The Million Women Study
A national survey of women invited for breast screening

We need one million women to help us in research that will benefit women all over the world.
Would you become one of these special women?

More and more women are taking hormone replacement therapy (HRT) so it is vital that we find out as much as possible about its benefits and any possible side effects. We have a unique opportunity through the NHS Breast Screening Programme to learn about the way different types of HRT and other lifestyle factors affect a woman’s health, particularly her breasts. Britain is the only country in the world that can carry out this study because it is the only one with the combination of a large population and a comprehensive national breast screening programme.

The NHS Breast Screening Programme, the Imperial Cancer Research Fund and the Medical Research Council have joined together to organise The Million Women Study. If one million women answer this questionnaire over the next three years we could have some of the answers to our most important questions about HRT within five years or so.

We would be very grateful if you could set aside some time to answer these questions. It should not take more than 10-15 minutes. You do not have to answer this questionnaire and if you decide not to you will still have your screening done in the normal way.

Please answer every question and do not leave blanks as all the information that you give us is very useful. If you are not sure about exact dates or ages an approximate answer is better than none. If you have any questions you can ring us on freephone 0800 262 872.

Even if you are not taking HRT it is just as important that you fill in the questionnaire.
Please bring this questionnaire to your breast screening appointment.

To help us read your answers please write as clearly as possible and be sure to complete the questionnaire as shown:
Please put a cross in the appropriate box(es) ☒ ☐ ☐ OR put numbers in the appropriate box e.g. 23rd April 1946 2 3 0 4 4 6 age 44 years

GENERAL QUESTIONS ABOUT YOU

1. What is your date of birth? (please put day/month/year)
   ☐ ☐ ☐

2. How old are you? ☐ ☐ years

3. How tall are you? (please give to the nearest inch)
   ☐ ☐ feet ☐ inches

4. About how much do you weigh?
   ☐ ☐ stone ☐ lbs

5. How old were you when you finished full time schooling? (please cross one box)
   ☐ did not go to school
   ☐ 13 or younger
   ☐ 14
   ☐ 15
   ☐ 16
   ☐ 17 or older

6. What qualification(s) do you have from school, college or the equivalent? (please put a cross in the most appropriate box(es))
   ☐ clerical or commercial qualifications (eg secretarial, hairdressing etc)
   ☐ nursing or teaching
   ☐ “O” level (or equivalent)
   ☐ “A” level (or equivalent)
   ☐ college/university degree (or equivalent)
   ☐ none of these

7. About how many cigarettes do you smoke on average each day, now? (please cross one box)
   ☐ none
   ☐ less than 5
   ☐ 5-9
   ☐ 10-14
   ☐ 15-19
   ☐ 20-24
   ☐ 25 or more

8. Are you an ex-smoker? ☐ No ☐ Yes

9. About how much wine, beer or spirits do you drink on average each week? (please cross one box for each type)

<table>
<thead>
<tr>
<th>Wine (glasses per week)</th>
<th>Lager/Cider/Beer (half pints per week)</th>
<th>Spirits (tots per week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ none</td>
<td>☐ none</td>
<td>☐ none</td>
</tr>
<tr>
<td>☐ less than 1</td>
<td>☐ less than 1</td>
<td>☐ less than 1</td>
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<tr>
<td>☐ 1-3</td>
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<td>☐ 4-6</td>
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<td>☐ 7-10</td>
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<td>☐ 11-15</td>
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<tr>
<td>☐ 16-20</td>
<td>☐ 16-20</td>
<td>☐ 16-20</td>
</tr>
<tr>
<td>☐ 21+</td>
<td>☐ 21+</td>
<td>☐ 21+</td>
</tr>
</tbody>
</table>

If you drink wine is it mostly red ☐ mostly white ☐ about the same amount of red and white?
10. How often do you do *any* exercise?  
- rarely/never  
- 2-3 times a week  
- less than once a week  
- 4-6 times a week  
- once a week  
- every day  

11. How often do you do *strenuous* exercise?  
- rarely/never  
- 2-3 times a week  
- less than once a week  
- 4-6 times a week  
- once a week  
- every day  

12. Have you ever had any children?  
- No  
- Yes  
*If No, please go on to question 15*  

13. How many children have you had?  
*Please include stillbirths; it is not necessary to include miscarriages.*  

14. When was each child born, and for how many months did you breastfeed each child, if at all?  

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>BREASTFEEDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If you had twins or triplets please repeat the same date for each child)</td>
<td>(Months that you breastfed each child; put &quot;0&quot; if you did not breastfeed that child &quot;1&quot; if you breastfed for 1 month or less)</td>
</tr>
<tr>
<td>1st child</td>
<td>day / month / year</td>
</tr>
<tr>
<td>2nd child</td>
<td>day / month / year</td>
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<tr>
<td>3rd child</td>
<td>day / month / year</td>
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<tr>
<td>4th child</td>
<td>day / month / year</td>
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<td>5th child</td>
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<td>7th child</td>
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<td>8th child</td>
<td>day / month / year</td>
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<tr>
<td>9th child</td>
<td>day / month / year</td>
</tr>
<tr>
<td>10th child</td>
<td>day / month / year</td>
</tr>
</tbody>
</table>

