



# Black Women's Health Study 2005



PLEASE USE A BLUE OR BLACK BALLPOINT PEN

1. How old are you?    
Age

2. Please write in your date of birth.   /   /     
(This information is helpful for identification) Month Day Year  
(example: June = 06)

3. What state were you born in?    
 Not born in the U.S. State  
What state did you live in at age 15?    
 Not living in the U.S. State

4. How old was your mother when she gave birth to you?    Don't know  
Age

5. How often do you attend religious services?  
 Never  2-3 times a month  
 Less than once a month  Once a week  
 About once a month  Several times a week

6. How often do you pray?  
 Rarely or never  Several times a week  
 Less than once a week  Once or twice a day  
 Once a week  Many times a day

7. To what extent is your religion or spirituality involved in understanding or dealing with stressful situations in any way?  
 Not involved at all  Somewhat involved  
 Not very involved  Very involved

8. To what extent do you consider yourself a religious or spiritual person?  
 Not religious/spiritual  Moderately religious/spiritual  
 Slightly religious/spiritual  Very religious/spiritual

9. What is your religious affiliation (eg. Baptist, AME, Muslim)?   
Religious Affiliation

10. Do you currently have health insurance coverage?  
 Yes  No

11. Have you ever delayed seeing a doctor until you were able to obtain insurance/benefits?  
 Yes  No

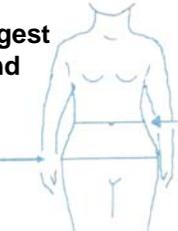
12. Between March 2003 and March 2005, did you have a:  
(Fill in all circles that apply.)  
 Mammogram  Sigmoidoscopy  
 Pap smear  Physical Exam  
 Colonoscopy

13. Between March 2003 and March 2005 did you use:  
 Birth control pills. How many months?    
Months  
 Name of Medication  
 Depo-Provera (injections). How many months?    
Months  
 Norplant. How many months?    
Months

14. How many cigarettes do you currently smoke each day?  
 None  5-14  25-34  
 Less than 5  15-24  35 or more  
Do you smoke menthol cigarettes?  
 Yes  No

15. On average, how many alcoholic beverages do you currently drink each week?  
 None  1 - 3  7 - 13  21 - 27  
 Less than 1  4 - 6  14 - 20  28 or more

16. Please write in your current weight.     
Pounds

17. What are your waist and hip sizes (in inches)?  
Hip: Measure the largest circumference around the hips (including buttocks).    
Waist: Measure at navel.    




**18. Have you ever been diagnosed with any of the following conditions?**

Please fill in the circle for yes and write in the year it was first diagnosed.

	Yes	Year
1. Heart Attack	<input type="radio"/>	<input type="text"/>
2. Stroke	<input type="radio"/>	<input type="text"/>
3. Diabetes (sugar, sugar diabetes)	<input type="radio"/>	<input type="text"/>
4. Breast Cancer	<input type="radio"/>	<input type="text"/>
5. Lung Cancer	<input type="radio"/>	<input type="text"/>
6. Colon Cancer	<input type="radio"/>	<input type="text"/>
7. Rectal Cancer	<input type="radio"/>	<input type="text"/>
8. Uterine Cancer (not including cervical cancer)	<input type="radio"/>	<input type="text"/>
9. Other type of cancer <input type="text"/>	<input type="radio"/>	<input type="text"/>
10. Coronary bypass surgery or angioplasty	<input type="radio"/>	<input type="text"/>
11. Angina (chest pain)	<input type="radio"/>	<input type="text"/>
12. Blood clot (lungs or legs)	<input type="radio"/>	<input type="text"/>
13. Hypertension (high blood pressure)	<input type="radio"/>	<input type="text"/>
14. High cholesterol	<input type="radio"/>	<input type="text"/>
15. Fibroids in womb	<input type="radio"/>	<input type="text"/>
15a. Confirmed by ultrasound	<input type="radio"/>	<input type="text"/>
15b. Confirmed by surgery (e.g. hysterectomy)	<input type="radio"/>	<input type="text"/>
16. Infertility	<input type="radio"/>	<input type="text"/>
17. Hydatidiform mole (molar pregnancy)	<input type="radio"/>	<input type="text"/>
18. Cyst in breast	<input type="radio"/>	<input type="text"/>
18a. Confirmed by biopsy?	<input type="radio"/>	<input type="text"/>
19. Lupus (systemic lupus erythematosus)	<input type="radio"/>	<input type="text"/>
20. Discoid Lupus	<input type="radio"/>	<input type="text"/>
21. Multiple Sclerosis	<input type="radio"/>	<input type="text"/>
22. Osteoarthritis	<input type="radio"/>	<input type="text"/>
23. Rheumatoid arthritis	<input type="radio"/>	<input type="text"/>
24. Asthma	<input type="radio"/>	<input type="text"/>
25. Sarcoidosis	<input type="radio"/>	<input type="text"/>
26. Ulcer (gastric or duodenal)	<input type="radio"/>	<input type="text"/>
27. Gallstones	<input type="radio"/>	<input type="text"/>
28. Kidney Stones	<input type="radio"/>	<input type="text"/>

