Black Women's Health Study 1999

PLEASE USE BLUE OR BLACK BALLPOINT PEN

1. How old are you? → Age

2. Please write in your date of birth and fill in the circles. (This information is helpful for identification)

MONTH	DAY	YEAR
○ JAN	0 1 2 3 / 0 1 2 3 4 5 6 7 8 9	1 9 / 0 1 2 3 4 6 7 / 0 1 2 3 4 5 6 7 8 9
○ FEB		
○ MAR		
○ APR		
○ MAY		
○ JUN		
○ JUL		
○ AUG		
○ SEP		
○ OCT		
○ NOV		
○ DEC		

3. What is your current marital status?

- ○ Married
- ○ Living as married
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Single, never married

4. Please write in your current weight and fill in the circles.

WEIGHT (Pounds)

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

5. At about what age did you reach your full height?

- ○ before age 13
- ○ 13 to 17 years of age
- ○ after age 17
- ○ don't know

6. Currently, where do you live?

- ○ Urban setting
- ○ Suburban setting
- ○ Rural or small town setting

7. Currently, what kind of neighborhood do you live in?

- ○ Predominantly black
- ○ Predominantly white
- ○ Mixed or other

8. Are you currently using any of these forms of birth control? (Mark all that you are currently using)

- ○ none
- ○ birth control pills
- ○ condom
- ○ foam/jelly
- ○ diaphragm/cap
- ○ Intrauterine device (IUD)
- ○ sponge
- ○ tubes tied (tubal ligation)
- ○ hysterectomy
- ○ vasectomy
- ○ rhythm
- ○ Norplant
- ○ Depo-Provera(injections)
- ○ other →

9. Between March 1997 and March 1999, did you use birth control pills?

- ○ Yes →
- ○ No → Go to question 10

9a. How many months did you use them between March 1997 and March 1999?

- ○ less than 6 months
- ○ 6 - 11 months
- ○ 12 - 17 months
- ○ 18 or more months

9b. Please give the name of the last birth control pill that you used since March 1997

9c. Do you use them currently?

- ○ Yes
- ○ No

9d. Why not?

- ○ Use another method now
- ○ No longer need them
- ○ Side effects bothered me
- ○ Serious illness while on pill

(Please specify the illness)

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DOR 1 2 3 4 5 6 7 8 9 10 11 12 / 0 1 2 3 - 0 1 2 3 4 5 6 7 8 9

Initials 0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9

9d 1 - 0 1 2 3 4 5 6 7 8 9 / 4 - 0 1 2 3 4 5 6 7 8 9

9b 1 - 0 1 2 3 4 5 6 7 8 9 2 - 0 1 2 3 4 5 6 7 8 9 / 2 - 0 1 2 3 4 5 6 7 8 9 3 - 0 1 2 3 4 5 6 7 8 9 / 5 - 0 1 2 3 4 5 6 7 8 9 6 - 0 1 2 3 4 5 6 7 8 9

8 - 1 2 3 4 5 6 7 8 9

10. Have your menstrual periods stopped permanently (menopause)? (Mark only one)

- ○ Yes, I went through menopause
- ○ Yes, I went through menopause but have periods now due to use of female hormones
- ○ No, but I am currently going through menopause
- ○ No, I still have my usual menstrual periods
- ○ Uncertain
- ○ Never had periods

10a. IF YES: Age periods stopped

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

10b. For what reason did your periods stop?

- ○ Natural menopause
- ○ Surgery
- ○ Medication/chemotherapy/radiation

11. Have you had surgery to remove your ovaries or uterus? (Mark all that apply)

- ○ No

Age at Removal

- ○ Both ovaries removed →
- ○ One ovary only removed →
- ○ Uterus removed →

12. Between March 1997 and March 1999, have you taken female hormones (like estrogen) for menopause?

○ Yes ○ No → Go to question 13

12a. If YES, between March 1997 and March 1999, how long did you take female hormone supplements?

- ○ less than 6 months
- ○ 6 - 11 months
- ○ 12 - 17 months
- ○ 18 or more months

12b. Type of hormone supplement used most recently?

