

Date Received: <u> </u> - <u> </u> - <u> </u> (M/D/Y) Reviewed By: <u> </u>	- Affix label here- Clinical Center/ID: <u> </u> - <u> </u> - <u> </u> First Name _____ M.I. _____ Last Name _____	
Contact Type: <input type="checkbox"/> ₁ Phone <input type="checkbox"/> ₂ Mail <input type="checkbox"/> ₃ Visit <input type="checkbox"/> ₈ Other	Visit Type: <input type="checkbox"/> ₂ Semi-Annual # <u> </u> <input type="checkbox"/> ₃ Annual # <u> </u> <input type="checkbox"/> ₄ Non-Routine	Form Administration: <input type="checkbox"/> ₁ Self <input type="checkbox"/> ₂ Group <input type="checkbox"/> ₃ Interview <input type="checkbox"/> ₄ Assistance
OFFICE USE ONLY		

This survey asks about your symptoms and feelings, how you manage them, and use of medicines. These questions may be similar to questions you have been asked to answer on other forms. The information you provide is important for helping us learn more about the experiences of women after they stop hormone study pills, whether they were taking active hormones or placebo. There is some space at the end of this form for any comments that you would like to share.

The questions on this survey ask you to think about different lengths of time, such as 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.

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

 -
 Month Year

2. Below is a list of symptoms people sometimes have. For each item, mark the one box that best describes how bothersome the symptom was for you during the past 4 weeks. Be sure to mark one box on each line.

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

- Mild** = symptom does not interfere with usual activities.
- Moderate** = symptom interferes somewhat with usual activities.
- Severe** = symptom is so bothersome that usual activities can not be performed.

	Symptom did not occur	Symptom occurred and was:		
		Mild	Moderate	Severe
2.1. Bloating or gas	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.2. Constipation (difficulty having bowel movements)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.3. Night sweats	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.4. General aches or pains	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.5. Breast tenderness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.6. Hot flashes	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.7. Diarrhea	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.8. Mood swings	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.9. Nausea	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.10. Dizziness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.11. Feeling tired	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.12. Forgetfulness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.13. Increased appetite	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.14. Heart racing or skipping beats	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.15. Tremors (shakes)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.16. Heartburn	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.17. Restless or fidgety	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.18. Low back pain	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.19. Neck pain	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.20. Skin dryness or scaling	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

	Symptom did not occur	Symptom occurred and was:		
		Mild	Moderate	Severe
2.21. Headaches or migraines	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.22. Clumsiness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.23. Any trouble seeing that is uncorrected by lenses	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.24. Vaginal or genital irritation or itching	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.25. Difficulty concentrating	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.26. Joint pain or stiffness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.27. Decreased appetite	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.28. Hearing loss	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.29. Swelling of hands or feet	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.30. Vaginal or genital dryness	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.31. Upset stomach or belly pain or discomfort	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.32. Pain or burning while urinating	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.33. Cough or wheezing	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.34. Vaginal or genital discharge	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.35. Vaginal spotting or bleeding	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.36. Uncontrolled leaking of urine	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.37. Irritability	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.38. Difficulty sleeping	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.39. Changes in my hair or nails	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.40. Weight gain	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.41. Weight loss	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
2.42. Other (<i>Specify</i>): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

3. If you had any symptoms, what kinds of things did you do during the past four weeks to try to deal with these symptoms? We are also interested in how well these worked. If you did not have any symptoms, please go to the next page.

	Did not try or not applicable	Tried this and it:		
		Helped	Did not help	Made things worse
3.1. Changed my diet	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.2. Drank more fluids	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.3. Started or increased exercising	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.4. Smoked more	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.5. Smoked less	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.6. Drank more caffeine	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.7. Drank less caffeine	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.8. Drank more alcohol	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.9. Drank less alcohol	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.10. Took herbal/natural hormones	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.11. Took Vitamin E	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.12. Took prescription hormones	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.13. Used vaginal lubricants	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.14. Used protection for leaking urine	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.15. Took depression medicine	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.16. Took sleeping medicine	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.17. Took other medicine	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.18. Used layered or cotton clothing	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.19. Used fans or air conditioners	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.20. Tried self-help techniques (like yoga, meditation, breathing exercises)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.21. Tried alternative medical techniques (like acupuncture, massage, chiropractic)	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.22. Socialized more	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.23. Socialized less	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.24. Talked to my health care provider	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3.25. Other (<i>Specify</i>): _____	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Questions 4 through 6 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.

