

Date Received: <input type="text"/> - <input type="text"/> - <input type="text"/> (M/D/Y) Reviewed By: <input type="text"/>	- Affix label here - 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>2</sub> Semi-Annual # <input type="text"/> <input type="checkbox"/> <sub>3</sub> Annual # <input type="text"/> <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>3</sub> Interview <input type="checkbox"/> <sub>4</sub> Assistance
<b>OFFICE USE ONLY</b>		

**This questionnaire asks about your symptoms and feelings, how you have managed them, and use of medicines since we asked you to stop your WHI hormone study pills in July 2002. These questions may be similar to questions you have answered on other forms in the past. Whether you were taking active or placebo study pills, the information you provide is important for helping us learn more about the experiences of women after they stop hormones. There is some space at the end of this form for any comments that you would like to share.**

1. On what date did you stop your study pills? *(If you do not remember the exact date, please give your best estimate.)*

-  
 Month      Year

**The questions on this form ask you to think about different lengths of time, such as since you stopped your study pills, during the past 4 weeks, or during the past week. Please read each question carefully--the length of time to think about for your answer is underlined.**

2. Did you take any female hormones since you stopped your study pills? (These may have been in the form of a pill, skin patch, shot, cream, suppository tablet, or vaginal ring.)

<sub>0</sub> No → Go to Question 3 on the next page.

<sub>1</sub> Yes  
↓

2.1. If you started or continued to take hormones since you stopped your study pills, what were your reasons? **(Mark all that apply.)**

- |  |   |
|--|---|
| <input type="checkbox"/> <sub>1</sub> Deal with symptoms                         | <input type="checkbox"/> <sub>7</sub> Advice from family or friends   |
| <input type="checkbox"/> <sub>2</sub> To look better                             | <input type="checkbox"/> <sub>8</sub> Advice from health care provider  |
| <input type="checkbox"/> <sub>3</sub> To feel better                             | <input type="checkbox"/> <sub>9</sub> Information on the Internet (World Wide Web)                                |
| <input type="checkbox"/> <sub>4</sub> To treat or prevent colorectal cancer      | <input type="checkbox"/> <sub>10</sub> Information in the media (for example, newspaper, magazine, or television) |
| <input type="checkbox"/> <sub>5</sub> To treat or prevent osteoporosis           | <input type="checkbox"/> <sub>88</sub> Other reason ( <i>Specify</i> ): _____                                     |
| <input type="checkbox"/> <sub>6</sub> To prevent Alzheimer's disease or dementia | _____   |

3. **Currently**, are you using any female hormones (estrogen or progesterone [also called progestin]) that were prescribed by a doctor? (These may have been in the form of a pill, skin patch, shot, cream, suppository tablet, or vaginal ring.) **(Mark all that apply).**

- <sub>0</sub> No
- <sub>1</sub> Yes, hormone pills
- <sub>2</sub> Yes, hormone patches
- <sub>3</sub> Yes, vaginal form (cream, tablet, ring)
- <sub>4</sub> Yes, other forms (*Specify*): \_\_\_\_\_
- <sub>9</sub> Don't know

4. Below is a list of symptoms people sometimes have. For each item, mark the one box that best describes how bothersome the symptom was **since you stopped your study pills**. Be sure to mark one box on each line. (Please mark any symptoms you had, even if you do not think they were related to taking or stopping study pills.)

If you did not have the problem, please mark the box under “symptom did not occur.” If you had the symptom, use the following key to indicate how bothersome it was:

**Mild** = symptom did not interfere with usual activities  
**Moderate** = symptom interfered somewhat with usual activities  
**Severe** = symptom was so bothersome that usual activities could not be performed.

	Symptom did not occur	Symptom occurred and was:		
		Mild	Moderate	Severe
4.1. Bloating or gas	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.2. Constipation (difficulty having bowel movements)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.3. Night sweats	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.4. General aches or pains	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.5. Breast tenderness	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.6. Hot flashes	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.7. Diarrhea	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.8. Mood swings	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.9. Nausea	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.10. Dizziness	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.11. Feeling tired	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.12. Forgetfulness	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.13. Increased appetite	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.14. Heart racing or skipping beats	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.15. Tremors (shakes)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.16. Heartburn	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.17. Restless or fidgety	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.18. Low back pain	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

	Symptom did not occur	Symptom occurred and was:		
		Mild	Moderate	Severe
4.19. Neck pain	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.20. Skin dryness or scaling	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.21. Headaches or migraines	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.22. Clumsiness	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.23. Any trouble seeing that is uncorrected by lenses	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.24. Vaginal or genital irritation or itching	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.25. Difficulty concentrating	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.26. Joint pain or stiffness	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.27. Decreased appetite	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.28. Hearing loss	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.29. Swelling of hands or feet	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.30. Vaginal or genital dryness	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.31. Upset stomach or belly pain or discomfort	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.32. Pain or burning while urinating	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.33. Cough or wheezing	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.34. Vaginal or genital discharge	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.35. Vaginal spotting or bleeding	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.36. Uncontrolled leaking of urine	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.37. Irritability	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.38. Difficulty sleeping	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.39. Changes in my hair or nails	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.40. Weight gain	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.41. Weight loss	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
4.42. Other ( <i>Specify</i> ): _____	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

**5. If you had any symptoms, what kinds of things did you do since you stopped your study pills to try to deal with these symptoms? We are also interested in how well these worked.**

5.1. <sub>0</sub> Did not have any symptoms —————> Go to Question 6 on the next page.

Tried this and it:

	Did not try or not applicable	Helped	Did not help	Made things worse
5.2. Changed my diet	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.3. Drank more fluids	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.4. Started or increased exercising	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.5. Smoked more	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.6. Smoked less	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.7. Drank more caffeine	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.8. Drank less caffeine	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.9. Drank more alcohol	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.10. Drank less alcohol	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.11. Took herbal/natural hormones	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.12. Took Vitamin E	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.13. Took prescription hormones	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.14. Used vaginal lubricants	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.15. Used protection for leaking urine	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.16. Took depression medicine	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.17. Took sleeping medicine	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.18. Took other medicine	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.19. Used layered or cotton clothing	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.20. Used fans or air conditioners	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.21. Tried self-help techniques (like yoga, meditation, breathing exercises)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.22. Tried alternative medical techniques (like acupuncture, massage, chiropractic)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.23. Socialized more	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.24. Socialized less	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.25. Talked to my health care provider	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
5.26. Other ( <i>Specify</i> ): _____	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

6. These questions are about your feelings during the past week. For each of the statements, please indicate the choice that tells how often you felt that way.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
6.1. You felt depressed (blue or down)	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
6.2. Your sleep was restless	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
6.3. You enjoyed life	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
6.4. You had crying spells	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
6.5. You felt sad	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
6.6. You felt that people disliked you	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

7. In the past year, have you had two weeks or more during which you felt sad, blue, depressed, or lost pleasure in things that you usually cared about or enjoyed?

<sub>0</sub> No      <sub>1</sub> Yes

8. Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

<sub>0</sub> No      <sub>1</sub> Yes

8.1. Have you felt depressed or sad much of the time in the past year?

<sub>0</sub> No      <sub>1</sub> Yes

During the last four weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days
9. Feeling nervous, anxious, on edge, or worrying a lot about different things	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
10. Feeling restless so that it is hard to sit still	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
11. Getting tired very easily	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
12. Muscle tension aches or soreness	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
13. Trouble falling asleep or staying asleep	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
14. Trouble concentrating on things, such as reading a book or watching TV	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
15. Becoming easily annoyed or irritable	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>
16. Having an anxiety attack – suddenly feeling fear or panic	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>

Questions 17 through 20 ask about some personal topics. Although the following questions are sensitive and personal, they are important. Your answers will help us understand the health of women and may help us find better treatment for their health problems. Please be assured that your responses to these questions will remain confidential.

17. Was sexual activity, either with a partner or alone, part of your life **while you were taking study pills?**

- <sub>9</sub> Do not want to answer
- <sub>0</sub> No
- <sub>1</sub> Yes

18. Has sexual activity, either with a partner or alone, been a part of your life **since you stopped your study pills?**

- <sub>9</sub> Do not want to answer —————→ Go to Question 21 on the next page.
- <sub>0</sub> No —————→
- <sub>1</sub> Yes, only through self stimulation
- <sub>2</sub> Yes

18.1 Reasons you have not been sexually active (Mark all that apply.)

- <sub>1</sub> Not interested
- <sub>5</sub> Partner is not able
- <sub>2</sub> Not able
- <sub>8</sub> Other (Specify): \_\_\_\_\_
- <sub>3</sub> Do not have a partner
- <sub>9</sub> Do not want to answer
- <sub>4</sub> Partner is not interested

19. Please rate how the following have changed (during sexual activity), if at all, **since you stopped your study pills:**

	Greater	The same or not applicable	Less	Do not want to answer
19.1. Level of sexual desire or interest	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>
19.2. Feeling sexually aroused (turned on)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>
19.3. Tightness of vagina	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>
19.4. Use of vaginal lubricants	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>
19.5. Ability to reach a climax (orgasm)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>
19.6. Satisfaction with sexual activity	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>

20. **Since you stopped your study pills,** have you had intercourse?