	Yes	Year
29. Colon or rectal polyp (benign)	<input type="radio"/>	<input type="text"/>
30. Pancreatitis	<input type="radio"/>	<input type="text"/>
31. Depression	<input type="radio"/>	<input type="text"/>
31a. Treated with medication starting in	<input type="radio"/>	<input type="text"/>
32. Glaucoma	<input type="radio"/>	<input type="text"/>
32a. Treated with laser surgery?	<input type="radio"/>	
32b. Treated with other surgery?	<input type="radio"/>	
33. Other serious illness	<input type="radio"/>	<input type="text"/>
<input type="text"/>		

**19. Do you take any of the following medications or vitamins at least 3 days a week?**

(Fill in the circle for YES, leave blank for NO.)

- Baby Aspirin for prevention of heart disease
- Other Aspirin (Anacin, Bufferin, Bayer, Excedrin, etc.)
- Acetaminophen (Tylenol, Panadol, etc.)
- Injections for diabetes
- Pills for diabetes **Name** →
- Diuretics (water pills) for high blood pressure or other reasons (Hydrodiuril/HCTZ, Lasix, Maxzide, etc.)  
**Name** →
- Other blood pressure medication (Tenormin/Atenolol, Toprol XL, Norvasc, etc.)  
**Name** →
- Antidepressants (Zoloft, Paxil, Effexor, Celexa, etc.)  
**Name** →
- Inhalers or pills for asthma  
**Name** →
- Pills to lower cholesterol  
**Name** →
- Eye drops for glaucoma  
**Name** →
- Multi-Vitamins       Calcium
- Folic acid by itself       Vitamin D by itself

**Please list all other medications or supplements that you currently take at least 3 days a week:**


Continue on next page →



**20. Women whose periods have stopped permanently (at least 12 months) are considered to have gone through menopause, even if they have not experienced any symptoms (hot flashes, etc.) Which of the following statements best describes your current situation?**

- I still have my usual menstrual periods
- I am currently going through menopause
- My menstrual periods have stopped permanently
- My periods stopped but I have periods now due to use of female hormones
- I don't know if my periods have stopped because I began taking female hormones when I still had periods
- Uncertain (Please describe):

Age periods stopped:

Reason periods stopped:

- Natural menopause
- Surgery
- Chemotherapy/radiation
- Other:

*Please continue with Question 21*

**21. Since March 2003, have you had surgery to remove your ovaries or uterus? (Fill in all circles that apply.)**

- No
- Both ovaries removed
- One ovary only removed
- Uterus removed

**22. Between March 2003 and March 2005, have you taken female hormones (like estrogen) for menopause?**

Yes. How many months?   Months

**Name of medication(s):**

**23. What is your current marital status?**

- Married
- Living as married
- Separated
- Divorced
- Widowed
- Single, never married

**PHYSICAL ACTIVITY**

**24. How many city blocks or their equivalent do you walk each day?**

Blocks  
(12 blocks = 1 mile)

**25. What is your usual pace of walking?**

- Casual or strolling (less than 2 mph)
- Average or normal (2 to 3 mph)
- Fairly brisk (3 to 4 mph)
- Brisk or striding (4 mph or faster)

**26. How many flights of stairs do you climb up each day?**

Flights  
(1 flight = 10 steps)

**27. List any sports or recreation you have actively participated in during the past year. Please remember seasonal sports or events.**