4. Has sexual activity, either with a partner or alone, been a part of your life in the last 3 months?

₉ Do not want to answer —————→ **Go to Question 7 on the next page.**

₀ No —————→

₁ Yes, only through self stimulation
₂ Yes

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

- ₁ Not interested
- ₂ Not able
- ₃ Do not have a partner
- ₄ Partner is not interested
- ₅ Partner is not able
- ₈ Other (Specify): _____
- ₉ Do not want to answer

Even though you have not been sexually active, please rate how much, if at all, you have experienced the following in the last 3 months:

	Rarely or not at all	Some of the time	A lot of the time	Do not want to answer
4.2. Sexual desire or interest	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
4.3. Feeling sexually aroused (turned on)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉

Go to Question 7 on the next page.

5. Please rate how much, if at all, you have experienced the following in the last 3 months.

	Rarely or not at all	Some of the time	A lot of the time	Do not want to answer
5.1. Sexual desire or interest	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
5.2. Feeling sexually aroused (turned on)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
5.3. Tightness of vagina	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
5.4. Use of vaginal lubricants	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
5.5. Ability to reach a climax (orgasm)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
5.6. Satisfaction with sexual activity	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉

6. Have you had intercourse **in the last 3 months?**

- ₀ No
- ₁ Yes
- ₉ Do not want to answer

Please rate the following **over the last 3 months:**

	Rarely or not at all	Some of the time	A lot of the time	Do not want to answer
6.1. Frequency of intercourse	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
6.2. Discomfort with intercourse	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
	No	Yes	Don't know	Do not want to answer
6.3. Did you have discomfort because of dryness?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉
6.4. Did you have discomfort because of tightness?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁	<input type="checkbox"/> ₃	<input type="checkbox"/> ₉

Questions 7 and 8 ask about medicines and natural hormones that you are **currently** taking.

7. **Currently**, are you using any medicines called “bisphosphonates” (like alendronate, Fosamax[®], risedronate, Actonel[®]), parathyroid hormone (PTH or Forteo[®]) or calcitonin (Miacalcin[®])?

- ₀ No
- ₁ Yes
- ₉ Don't Know

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

- ₁ Alendronate (Fosamax[®]) or risedronate (Actonel[®])
- ₂ Calcitonin (Miacalcin[®])
- ₃ Parathyroid hormone (PTH, Forteo[®])
- ₈ Other (Specify): _____

8. **Currently**, are you using “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.

- ₀ No
- ₁ Yes
- ₉ Don't know

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

<input type="checkbox"/> ₁ Wild yam cream, pills, liquid	<input type="checkbox"/> ₆ Red clover, Promensil [®]
<input type="checkbox"/> ₂ Progesterone cream, suppositories	<input type="checkbox"/> ₇ Soy or phytoestrogen pills, powders, creams, or foods
<input type="checkbox"/> ₃ DHEA (dehydroepiandrosterone) pills	<input type="checkbox"/> ₈ Other (Specify): _____
<input type="checkbox"/> ₄ Black cohosh, RemiFemin [®]	<input type="checkbox"/> ₉ Don't know
<input type="checkbox"/> ₅ Chasteberry, Vitex [®]	

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

₀ No

₁ Yes →

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

<p><input type="checkbox"/>₁ Deal with symptoms</p> <p><input type="checkbox"/>₂ To look better</p> <p><input type="checkbox"/>₃ To feel better</p> <p><input type="checkbox"/>₄ To treat or prevent heart disease</p> <p><input type="checkbox"/>₅ To treat or prevent colorectal cancer</p> <p><input type="checkbox"/>₆ To treat or prevent osteoporosis</p> <p><input type="checkbox"/>₇ To prevent Alzheimer’s disease or dementia</p>	<p><input type="checkbox"/>₈ Advice from family or friends</p> <p><input type="checkbox"/>₉ Advice from health care provider</p> <p><input type="checkbox"/>₁₀ Information on the Internet (World Wide Web)</p> <p><input type="checkbox"/>₁₁ Information in the media (for example, newspaper, magazine, or television)</p> <p><input type="checkbox"/>₈₈ Other reason (Specify): _____ _____</p>
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10. **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 pills, skin patches, shots, cream, suppository, or vaginal ring.) (Mark all that apply).

₀ No

₃ Yes, vaginal form (cream, tablet, ring)

₁ Yes, hormone pills

₄ Yes, other forms (Specify): _____

₂ Yes, hormone patches

₉ Don’t know

11. **Currently,** are you taking any selective estrogen receptor modulators (SERMs)? These may be prescribed to prevent osteoporosis or breast cancer. Examples are raloxifene (Evista[®]) and tamoxifen (Nolvadex[®]).

₀ No

₁ Yes →

₉ Don’t know

11.1. In the past year, what did you take? (Mark all that apply.)

₁ Evista[®] (Raloxifene)

₂ Nolvadex[®] (Tamoxifen)

₈ Other (Specify): _____

12. 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

₀

A little bit

₁

Moderately

₂

Quite a bit

₃

Extremely

₄

Thank you. Please take a few minutes to review any questions you may have missed. Feel free to write any comments here:
