

THE MILLION WOMEN STUDY

Confidential National Study of Women's Health

The Million Women Study is an important national study of women's health. A few years ago you received the first questionnaire with your invitation to the National Health Service Breast Screening Programme. Your help is needed again. Can you find time to complete this second questionnaire? Some of the questions may seem familiar and others are new, but all will provide vital up to date information for the study. Your answers are valuable and important - the enclosed leaflet explains how the study will benefit women and improve medical knowledge world-wide. We very much hope you are still willing to be one of the Million Women in the study.

We guarantee that all information provided will be treated with absolute confidentiality and used for medical research only. +

To help us read your answers please write as clearly as possible and complete the questionnaire as shown:

Please put a cross in the appropriate box(es)

OR put numbers in the appropriate boxes

eg 28th October 1946 / /

Any questions? Ring us on Freephone 0800 262 872

QUESTIONS ABOUT YOU AND YOUR HEALTH

Please answer every question as best you can 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. Please use a black pen, if possible.

1. Have you had any of the following conditions diagnosed for the first time in the last 5 years?

Please cross "yes" if appropriate, and write when the condition was first diagnosed.

	Yes	If Yes, when was it first diagnosed?	
		Month	Year
Heart disease <i>heart attack, angina etc</i>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Stroke	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Blood clot in leg	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Blood clot in lung or elsewhere	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
High blood cholesterol	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
High blood pressure <i>hypertension</i>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Asthma	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Gallstones/gallbladder disease	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Osteoporosis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Abnormal cervical smear test <i>Pap smear</i>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Breast cancer	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other cancer <i>Please describe the cancer below</i>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

2. Have you had any broken/fractured bones, in the last 5 years?

	Month	Year
<input type="checkbox"/> No <input type="checkbox"/> Yes - <i>if Yes</i> , when?	<input type="text"/>	<input type="text"/>

If Yes, which bone(s) were broken? (please cross)

hip ankle wrist/arm
 spine other- *please describe* _____

If Yes, how did the fracture(s) occur?

after a fall in a car accident in another accident
 fracture found on X-ray without you knowing about it in some other way

3. Have you had any other serious illness diagnosed for the first time, in the last 5 years?

	Month	Year
<input type="checkbox"/> No <input type="checkbox"/> Yes - <i>if Yes</i> , when?	<input type="text"/>	<input type="text"/>

If yes, please describe the illness

4. Have you had any major operations in the last 5 years?

	Month	Year
<input type="checkbox"/> No <input type="checkbox"/> Yes - <i>if Yes</i> , when?	<input type="text"/>	<input type="text"/>

If yes, please describe the operation(s)

5. Are you NOW being treated for:

	Yes	If yes, about how long were you when treatment began?
Heart disease <i>heart attack, angina etc</i>	<input type="checkbox"/>	<input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="text"/>
High blood pressure <i>hypertension</i>	<input type="checkbox"/>	<input type="text"/>
Asthma	<input type="checkbox"/>	<input type="text"/>
Osteoarthritis	<input type="checkbox"/>	<input type="text"/>
Osteoporosis	<input type="checkbox"/>	<input type="text"/>
Any other serious illness or disability (please describe below)	<input type="checkbox"/>	<input type="text"/>

6. How would you describe your health now?

excellent good fair poor +

QUESTIONS ABOUT MEDICATIONS

7. Have you ever used HRT (hormone replacement therapy)? No - *if No - please go to question 12.*

Yes

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

9. Are you *now* using HRT?

No - *if No*, when did you stop using HRT?

Month Year

10. For about how many years *in total* have you used HRT? years of use
(Add together all the years and months when you were using HRT. Please write "0" if you used HRT for less than a year in total)

11. Which HRT did you use MOST RECENTLY?

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Prempak C 0.625mg | <input type="checkbox"/> Premarin 0.625mg | |
| <input type="checkbox"/> Prempak C 1.25mg | <input type="checkbox"/> Premarin 1.25mg | |
| <input type="checkbox"/> Tridestra | <input type="checkbox"/> Evorel 25mcg/50mcg | |
| <input type="checkbox"/> Trisequens | <input type="checkbox"/> Evorel 75mcg/100mcg | |
| <input type="checkbox"/> Cycloprogynova 1mg | <input type="checkbox"/> Progynova 1mg | |
| <input type="checkbox"/> Cycloprogynova 2mg | <input type="checkbox"/> Progynova 2mg | |
| <input type="checkbox"/> Estrapak | <input type="checkbox"/> Estraderm 25mcg | |
| <input type="checkbox"/> Estracombi | <input type="checkbox"/> Estraderm 50mcg | |
| <input type="checkbox"/> Climaval 1mg | <input type="checkbox"/> Estraderm 100mcg | |
| <input type="checkbox"/> Climaval 2mg | <input type="checkbox"/> Zumenon 1mg | |
| <input type="checkbox"/> Premique Cycle | <input type="checkbox"/> Zumenon 2mg | |
| <input type="checkbox"/> Premique | <input type="checkbox"/> Ethinyloestradiol | |
| <input type="checkbox"/> Nuvelle | <input type="checkbox"/> Oestrogel | <input type="checkbox"/> Micronor |
| <input type="checkbox"/> Kliofem | <input type="checkbox"/> Implants | <input type="checkbox"/> Duphaston |
| <input type="checkbox"/> Livial | <input type="checkbox"/> Provera | <input type="checkbox"/> Do not know |

Other (please write here)

12. Have you taken any medications (other than HRT) for most of the last 4 weeks? No Yes

- If Yes*, was it: thyroxine ibuprofen aspirin
 tamoxifen bendrofluzide amiodipine digoxin
 paracetamol propranolol atenolol warfarin
 prednisolone Losec/Zoton Prozac insulin
 co-proxamol amitriptyline sleeping pills lithium
Distalgesic *Tryptizol etc*

Please give the name(s) of any other medication you have used for most of the last 4 weeks:

13. Do you regularly take any vitamins, minerals or supplements? No Yes - *if Yes*, do you take:

- | | | | |
|---|--|----------------------------------|------------------------------------|
| <input type="checkbox"/> multivitamins (with minerals) | <input type="checkbox"/> vitamin A | | |
| <input type="checkbox"/> multivitamins (without minerals) | <input type="checkbox"/> vitamin B (including B ₆ , B ₁₂) | | |
| <input type="checkbox"/> fish oil (including cod liver oil) | <input type="checkbox"/> vitamin C | | |
| <input type="checkbox"/> evening primrose oil | <input type="checkbox"/> vitamin D | | |
| <input type="checkbox"/> iron | <input type="checkbox"/> zinc | <input type="checkbox"/> calcium | <input type="checkbox"/> vitamin E |

for office use only

QUESTIONS ABOUT YOUR DIET

We know it may be difficult for you to give exact answers to these questions about your diet. An approximate answer is very valuable for this study. So, please answer as best you can, thinking of a typical week.

14. Which types of meat do you eat about once a week or more often? (you can cross more than one box)

- | | | |
|---|---|--|
| <input type="checkbox"/> beef | <input type="checkbox"/> bacon | <input type="checkbox"/> chicken/poultry |
| <input type="checkbox"/> lamb | <input type="checkbox"/> ham | <input type="checkbox"/> kidney |
| <input type="checkbox"/> pork | <input type="checkbox"/> sausages | <input type="checkbox"/> liver/pâté |
| <input type="checkbox"/> beefburger/hamburger | <input type="checkbox"/> never eat meat | |

15. Which types of fish do you eat about once a week or more often? (you can cross more than one box)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> tuna | <input type="checkbox"/> trout | <input type="checkbox"/> mackerel | <input type="checkbox"/> "fish & chips" |
| <input type="checkbox"/> salmon | <input type="checkbox"/> sardines | <input type="checkbox"/> other seafood (prawns, scampi etc) | |
| <input type="checkbox"/> cod/haddock or other white fish | <input type="checkbox"/> never eat fish | | |

16. About how many times each week do you eat: (please count all meals and snacks. put '0' if eaten less than once a week)

- | | | |
|-------------------------|----------------------|---|
| meat | <input type="text"/> | number of times eaten each week (remember meat in sandwiches) |
| fish/seafood | <input type="text"/> | number of times eaten each week |
| chips | <input type="text"/> | number of times eaten each week |
| potatoes (except chips) | <input type="text"/> | number of times eaten each week |
| pasta/spaghetti | <input type="text"/> | number of times eaten each week |
| rice | <input type="text"/> | number of times eaten each week |
| cheese | <input type="text"/> | number of times eaten each week (remember cheese in pizzas, quiches, cheese sauce, etc) |

17. About how many eggs do you eat each week?

- eggs number of eggs eaten each week (remember eggs in omelettes, quiches, cakes etc. put '0' if less than one)