- ○ Premarin or other estrogen pills alone
- ○ Progesterone (Provera etc.) pills alone
- ○ Estrogen and progesterone pills
- ○ Patch estrogen with or without progesterone
- ○ Estrogen vaginal cream
- ○ Birth control pill (for menopause)

Name of medication

13. Do you currently take any of the following herbals at least 3 days a week? (Mark all that apply)

- ○ Echinacea
- ○ Garlic
- ○ Ginger
- ○ St. John's Wort
- ○ Ginkgo
- ○ Chamomile
- ○ Feverfew
- ○ Hawthorn
- ○ Milk Thistle
- ○ Goldenseal
- ○ Ginseng
- ○ Aloe
- ○ Ephedra products
- ○ Cat's claw

14. Do you take any of the following medications or vitamins at least 3 days a week?

Mark circle for YES, Leave blank for NO

- ○ Aspirin (Anacin, Bufferin, Bayer, Excedrin, etc.)
- ○ Acetaminophen (Tylenol, Anacin-3, Panadol, etc.)
- ○ Injections for diabetes
- ○ Pills for diabetes — Name →
- ○ Diuretics (water pills) for high blood pressure or other reasons (Diuril, Hydrodiuril, etc.) — Name →
- ○ Other blood pressure medication (Vasotec, Minipres, Calan, etc.) — Name →
- ○ Antidepressants (Prozac, Zoloft, Elavil, etc.) — Name →
- ○ Inhalers or pills for asthma — Name →
- ○ Pills to lower cholesterol — Name →
- ○ Medication for weight reduction — Name →
- ○ Multi-Vitamins
- ○ Folic acid by itself

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

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12b 1 2 3 4 5 6 7 8 9

11 0 1 2 3 4 5 6 7 8 9 11 0 1 2 3 4 5 6 7 8 9 11 0 1 2 3 4 5 6 7 8 9

BO 0 1 2 3 4 5 6 7 8 9 OV 0 1 2 3 4 5 6 7 8 9 U 0 1 2 3 4 5 6 7 8 9

15. Between March 1997 and March 1999, if you were diagnosed with any of the following conditions, please fill in the circle(s) and indicate the year it was first diagnosed.

Leave blank for NO, mark circle for YES — **YEAR**

1. High blood pressure (in pregnancy)	○	
2. High blood pressure (not in pregnancy)	○	
3. High cholesterol	○	
4. Heart attack	○	
5. Angina (chest pain)	○	
6. Stroke	○	
7. Coronary bypass/angioplasty	○	
8. Blood clot in lungs or legs	○	
9. Cyst in breast	○	
Was it confirmed by biopsy?	○	
10. Colon or rectal polyp (benign)	○	
11. Toxemia/Pre-eclampsia of pregnancy	○	
12. Hydatidiform mole of pregnancy	○	
13. Fibroids in womb	○	
Confirmed by pelvic exam	○	
Confirmed by ultrasound/hysterectomy	○	
14. Polycystic ovarian syndrome	○	
15. Premenstrual syndrome (PMS)	○	
16. Kidney stones	○	
17. Endometriosis	○	
Confirmed by laparoscopy	○	
18. Gastric or duodenal ulcer	○	
19. Gallstones	○	
20. Lupus (Systemic lupus erythematosus)	○	
21. Discoid lupus	○	
22. Rheumatoid arthritis	○	
23. Osteoarthritis	○	
24. Sickle cell anemia	○	
25. Gingivitis (bleeding gums)	○	
26. Depression treated with medication	○	
27. Sarcoidosis	○	
28. Asthma	○	
29. Raynaud's disease	○	
30. Diabetes not during pregnancy	○	
31. Diabetes during pregnancy	○	
32. Breast cancer	○	
33. Cervical cancer	○	
34. Uterine cancer	○	
35. Lung cancer	○	
36. Colon cancer	○	
37. Rectal cancer	○	

Other cancer or other serious illness?

38. _____ → ○

39. _____ → ○

16. Do you have unusual sensitivity to the cold in your fingers?

○ Yes ○ No → Go to question 17

16a. If YES, do your fingers turn:

○ white ○ purple ○ blue ○ none of these

17. During the past 2 years, have you had unintentional weight loss?

(e.g., due to illness, depression, stress, appetite problems)

○ Yes ○ No → Go to question 18

17a. If YES, how many pounds did you lose?

○ 2 - 4 pounds
○ 5 - 9 pounds
○ 10 - 14 pounds
○ 15 - 29 pounds
○ 30 - 49 pounds
○ 50+ pounds

18. Have you ever intentionally lost 15 pounds or more?

○ Yes ○ No → Go to question 19

18a. If YES, what method did you use? (Mark all that apply)

○ Exercise / working out
○ General increase in routine activities
○ Balanced low calorie/ low fat food
○ Smaller portions
○ Popular diet (e.g. Zone, Atkins)
○ Diet pills/medications
○ Fasting
○ Vomiting
○ Laxatives
○ Gastric surgery
○ Commercial weight loss program →
○ Commercial diet supplement →
○ Other →

18b. The last time you lost weight, did you:

○ Keep most of it off
○ Gain some of it back
○ Gain all of it back
○ Gain back more than you lost

18c. What methods have you found most useful in keeping weight off? (Mark all that apply)

○ Exercise / working out
○ General increase in routine activities
○ Balanced low calorie/ low fat food
○ Smaller portions
○ Popular diet (e.g. Zone, Atkins)
○ Diet pills/medications
○ Fasting
○ Vomiting
○ Laxatives
○ Gastric surgery
○ Commercial weight loss program →
○ Commercial diet supplement →
○ Cigarette smoking
○ Other →

19. Do any of the following describe your eating pattern in the last 2 years? (Mark all that apply)

- ○ Eat to excess at least every few days
- ○ Eat to excess followed by vomiting at least every few days
- ○ Often do not eat (anorexia)
- ○ Eat only one meal a day
- ○ Skip breakfast most days
- ○ Usually eat something late at night
- ○ None of the above

20. In the past two years, have you had:

Colonoscopy or sigmoidoscopy	○ No	○ Yes, for screening	○ Yes, for symptoms
Mammogram	○ No	○ Yes, for screening	○ Yes, for symptoms
Pap smear	○ No	○ Yes	
Bone mineral density measurement	○ No	○ Yes	
Routine blood test in the course of a physical exam	○ No	○ Yes	

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

○ None ○ Less then 5 per day ○ 5 - 14 ○ 15 - 24 ○ 25 - 34 ○ 45 or more

22. In the last year on average, how many alcoholic beverages did you drink each week?

○ Less than 1 ○ 1 - 3 ○ 4 - 6 ○ 7 - 13 ○ 14 - 20 ○ 21 - 27 ○ 28 or more

23. On average, during the past year, how many hours each day did you spend:

	None	less than 1 hr	1 - 2 hours	3 -4 hours	5 or more
Watching TV, videos, home computer	○	○	○	○	○
Sitting at work	○	○	○	○	○
Walking as part of your job	○	○	○	○	○

24. On average, during the past year, how many hours each week did you spend:

	None	less than 1hr	1-2 hrs	3-4 hrs	5-6 hrs	7-9 hrs	10 or more hours
Walking to and from church, store, school, work	○	○	○	○	○	○	○
Walking for exercise	○	○	○	○	○	○	○
Moderate activity (such as housework, childcare, gardening, bowling)	○	○	○	○	○	○	○
Vigorous activity (such as basketball, swimming, running, aerobics)	○	○	○	○	○	○	○

25. Please indicate which best describes how often you felt or behaved this way during the past week

	Rarely or none of the time	Some or a little of the time	Moderate amount of time	Most or all of the time
I was bothered by things that usually do not bother me	○	○	○	○
I did not feel like eating; my appetite was poor	○	○	○	○
I felt that I could not shake off the blues even for family/friends	○	○	○	○
I felt that I was just as good as other people	○	○	○	○
I had trouble keeping my mind on what I was doing	○	○	○	○
I felt depressed	○	○	○	○
I felt that everything I did was an effort	○	○	○	○
I felt hopeful about the future	○	○	○	○
I thought my life had been a failure	○	○	○	○
I felt fearful	○	○	○	○
My sleep was restless	○	○	○	○
I was happy	○	○	○	○
I talked less than usual	○	○	○	○
I felt lonely	○	○	○	○
People were unfriendly	○	○	○	○
I enjoyed life	○	○	○	○
I had crying spells	○	○	○	○
I felt sad	○	○	○	○
I felt that people disliked me	○	○	○	○
I could not get going	○	○	○	○

26. For all family members who are biologically related to you, mark the circle if they have ever had any of the following medical conditions.

Medical Condition	Mother	Father	Any Sister	Any Brother	Any Son	Any Daughter
Breast Cancer	○	○	○	○	○	○
Lung Cancer	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Rectal Cancer	○	○	○	○	○	○
Prostate Cancer	○	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Heart Attack	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○
Lupus	○	○	○	○	○	○
Asthma	○	○	○	○	○	○
Other Serious Condition	○	○	○	○	○	○

27. Between March 1997 and March 1999, have you been pregnant?

○ Yes ○ No → Go to page 7

27a. Mark the number of times between March 1997 and March 1999:

Miscarriage	①	②	③
Abortion	①	②	③
Birth of single child	①	②	③
Birth of twins or triplets	①	②	③
Other →	①	②	③

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27 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

30 ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Between March 1997 and March 1999, if you gave birth to a single child, either liveborn or stillborn, please answer the following questions. If more than 1 birth during this period please answer only about the most recent. If no births between March 1997 and March 1999, please skip this section and go to page 7.

28. What was your due date?

(If due date changed during pregnancy, give last one doctor told you)

MONTH: ○ Jan ○ Feb ○ Mar ○ Apr ○ May ○ Jun ○ Jul ○ Aug ○ Sep ○ Oct ○ Nov ○ Dec

DAY: ⓪ ① ② ③ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

YEAR: ○ 1997 ○ 1998 ○ 1999 ○ 2000

29. What was the child's birth date?

MONTH: ○ Jan ○ Feb ○ Mar ○ Apr ○ May ○ Jun ○ Jul ○ Aug ○ Sep ○ Oct ○ Nov ○ Dec

DAY: ⓪ ① ② ③ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

YEAR: ○ 1997 ○ 1998 ○ 1999 ○ 2000

30. Did this pregnancy result from:

○ IVF (in-vitro fertilization)
○ GIFT (gamete intrafallopian transfer)
○ Other assisted reproductive technology →
○ None of these

31. How much weight did you gain during this pregnancy?

○ less than 10 lbs ○ 10 - 14 lbs ○ 15 - 19 lbs ○ 20 - 24 lbs ○ 25 - 29 lbs ○ 30 - 34 lbs ○ 35 - 39 lbs ○ more than 39 lbs

32. Since the birth, how much of the pregnancy weight gain have you lost?

○ Almost all ○ About half ○ About a quarter ○ Almost none

33. Did you breast feed the baby?

○ Yes ○ No → Go to question 34

33a. How long?

○ less than 3 months ○ 3 - 5 months ○ 6 months or more ○ none

34. Did you plan to get pregnant when you conceived this baby?

○ Yes, planned ○ No, unplanned

35. What is the race of the father?

○ Black ○ White ○ Other race →

36. Did you take multi-vitamins during this pregnancy?

○ Yes ○ No → Go to question 37

36a. When did you take them? (Mark all that apply)

○ Before the pregnancy ○ During 1st trimester ○ During 2nd trimester ○ During 3rd trimester

37. Did you use vaginal douching during this pregnancy or in the 6 months before it? (Mark all that apply)

○ No
○ Yes, in the 6 months before this pregnancy
○ Yes, less then 5 times during this pregnancy
○ Yes, 5 or more times during this pregnancy

38. Did you smoke during this pregnancy or just before it?

○ Yes ○ No → Go to question 39

38a. When did you smoke? (Mark all that apply)

○ Before the pregnancy ○ During 1st trimester ○ During 2nd trimester ○ During 3rd trimester

38b. How many cigarettes did you smoke on average during this pregnancy?

○ Less then 5 per day ○ 5 - 14 per day ○ 15 - 24 per day ○ 25 or more per day

39. When did you first see a doctor or nurse for prenatal care?

○ During 1st trimester ○ During 2nd trimester ○ During 3rd trimester ○ Never

40. How much did this baby weigh at birth?

Please write in the child's weight in pounds and ounces and fill in the circles. If not certain give approximate weight.

POUNDS		①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	⑪	⑫	⑬	⑭	⑮
OUNCES		⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	⑪	⑫	⑬	⑭	⑮

41. Did the doctor say this child was born at least 3 weeks early (premature/preterm)?

○ Yes ○ No → Go to question 42

41a. How early?

○ 3 weeks ○ 5 weeks ○ 7 weeks ○ 9 weeks ○ Don't know
○ 4 weeks ○ 6 weeks ○ 8 weeks ○ 10 weeks or more

41b. Were you told that the birth was early for any of the following reasons?

○ labor began early for no known reason
○ membranes ruptured (water broke) early and baby was delivered to prevent infection
○ labor was induced or had c-section because (mark all that apply):
  ○ blood pressure was too high (preeclampsia, toxemia)
  ○ baby was too big
  ○ placenta detached or in wrong position (bleeding)
  ○ breech birth
  ○ baby too small or not growing properly (or had defect)
  ○ some other reason →

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35	①	②	③	④	⑤	⑥	⑦	⑧	⑨
41	①	②	③	④	⑤	⑥	⑦	⑧	⑨

42. Did this child stay in a neonatal intensive care unit before going home?

○ Yes, less than 1 day ○ Yes, 1 - 4 days ○ Yes, 5 - 9 days ○ Yes, 10 or more days ○ No