for YES →		Before 1986	1987	1988	1989	1990	1991	1992
Herniated disk	Ⓨ	○	○	○	○	○	○	○
Asthma	Ⓨ	○	○	○	○	○	○	○
Cataract	Ⓨ	○	○	○	○	○	○	○

Was this herniated disk confirmed by CT or MRI? ○ No ○ Yes

26. Current Medication *(mark if used regularly):*

- ○ No regular medication
- ○ Acetaminophen, 2+ times/week (e.g., Tylenol)
- ○ Aspirin, 2+ times/week (e.g., Anacin, Bufferin, Alka-Seltzer)
- ○ Other anti-inflammatory (e.g., Advil, Motrin, Indocin)
- ○ Furosemide-like diuretics (e.g., Lasix, Bumex)
- ○ Thiazide diuretic
- ○ Calcium blocker (e.g., Calan, Procardia, Cardizem)
- ○ Cimetidine, Ranitidine (e.g., Tagamet, Zantac)
  - **How long have you been taking Cimetidine?**
  - ○ 0-3 years ○ 4-6 years ○ 7-9 years ○ 10+ years
- ○ Beta-blocker (e.g., Inderal, Lopressor, Tenormin, Corgard)
- ○ Other antihypertensive (e.g., Aldomet, Capoten, Apresoline)
- ○ Steroids taken orally (e.g., Prednisone, Decadron, Medrol)
- ○ Antiarrhythmic (e.g., Quinaglute, Procan, Tonocard, Norpace)
- ○ Cholesterol-lowering drug (e.g., Questran, Mevacor, Lopid)
- ○ Theophyllines (e.g., Choledyl, Slo-Phyllin, Uniphyl)
- ○ Levodopa (e.g., Sinemet, Larodopa)
- ○ Nitrate (e.g., Isordil, Nitrostat, Transderm, Isosorbide)
- ○ Minor Tranquilizers (e.g., Valium, Xanax, Ativan, Librium, Klonopin)
- ○ Major Tranquilizers (e.g., Stelazine, Thorazine, Haldol, Prolixin, Mellaril, Trilafon)
- ○ Antidepressants
- ○ Digoxin (e.g., Lanoxin)
- ○ Other prescription medicine(s)

Please give NAME and DOSE

27. On average, how many days each month do you take aspirin? (Include Anacin, Bufferin, etc. Do not include Tylenol or other aspirin-free products.)

○ Never ○ 1-4 days/month ○ 5-14 days/month ○ 15-21 days/month ○ 22 + days/month

28. On days that you do take aspirin, how many do you usually take?

○ Never ○ < 1 aspirin (e.g. baby aspirin) ○ 1 aspirin ○ 2 aspirin ○ 3-4 aspirin ○ 5-6 aspirin ○ 7 + aspirin

29. Did you ever take Tetracycline for at least two months at a time (e.g., for acne or other reason)?

○ No ○ Yes ➡ **For how long?** ➡ ○ 2-11 months ○ 1-2 years ○ 2-3 years ○ more than 4 years

Because little is known about the causes of prostate cancer, we are focusing on this organ. You may ignore questions that you feel are too sensitive.

30. During the past month, please indicate how frequently you had these urinary symptoms and how large of a problem they were to you:

	% OF TIME EXPERIENCED SYMPTOMS							HOW LARGE A PROBLEM?				
	0%	10%	25%	50%	75%	Almost 100%		None	Very Small	Small	Medium	Big
Sensation of incomplete bladder emptying	○	○	○	○	○	○	→	○	○	○	○	○
Having to urinate again after less than 2 hours	○	○	○	○	○	○	→	○	○	○	○	○
Stopping and starting several times during urination	○	○	○	○	○	○	→	○	○	○	○	○
Found it difficult to postpone urinating	○	○	○	○	○	○	→	○	○	○	○	○
Weak urinary stream	○	○	○	○	○	○	→	○	○	○	○	○
Had to push or strain to begin urination	○	○	○	○	○	○	→	○	○	○	○	○

31. a. Over the past month, how many times per night did you typically get up to urinate?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 or more times per night

b. How large of a problem was this to you? ○ None ○ Very small ○ Small ○ Medium ○ Large

32. Have you ever had an enlarged prostate detected by rectal exam?

○ No ○ Yes ➡ **IF YES, when?** ○ 1986 or earlier ○ After 1986

33. Since January 1, 1990, have you had surgery for enlarged benign prostate or BPH (e.g., transurethral resection)?

○ No ○ Yes ➡ **Year of surgery?** ○ 1990 ○ 1991 ○ 1992

34. Have you ever had prostatitis or prostatic infection?

○ No ○ Yes ➡

a. How long did the symptoms persist?

○ <1 year ○ 1-2 years ○ 3-5 years ○ 6-10 years ○ >10 years

b. Were you ever treated for prostatitis?

