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Dear Colleague:

On behalf of our research group, I thank you once more for your invaluable participation in the Health Professionals Follow-Up Study. The response rate to our follow-up questionnaire in 2008 was again over 90%, insuring valid data on the relation of diet and other lifestyle factors to heart disease, stroke, cancer, prostatic symptoms, and other major illnesses.

Many important findings have been reported from this study during the last two years, including a positive relation between sugar-sweetened beverages and gout (BMJ, 2008, Vol. 336, p. 309), protective effects of regular exercise on diverticular disease (AMJ Gastroenterol, 2009, Vol. 104, p. 1221) and a small increase in risk of overall cancer among men with periodontal disease (Lancet Oncol, 2008, Vol. 9, p. 500). We will provide more detail on these and other analyses in our 2011 newsletter.

We are now conducting the twenty two-year follow-up of the study. For the validity of statistical analyses, it is essential that we receive updated information on your health status. Most importantly, we are requesting information about the diagnosis of specific diseases since January 1, 2008.

Again, I am grateful for the invaluable contribution of your time and effort toward our investigation of factors that influence the health of men. With your continued participation, this study has become one of the most important investigations of the long-term effects of diet in men.

Sincerely,

Walter Willett

Walter Willett, M.D.
 Principal Investigator

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:

LEAVE BLANK FOR "NO,"
MARK HERE FOR "YES"

	YEAR OF DIAGNOSIS			
	BEFORE 2008	2008	2009	2010 OR LATER
Other major illness?	<input checked="" type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
DIAGNOSIS		DATE		
Inguinal hernia		9/1/08		

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 Office of Human Research at the Harvard School of Public Health (866-606-0573).
 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 866-762-6609.

Thank you for completing the 2010 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.



HEALTH PROFESSIONALS FOLLOW-UP STUDY

HPFS SH 10

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

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
 3

4. Since January 1, 2008, have you had any of the following clinician diagnosed conditions or procedures?

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	BEFORE 2008	2008	2009	2010 OR LATER	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3
Elevated triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4
Myocardial infarction (heart attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5
↳ Hospitalized for this MI? <input type="checkbox"/> No <input type="checkbox"/> Yes					6
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7
↳ Confirmed by an angiogram? <input type="checkbox"/> No <input type="checkbox"/> Yes					8
Coronary artery bypass or coronary angioplasty, stent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9
Congestive heart failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11
Pulmonary embolus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12
TIA (Transient Ischemic Attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13
Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14
Carotid artery surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15
Intermittent claudication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16
Surgery or angioplasty for arterial disease of the leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17
Aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19
Cataract (1st Diagnosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20
Cataract extraction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23
Other arthritis (e.g., osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24
Hip replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	BEFORE 2008	2008	2009	2010 OR LATER	
Colon or rectal polyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26
Cancer of the colon or rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27
Basal cell skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28
Squamous cell skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30
Prostatic enlargement treated by drugs, surgery, or laser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32
Lymphoma or leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33
Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34
↳ Please specify site and year: <input type="text"/>					35
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36
Periodontal disease with bone loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37
Ulcerative colitis/ Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38
Barrett's esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39
Diverticulitis or Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42
Emphysema or chronic bronchitis (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43
Other major illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44
↳ DIAGNOSIS <input type="text"/> DATE <input type="text"/>					45
Fracture of hip or forearm (wrist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	46
↳ Please specify fracture site and circumstances on back.					47
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	48
Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	49
PSA Test within past 2 years? <input type="checkbox"/> No <input type="checkbox"/> Yes					50
If yes, was it elevated? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes					51

1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
4	4	4	4	4	4	4	4
8	8	8	8	8	8	8	8
P	P	P	P	P	P	P	P

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

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

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

CA

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

MED

1	11	○
2	12	○
3		○
4		
5		
6		
7		
8		
9		
10		
11		
12		

**PLEASE
DO NOT
WRITE IN
SHADED
AREA**

**THANK YOU
FOR YOUR CONTINUED
PARTICIPATION**