- <sub>9</sub> Do not want to answer —————→ Go to Question 21 on the next page.
- <sub>0</sub> No
- <sub>1</sub> Yes

Please rate how the following have changed, if at all, **since you stopped your study pills:**

	Greater	The same or not applicable	Less	Do not want to answer
20.1. Frequency of intercourse	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>
20.2. Discomfort with intercourse	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>

Questions 21 through 23 ask about medications you are currently taking.

21. **Currently**, are you using any medicines called “bisphosphonates” (like alendronate, Fosamax<sup>®</sup>, risedronate, Actonel<sup>®</sup>), parathyroid hormone (PTH, teriparatide, Forteo<sup>®</sup>) or Calcitonin (Miacalcin<sup>®</sup>)?

<sub>0</sub> No

<sub>9</sub> Don't know

<sub>1</sub> Yes →

21.1. Which one(s)? (Mark all that apply.)

<sub>1</sub> Alendronate (Fosamax<sup>®</sup>) or risedronate (Actonel<sup>®</sup>)

<sub>2</sub> Calcitonin (Miacalcin<sup>®</sup>)

<sub>3</sub> Parathyroid hormone (PTH, teriparatide, Forteo<sup>®</sup>)

<sub>8</sub> Other (Specify: \_\_\_\_\_)

22. **Currently**, are you taking any non-estrogen prescription medicines for hormone replacement? These may be prescribed to prevent osteoporosis or breast cancer and are sometimes called “designer estrogens” or selective estrogen receptor modulators (SERMs). Examples are Evista (raloxifene<sup>®</sup>) and Nolvadex<sup>®</sup> (tamoxifen).

<sub>0</sub> No

<sub>9</sub> Don't know

<sub>1</sub> Yes →

22.1. In the past year, what types of non-estrogen treatments for hormone replacement did you take? (Mark all that apply.)

<sub>1</sub> Evista (Raloxifene<sup>®</sup>)

<sub>2</sub> Nolvadex (Tamoxifen<sup>®</sup>)

<sub>8</sub> Other (Specify: \_\_\_\_\_)

23. **Currently**, are you using any “natural” hormones that you can get without a doctor’s prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, powder, skin cream, or soy-enriched foods.

<sub>0</sub> No

<sub>9</sub> Don't know

<sub>1</sub> Yes

→ Go to Question 24 on the next page.



23.1. What types of “natural” hormones are you using? (Do not include hormone preparations that need a doctor’s prescription.) (Mark all that apply.)

<sub>1</sub> Wild yam cream, pills, liquid

<sub>6</sub> Red clover, Promensil<sup>®</sup>

<sub>2</sub> Progesterone cream, suppositories

<sub>7</sub> Soy or phytoestrogen pills, powders, creams, or foods

<sub>3</sub> DHEA (dehydroepiandrosterone) pills

<sub>8</sub> Other (Specify) \_\_\_\_\_

<sub>4</sub> Black cohosh, RemiFemin<sup>®</sup>

<sub>9</sub> Don't know

<sub>5</sub> Chasteberry, Vitex<sup>®</sup>

24. Overall, how would you rate your quality of life? (Mark one box below.)

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worst			Halfway				Best			

As bad or worse  
than being dead

Best quality  
of life

25. How would you rate your **current** sense of well-being? (Mark one box below.)

0	1	2	3	4	5	6	7	8	9	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worst			Halfway				Best			

26. How does your **current** sense of well-being compare to your sense of well-being when you were taking study pills?

Much worse  
<sub>0</sub>

Somewhat worse  
<sub>1</sub>

The same  
<sub>2</sub>

Somewhat better  
<sub>3</sub>

Much better  
<sub>4</sub>

27. Based on your experience with the WHI Hormone Program, how interested are you in participating in research about women’s health **in the future**?

Not at all  
<sub>0</sub>

A little bit  
<sub>1</sub>

Moderately  
<sub>2</sub>

Quite a bit  
<sub>3</sub>

Extremely  
<sub>4</sub>

**Thank you. Please take a few minutes to review any questions you may have missed.**

**Feel free to write any comments here:**

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