Sport, Recreation, or Other Physical Activity	Number of Times per Year	Average Time per Episode		Number of Years Participated
		Hours	Minutes	
a.	<input style="width: 40px; height: 20px;" type="text"/>			
b.	<input style="width: 40px; height: 20px;" type="text"/>			
c.	<input style="width: 40px; height: 20px;" type="text"/>			
d.	<input style="width: 40px; height: 20px;" type="text"/>			
e.	<input style="width: 40px; height: 20px;" type="text"/>			
f.	<input style="width: 40px; height: 20px;" type="text"/>			

*Continue on next page* →



**28. If you have been pregnant between March 2003 and March 2005, please mark the number of times that you had the following:**

Birth of single child      ①      ②      ③

Birth of twins or triplets      ①      ②      ③

Miscarriage      ①      ②      ③

Abortion      ①      ②      ③

Other, specify below:      ①      ②      ③

**29. If you had a baby between March 2003 and March 2005, did you breastfeed the baby?**

Yes. How many months?

Months

No

*Please continue with Question 30*

**30. If you had a baby between March 2003 and March 2005, what was the child's birth date?**

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Month			Day			Year	

**31. Are you currently pregnant?**

Yes

No

**32. Please indicate which best describes how often you felt or behaved this way during the past week.**

	Rarely or none of the time	Some or a little of the time	Moderate amount of time	Most or all of the time
I was bothered by things that usually do not bother me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I did not feel like eating; my appetite was poor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that I could not shake off the blues even for family/friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that I was just as good as other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had trouble keeping my mind on what I was doing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that everything I did was an effort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt hopeful about the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I thought my life had been a failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt fearful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My sleep was restless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was happy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I talked less than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt lonely	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People were unfriendly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I enjoyed life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had crying spells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt that people disliked me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I could not get going	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





**33. In my lifetime, people have done the following to me:** (Fill in the circle that best describes how often this happened when you were a child, a teenager, or an adult and in the last year.)

	As a child (up to age 11)			As a teenager (age 12-18)			As an adult (age 19 to present)			In the last year	
	Never	1-3 Times	4 or More Times	Never	1-3 Times	4 or More Times	Never	1-3 Times	4 or More Times	No	Yes
Someone... pushed, grabbed, or shoved me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
threw something at me that could hurt me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
kicked, bit, or punched me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
hit me with something including hand or fist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
choked or burned me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
physically attacked me in some other way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
exposed their genitals against my will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
was sexual with me against my will	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
seriously harmed someone I loved	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**34. Please indicate how often you felt physically or sexually in danger in each of the following places:**

	As a child (up to age 11)			As a teenager (age 12-18)			As an adult (age 19 to present)			In the last year	
	Never	1-3 Times	4 or More Times	Never	1-3 Times	4 or More Times	Never	1-3 Times	4 or More Times	No	Yes
I felt in danger:											
in my home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
in my neighborhood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
in my school/workplace	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**NIGHT SHIFT WORK**

**35. Have you ever worked a night shift (graveyard shift, Midnight to 8 AM)?**  Yes  No → Skip to Question 38

**36. How often did you work a night shift?**  Never  Once a year  Every week  
 A couple of times a year  Once a month

**37. How many years did you work night shifts?**   Years

Continue on next page →



These questions are about your feelings and thoughts during the last month. Please indicate how often you felt or thought a certain way.

38. In the last month how often have you...	Never	Almost Never	Sometimes	Fairly Often	Very Often
been upset because of something that happened unexpectedly?	<input type="radio"/>				
felt that you were unable to control the important things in your life?	<input type="radio"/>				
felt nervous and "stressed"?	<input type="radio"/>				
felt confident about your ability to handle your personal problems?	<input type="radio"/>				
felt that things were going your way?	<input type="radio"/>				
found that you could not cope with all the things that you had to do?	<input type="radio"/>				
been able to control irritations in your life?	<input type="radio"/>				
been angered because of things that were outside of your control?	<input type="radio"/>				
felt difficulties were piling up so high that you could not overcome them?	<input type="radio"/>				

The next items deal with ways you've been coping with the stress in your life. Use these response choices to tell how much you've been doing each of the things listed. Don't answer on the basis of whether it seems to be working or not — just whether or not you're doing it.

39. I've been...	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
concentrating my efforts on doing something about the situation I'm in	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
getting emotional support from others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
taking action to try to make the situation better	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
getting help and advice from other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
trying to see it in a different light, to make it seem more positive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
getting comfort and understanding from someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
looking for something good in what is happening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
accepting the reality of the fact that it has happened	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
trying to get advice or help from other people about what to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
learning to live with it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

