INSTRUCTIONS

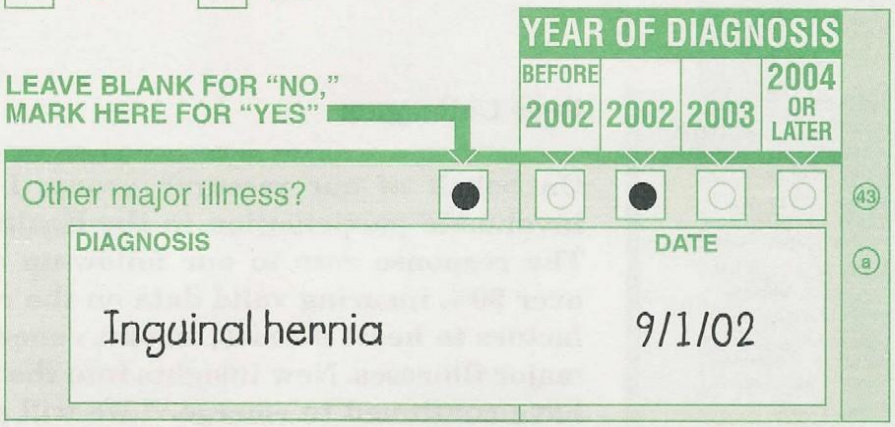
Use a No. 2 pencil to fill in the appropriate circle completely, or write the requested information in the boxes provided. If you have any comments, please write them on a separate piece of paper.

EXAMPLE 1:

3. Do you currently smoke a pipe, cigar or cigarettes?

○ No ● Yes

EXAMPLE 2:



Keep all handwriting within borders of the response box.

Federal research regulations require us to include the following information:

There are no direct benefits to you from participating in this study.
The risk of breach of confidentiality associated with participation in this study is very small.
Your choice to participate in this study is completely voluntary and you may decline or withdraw at any time without penalty.
You may skip any question you do not wish to answer.
You will not receive monetary compensation for participating.
If you have any questions regarding your rights as a research participant, you are encouraged to call a representative of the Human Subjects Committee at the Harvard School of Public Health (617-384-5480).
If you have any questions regarding your status in our study or a question pertaining to the questionnaire, please call the study Project Coordinator, Betsy Frost-Hawes, at 617-384-8657.

Thank you for completing the 2004 Health Professionals Follow-up Study short questionnaire.

Please tear off the cover letter (to preserve confidentiality) and return the questionnaire in the enclosed postage paid envelope.

HPFS SH 049

HEALTH PROFESSIONALS FOLLOW-UP STUDY

1. Please WRITE in your date of birth: ____ / ____ / ____ (MONTH DAY YEAR)

2. Your CURRENT weight: ____ lbs.

3. Do you currently smoke a pipe, cigar or cigarettes? ◯ No ◯ Yes

4. Since January 1, 2002, have you had any of the following professionally diagnosed conditions or procedures?

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"		YEAR OF DIAGNOSIS: BEFORE 2002	2002	2003	2004 OR LATER	
High blood pressure	Y	◯	◯	◯	◯	1
Diabetes mellitus	Y	◯	◯	◯	◯	2
Elevated cholesterol	Y	◯	◯	◯	◯	3
Elevated triglycerides	Y	◯	◯	◯	◯	4
Myocardial infarction (heart attack)	Y	◯	◯	◯	◯	5
↳ Hospitalized for this MI? ◯ No ◯ Yes						a
Angina pectoris	Y	◯	◯	◯	◯	6
↳ Confirmed by an angiogram? ◯ No ◯ Yes						a
Coronary artery bypass or coronary angioplasty, stent	Y	◯	◯	◯	◯	7
Congestive heart failure (CHF)	Y	◯	◯	◯	◯	8
Pulmonary embolus	Y	◯	◯	◯	◯	9
TIA (Transient Ischemic Attack)	Y	◯	◯	◯	◯	10
Stroke (CVA)	Y	◯	◯	◯	◯	11
Carotid artery surgery	Y	◯	◯	◯	◯	12
Intermittent claudication	Y	◯	◯	◯	◯	13
Surgery or angioplasty for arterial disease of the leg	Y	◯	◯	◯	◯	14
Aortic aneurysm	Y	◯	◯	◯	◯	15
Glaucoma	Y	◯	◯	◯	◯	16
Cataract (1st Diagnosis)	Y	◯	◯	◯	◯	17
Cataract extraction	Y	◯	◯	◯	◯	18
Macular degeneration	Y	◯	◯	◯	◯	19
Rheumatoid arthritis	Y	◯	◯	◯	◯	20
Other arthritis (e.g., osteoarthritis)	Y	◯	◯	◯	◯	21
Hip replacement	Y	◯	◯	◯	◯	22
PSA Test within past 2 years? ◯ No ◯ Yes						a
If yes, was it elevated? ◯ No ◯ Unknown ◯ Yes						b

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"		YEAR OF DIAGNOSIS: BEFORE 2002	2002	2003	2004 OR LATER	
Colonoscopy	Y	◯	◯	◯	◯	23
Sigmoidoscopy	Y	◯	◯	◯	◯	24
Colon or rectal polyp	Y	◯	◯	◯	◯	25
Cancer of the colon or rectum	Y	◯	◯	◯	◯	26
Basal cell skin cancer	Y	◯	◯	◯	◯	27
Squamous cell skin cancer	Y	◯	◯	◯	◯	28
Melanoma	Y	◯	◯	◯	◯	29
Prostatic enlargement, surgically treated (e.g., TURP)	Y	◯	◯	◯	◯	30
Prostate cancer	Y	◯	◯	◯	◯	31
Lymphoma or leukemia	Y	◯	◯	◯	◯	32
Other cancer	Y	◯	◯	◯	◯	33
↳ Please specify site and year:						a
Parkinson's disease	Y	◯	◯	◯	◯	34
Periodontal disease with bone loss	Y	◯	◯	◯	◯	35
Leukoplakia or other oral precancerous lesions	Y	◯	◯	◯	◯	36
Alcohol dependence problem	Y	◯	◯	◯	◯	37
Gallbladder removal	Y	◯	◯	◯	◯	38
Kidney stones	Y	◯	◯	◯	◯	39
Asthma	Y	◯	◯	◯	◯	40
Emphysema or chronic bronchitis (COPD)	Y	◯	◯	◯	◯	41
Pneumonia (X-ray confirmed)	Y	◯	◯	◯	◯	42
Other major illness?	Y	◯	◯	◯	◯	43
↳ DIAGNOSIS / DATE						a
Fracture of hip or forearm (wrist)	Y	◯	◯	◯	◯	44
↳ Please specify fracture site and circumstances on back.						a b c

If hip or forearm fracture, please specify exact date, site and circumstances.
If a fall, include site of fracture, cause, impact, surface, and height of fall.

MONTH / DAY / YEAR

CA

MED

THANK YOU FOR YOUR CONTINUED PARTICIPATION

PLEASE DO NOT WRITE IN SHADED AREA

Mark Reflex® forms by NCS Pearson EM-234459-3:654321 Printed in U.S.A.