○ No ○ Yes ➡ **IF YES, at what age were you first treated?**

○ < 30 ○ 30-39 ○ 40-49 ○ 50-59 ○ 60 or older

35. Did you ever have a diagnosis of: ○ Syphilis ○ Gonorrhea ○ Neither

36. On average, how many ejaculations did you have per month during these ages?

Ages 20-29: ○ None	○ 1-3/month	○ 4-7	○ 8-12	○ 13-20	○ > 20/month
Ages 40-49: ○ None	○ 1-3/month	○ 4-7	○ 8-12	○ 13-20	○ > 20/month
Past year: ○ None	○ 1-3/month	○ 4-7	○ 8-12	○ 13-20	○ > 20/month

37. Did you have a vasectomy before 1986?

○ No ○ Yes ➡ **At what age?**

OFFICE USE ONLY

⓪①②③④⑤⑥⑦⑧⑨
⓪①②③④⑤⑥⑦⑧⑨

Please continue on page 4 ➡

38. In which state were you born? →
In which state did you live in at age 15? →
In which state did you live in at age 25? →

39. On the average, how many months of the year did you participate in strenuous (aerobic) physical activity or sports at least twice per week (e.g., swimming, aerobics, hockey, basketball, cycling, running):

During high school:	○ Never	○ 1-3 months/yr	○ 4-6 months/yr	○ 7-9 months/yr	○ 10-12 months/yr
During college:	○ Never	○ 1-3 months/yr	○ 4-6 months/yr	○ 7-9 months/yr	○ 10-12 months/yr
During ages 30 to 40:	○ Never	○ 1-3 months/yr	○ 4-6 months/yr	○ 7-9 months/yr	○ 10-12 months/yr

40. As an adolescent, at the beginning of the summer, if you were out in the sun for the first time and were to stay out for one hour without sunscreen, would you: ○ Painfully burn then peel ○ Burn then tan ○ Tan without burning

41. During summers as a teenager, on average, how many times per week were you outdoors in a swimsuit?
○ < 1/week ○ 1/week ○ 2/week ○ Several/week ○ Daily

42. a. How many times in your life have you had a sunburn that blistered?
○ Never ○ 1-2 times ○ 3-5 times ○ 6-9 times ○ 10 or more times

b. How many of these involved:

Face:	○ Never	○ 1-2 times	○ 3-5	○ 6-9	○ 10 or more times
Back or chest:	○ Never	○ 1-2 times	○ 3-5	○ 6-9	○ 10 or more times
Thighs or legs:	○ Never	○ 1-2 times	○ 3-5	○ 6-9	○ 10 or more times

c. During the past summer, when you were outside at the pool or beach, what % of the time did you wear sunscreen: ○ Not in sun ○ 0% ○ 25% ○ 50% ○ 75% ○ 100%

43. Between the ages of 18-30, how many times did you purposely lose 10 or more pounds (excluding illness)?
○ 0 times ○ 1-2 times ○ 3-4 times ○ 5-6 times ○ 7+ times

44. Within the last 20 years (exclude illness):
a. What was your: Minimum weight _____ lbs. Maximum weight _____ lbs.
b. How many times did you lose each of the following amounts of weight on purpose (excluding illness):

5-9 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
10-19 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
20-49 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
50+:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times

45. Within the last 4 years (exclude illness):
a. What was your: Minimum weight _____ lbs. Maximum weight _____ lbs.
b. How many times did you lose each of the following amounts of weight on purpose (excluding illness):

5-9 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
10-19 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
20-49 pounds:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times
50+:	○ 0 times	○ 1-2 times	○ 3-4 times	○ 5-6 times	○ 7+ times

c. If you lost 10 or more pounds, what primary method(s) did you use for your most recent weight loss (fill in all that apply)?
○ Did not lose 10 or more pounds ○ Weight loss was unintentional (e.g., illness, unusual stress, depression)
○ Low calorie diet ○ Skipped meals/fasted ○ Increased exercise ○ Diet pills
○ Commercial weight loss program ○ Gastric surgery/intestinal bypass ○ Other

46. Your hair pattern at age 45:

47. How would you rate the amount of stress in your daily life?

At work:	○ Severe	○ Moderate	○ Light	○ Minimal
At home:	○ Severe	○ Moderate	○ Light	○ Minimal

48. In a typical month, what is the largest number of drinks of beer, wine and/or liquor you may have in one day?
○ None ○ 1-2 drinks/day ○ 3-5 ○ 6-9 ○ 10-14 ○ 15 or more drinks/day

49. Apart from communion or passover, have you drunk 50 or more drinks in your life? ○ Yes ○ No

50. What is your best visual acuity (corrected by glasses if you wear them) for each eye?

LEFT EYE	RIGHT EYE
○ 20/25 or better	○ 20/25 or better
○ 20/30 to 20/65	○ 20/30 to 20/65
○ 20/70 to 20/180	○ 20/70 to 20/180
○ 20/200 or worse	○ 20/200 or worse

51. What is your heart rate after sitting for 10-15 minutes (e.g., after completing this form)?
_____ (/Min)

52. In this study, it will be important to maintain contact for a number of years:
Please indicate the name of someone at a different address that we might write to in the event we are unable to contact you:

Name: _____

Address: _____

_____

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Thank you! Please return forms in prepaid return envelope to Dr. Walter Willett, 677 Huntington Ave., Boston, MA 02115

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