15. Have you ever been for breast screening before?  
- No  
- Yes- If Yes, about how many years ago was your last screen? __ __ years ago  

16. Have you ever had a breast lump removed or any operations on your breast(s)?  
- No  
- Yes- If Yes, how old were you? __ __ years  
*If you have had more than one operation please write your age at the first operation*  

17. Have you ever had breast cancer diagnosed?  
- No  
- Yes- If Yes, how old were you when the cancer was first diagnosed? __ __ years  

18. Has your mother ever had breast cancer diagnosed?  
- No  
- Don’t know  
- Yes- If Yes, how old was she when the cancer was first diagnosed? __ __ years  

19. How many sisters do you have?  
- sisters  
*Please include any sisters who have died.*  

20. Have any of your sisters ever had breast cancer diagnosed?  
- No/No sisters  
- Don’t know  
- Yes- If Yes, how old were they when the cancer was first diagnosed?  
  - 1st sister __ __ years  
  - 2nd sister __ __ years  

21. Have you ever had any other cancer?  
- Yes  
- No  
*Please describe*  

22. Have you EVER had:  
*Please cross "Yes" or "No" for each condition*  

- High blood pressure - when pregnant  
- Yes  
- No  
- High blood pressure - when not pregnant  
- Yes  
- No  
- Heart disease *(eg heart attack/angina)*  
- Yes  
- No  
- Stroke  
- Yes  
- No  
- Diabetes  
- Yes  
- No  
- High blood cholesterol  
- Yes  
- No  
- Blood clot *(thrombosis)*  
- Yes  
- No  

23. Are you NOW being treated for:  
- High blood pressure *(hypertension)*  
- Yes  
- No  
- Heart disease  
- Yes  
- No  
- Diabetes  
- Yes  
- No  
- High blood cholesterol  
- Yes  
- No  
- Varicose veins  
- Yes  
- No  
- Clotting problems  
- Yes  
- No  
- Asthma  
- Yes  
- No  
- Rheumatoid arthritis  
- Yes  
- No  
- Osteoarthritis  
- Yes  
- No  
- Thyroid problems  
- Yes  
- No  
- Osteoporosis  
- Yes  
- No  
- Depression/Anxiety  
- Yes  
- No
24. Are you NOW being treated for any other serious illness?
   - Yes
   - No

   Please describe this illness

   Please describe the treatment

25. Have you had a hysterectomy?
   - No
   - Yes - If Yes, how old were you? __________ years

26. Have you had BOTH ovaries removed?
   - No
   - Not sure
   - Yes - If Yes, how old were you? __________ years

27. Have you been sterilised (had your tubes tied)?
   - No
   - Yes - If Yes, how old were you? __________ years

28. Have you ever used the pill (oral contraceptive)?
   - Yes
   - No - if No, please go to question 32

29. About how old were you when you first went on the pill? __________ years

30. About how old were you when you last came off the pill? __________ years

31. For how many years in total did you take the pill?
   __________ years

   (Add together the years and months when you actually took the pill - do not count the years and months when you were not taking it. Please write "0" if you used the pill for less than a year in total)

32. Have you ever used hormone replacement therapy (HRT)?
   - No - if No - please go to question 39
   - Yes

33. How old were you when you first started using HRT?
   __________ years

34. Had your periods stopped before you started using HRT? (Cross "Yes" if you had a hysterectomy before starting HRT)
   - No
   - Yes - If Yes, how old were you when your periods stopped? __________ years

35. For about how many years in total have you used HRT?
   __________ years

   (Add together the years and months when you used HRT - do not count the years and months when you were not using HRT. Please write "0" if you used HRT for less than a year in total)

36. Are you now using HRT?
   - Yes
   - No - if No, how old were you when you last used HRT? __________ years

37. What is the name of the most recent HRT you have used?
   - Prempak C 0.625mg
   - Premarin 0.625mg
   - Prempak C 1.25mg
   - Premarin 1.25mg
   - Tridestra
   - Evorel 25mcg/50mcg
   - Trisequens
   - Evorel 75mcg/100mcg
   - Trisequens Forte
   - Progynova 1mg
   - Cycloprogynova 1mg
   - Progynova 2mg
   - Cycloprogynova 2mg
   - Estraderm 25mcg
   - Estraderm 50mcg
   - Estraderm 100mcg
   - Estracombi
   - Estradapro
   - Climaval 1mg
   - Zumenon 1mg
   - Climaval 2mg
   - Zumenon 2mg
   - Premique Cycle
   - Ethinylodiol
   - Premique
   - Micronor
   - Nuvelle
   - Provera
   - Klofol
   - Duophaston
   - Livial
   - Other (please write here)

38. For how many years in total did you use the most recent type of HRT?
   __________ years

   (Please write "0" if you used this recent HRT for less than a year in total)
PLEASE BRING THIS QUESTIONNAIRE TO YOUR BREAST SCREENING APPOINTMENT

THANK YOU VERY MUCH FOR YOUR HELP