18. Which types of vegetables/salads (fresh, frozen or tinned) do you eat once a week or more often? (you can cross more than one box)

- | | | |
|-------------------------------------|------------------------------------|---|
| <input type="checkbox"/> green peas | <input type="checkbox"/> tomatoes | <input type="checkbox"/> green beans |
| <input type="checkbox"/> broccoli | <input type="checkbox"/> onions | <input type="checkbox"/> baked beans |
| <input type="checkbox"/> cabbage | <input type="checkbox"/> garlic | <input type="checkbox"/> soya meat/tofu |
| <input type="checkbox"/> carrots | <input type="checkbox"/> swede | <input type="checkbox"/> chick peas/lentils |
| <input type="checkbox"/> courgettes | <input type="checkbox"/> spinach | <input type="checkbox"/> cauliflower |
| <input type="checkbox"/> beetroot | <input type="checkbox"/> sweetcorn | <input type="checkbox"/> green/red peppers |
| <input type="checkbox"/> leeks | <input type="checkbox"/> avocado | <input type="checkbox"/> brussels sprouts |
| <input type="checkbox"/> parsnip | <input type="checkbox"/> aubergine | <input type="checkbox"/> mushrooms |
| <input type="checkbox"/> lettuce | <input type="checkbox"/> celery | <input type="checkbox"/> cucumber |

19. About how much do you eat each week of: (put "0" if less than one)

- cooked vegetables (except potatoes) number of heaped tablespoons each week
 salad items/raw vegetables number of heaped tablespoons each week (please count lettuce, tomato etc in sandwiches)

20. Which types of fruit do you eat once a week or more often, when in season? (you can cross more than one box)

- | | | |
|-------------------------------------|----------------------------------|---|
| <input type="checkbox"/> apples | <input type="checkbox"/> bananas | <input type="checkbox"/> oranges, satsumas, etc |
| <input type="checkbox"/> grapefruit | <input type="checkbox"/> pears | <input type="checkbox"/> stone fruit (peaches, plums, nectarines etc) |

21. About how much fruit or fruit juice do you eat or drink each week? (count 10 grapes, berries or raisins as one piece; put "0" if less than one a week)

- | | |
|--|--|
| <input type="text"/> number of pieces of fresh fruit eaten each week | <input type="text"/> number of pieces of dried fruit eaten each week |
| <input type="text"/> number of glasses of fruit juice each week | <input type="text"/> number of tablespoons of stewed or tinned fruit eaten each week |

MORE ABOUT YOUR DIET

22. About how many of the following do you eat:

(put "0" if none or less than one)

slices/pieces of white bread	<input type="text"/>	slices each week
slices/pieces of brown/wholemeal bread (also include granary, rye bread etc)	<input type="text"/>	slices each week
crackers, crispbread etc (ryvita, water biscuits etc)	<input type="text"/>	number each week
crisps, hula hoops etc	<input type="text"/>	packets each week
sweet biscuits	<input type="text"/>	number each week
dairy desserts (yoghurts etc)	<input type="text"/>	number each week
cakes, puddings, pies, buns etc	<input type="text"/>	number each week
chocolate (in any food or drink)	<input type="text"/>	approx. number of pieces each week
boiled sweets, peppermints etc	<input type="text"/>	number each week
nuts (including peanut butter)	<input type="text"/>	tablespoons each week
gravy, cream/cheese sauces etc	<input type="text"/>	tablespoons each week
jams, marmalade	<input type="text"/>	tablespoons each week
breakfast type cereal	<input type="text"/>	bowls each week

If you eat breakfast cereal is it usually: (please cross)

<input type="checkbox"/> bran cereal (allbran, branflakes etc)	<input type="checkbox"/> muesli
<input type="checkbox"/> biscuit cereal (weetabix, shreddies etc)	<input type="checkbox"/> other
<input type="checkbox"/> oat cereal (porridge, ready brek etc)	(cornflakes, rice crispies etc)

23. What type of spread do you use on bread, crispbreads etc, once a week or more often? (you can cross more than one box)

<input type="checkbox"/> butter	<input type="checkbox"/> margarine	<input type="checkbox"/> soft cheese
<input type="checkbox"/> low fat spread	<input type="checkbox"/> mayonnaise	<input type="checkbox"/> salad cream
<input type="checkbox"/> olive oil spread	<input type="checkbox"/> marmite etc	<input type="checkbox"/> rarely use spread

Do you spread it: thick? medium? thin? (please cross)

Do you add butter etc to: potatoes? other vegetables?

24. Which types of fats or oils do you use for cooking or salad dressing once a week or more often?

(you can cross more than one box)

<input type="checkbox"/> butter	<input type="checkbox"/> soft (tub) margarine	<input type="checkbox"/> white flora
<input type="checkbox"/> olive oil	<input type="checkbox"/> hard (block) margarine	<input type="checkbox"/> lard/dripping
<input type="checkbox"/> corn oil	<input type="checkbox"/> sunflower oil	<input type="checkbox"/> mayonnaise
<input type="checkbox"/> soya oil	<input type="checkbox"/> other vegetable oil	<input type="checkbox"/> salad cream

Please put a cross in the box if you RARELY OR NEVER:

<input type="checkbox"/> use fats or oils for cooking	<input type="checkbox"/> use salad dressing/cream
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25. Please put a cross in the box if you NEVER eat:

<input type="checkbox"/> beef	<input type="checkbox"/> pork/ham	<input type="checkbox"/> lamb	<input type="checkbox"/> dairy products
<input type="checkbox"/> kidney	<input type="checkbox"/> liver/pâté	<input type="checkbox"/> sugar	<input type="checkbox"/> wheat products
<input type="checkbox"/> salami	<input type="checkbox"/> sausages	<input type="checkbox"/> eggs	<input type="checkbox"/> beefburgers

26. What type of milk or cream do you drink or use once a week or more often? (you can cross more than one box)

<input type="checkbox"/> full cream milk	<input type="checkbox"/> single cream
<input type="checkbox"/> semi-skimmed milk	<input type="checkbox"/> double cream
<input type="checkbox"/> skimmed/fat free milk	<input type="checkbox"/> dairy ice cream
<input type="checkbox"/> soya milk	<input type="checkbox"/> never have milk/cream

27. Do you:	never	some-times	usually	always
add milk to your tea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
add milk to your coffee?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
add salt to your food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
remove fat from meat? (cross "never" if vegetarian)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
eat breakfast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
eat an afternoon snack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
eat organic food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. Have you made any major changes to your diet in the last 5 years? No Yes^{because of illness} Yes^{for some other reason}

29. About how much alcohol do you drink each week?

number of drinks of alcohol each week
(one drink = a glass of wine, half pint of lager, or tot of spirits; put "0" if you drink less than one drink each week)

If you have more than one drink of alcohol each week:

is it usually with meals? No Yes it varies

on how many days each week do you usually drink? days each week

30. About how much do you drink EACH DAY of:

tea? cups daily	<input type="text"/>	milk, hot chocolate etc? cups daily	<input type="text"/>	fizzy/soft drink? glasses daily	<input type="text"/>
coffee? cups daily	<input type="text"/>	water? glasses daily	<input type="text"/>	fruit squash? glasses daily	<input type="text"/>

31. How many teaspoons of sugar do you add to tea, coffee, cereal, fruit etc EACH DAY? teaspoons of sugar each day

32. What size clothes do you wear now? (you can cross more than one box if the size varies)

Clothes	<input type="checkbox"/> 10 or less	<input type="checkbox"/> 12	<input type="checkbox"/> 14	<input type="checkbox"/> 16	<input type="checkbox"/> 18	<input type="checkbox"/> 20+
Bra	<input type="checkbox"/> 32	<input type="checkbox"/> 34	<input type="checkbox"/> 36	<input type="checkbox"/> 38	<input type="checkbox"/> 40	<input type="checkbox"/> 42+
Cup	<input type="checkbox"/> AAA	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> DD/E +	

33. What is your: (please put "0" if you do not know)

waist measurement?	<input type="text"/>	inches	hip measurement?	<input type="text"/>	inches
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34. About how much do you weigh now? stone lbs (Put "0" if you do not know)

WHEN YOU WERE YOUNG

35. About how much did you weigh when you were born? lbs ozs (Put "0" if you do not know)

36. Were you breastfed when you were a baby?

No Yes do not know

37. Did your parents smoke at around the time that you were born?

Mother	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> do not know
Father	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> do not know

38. Did your parents smoke at around the time that you were 10 years old?

Mother	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> do not know
Father	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> do not know

39. When you were about 10 years old, compared to average, would you describe yourself as (please cross):

thinner? plumper? about average?

40. What size clothes did you wear when you were about 20 years old? (you can cross more than one box)

8 or less 10 12 14 16 18 +

