Black Women's Health Study

BOSTON UNIVERSITY SCHOOL OF MEDICINE • HOWARD UNIVERSITY COLLEGE OF MEDICINE

MARKING INSTRUCTIONS

Please use a No. 2 pencil or blue or black ink pen only.

● **Correct Mark** ✓ ✗ ● ⊙ **Incorrect Marks**

1. How old are you?

AGE (Years)

Write your age in the boxes.

Then fill in the matching ovals.

2. Please write in your birth date *and* fill in the ovals.

(Your birth date is needed for purposes of identification.)

MONTH	DAY	YEAR
○ Jan		19
○ Feb	0 0	0 0
○ Mar	1 1	1 1
○ Apr	2 2	2 2
○ May	3 3	3 3
○ June	4	4 4
○ July	5	5 5
○ Aug	6	6 6
○ Sept	7	7 7
○ Oct	8	8 8
○ Nov	9	9 9
○ Dec		

3. Please fill in the appropriate ovals below to indicate where you, your mother and your father were born.

	UNITED STATES?	OTHER COUNTRY?	UNKNOWN
You	○	○ Specify	○
Your Mother	○	○ Specify	○
Your Father	○	○ Specify	○

4. *Up to the age of 18*, where did you live?

- ○ Urban setting
- ○ Suburban setting
- ○ Rural or small town setting
- ○ Combination of these settings

5. *Up to the age of 18*, what kind of neighborhood did you live in?

- ○ Predominately black
- ○ Predominately white
- ○ Mixed or other

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DOR	1 2 3 4 5 6 7 8 9 10 11 12 97 98	10c	0 1 2 3 4 5 6 7 8 9
3a	0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9	10d	0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9
3b	0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9		
3c	0 1 2 3 4 5 6 7 8 9 / 0 1 2 3 4 5 6 7 8 9		
9	0 1 2 3 4 5 6 7 8 9		

6a. What is your race?

- ○ Black
- ○ White
- ○ Asian or Pacific Islander
- ○ American Indian or Alaskan Native

b. What is your ethnicity?

- ○ Hispanic
- ○ Non-Hispanic

7. What is your current marital status?

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

8. *Since March 1, 1995* have you . . .

	YES	NO
had health insurance?	○	○
had your own regular physician or nurse practitioner?	○	○
visited a doctor or nurse practitioner for a general physical?	○	○
had your blood pressure checked?	○	○
had a mammogram?	○	○
had a pap smear?	○	○

9. Are you *currently* using any of these forms of birth control?

*(Please mark **all** that you are currently using.)*

- ○ None
- ○ Condom
- ○ Sponge
- ○ Foam/jelly
- ○ Vasectomy
- ○ Rhythm
- ○ Diaphragm/cap
- ○ Hysterectomy
- ○ Birth control pills
- ○ Tubes tied (tubal ligation)
- ○ Intrauterine device (IUD)
- ○ Norplant
- ○ Depo-Provera
- ○ Other *(Specify)*

10. *Since March 1, 1995*, have you used birth control pills?

○ Yes ○ No → *Go to question 11.*

a. How many months have you used them *since March 1, 1995?*

- ○ Less than 6 months
- ○ 6–11 months
- ○ 12–17 months
- ○ 18 or more months

b. Do you use them *currently?*

○ Yes ○ No

c. Why not?

- ○ Use another method now
- ○ No longer need them
- ○ Side effects bothered me
- ○ Serious illness while on the pill *(Please specify the illness.)*

d. Please give the name of the birth control pill that you last used.

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11. Have you gone through menopause?

(Please choose only one.)

- ○ Yes, went through menopause.
- ○ Yes, went through menopause but have periods now due to use of female hormone supplements.
- ○ No, but I am currently going through menopause.
- ○ No, I am premenopausal.
- ○ Uncertain

→ *If no or uncertain, go to question 12.*

a. If yes: age at menopause?

(age periods stopped)

AGE AT MENOPAUSE

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

b. What caused your menopause?

- ○ Surgery
  - *Were your ovaries removed?*
    - ○ Yes, both
    - ○ Only one
    - ○ Only uterus removed
- ○ Medication/chemotherapy/radiation
- ○ Natural menopause
  - *Have you had subsequent surgery to remove ovaries or uterus?*
    - ○ No
    - ○ One ovary removed
    - ○ Both ovaries removed
    - ○ Uterus removed

12. *Since March 1, 1995*, have you used estrogen replacement therapy (pills, injections, or patches)?

- ○ Yes ○ No

a. *Since March 1, 1995*, how long did you take them?

- ○ Less than 6 months
- ○ 6–11 months
- ○ 12–17 months
- ○ 18 or more months

b. Type of hormone used most recently?

- ○ Premarin or other estrogen pills alone
- ○ Progesterone (Provera, etc.) pills alone
- ○ Estrogen and progesterone pills
- ○ Patch estrogen alone
- ○ Patch estrogen and progesterone
- ○ Estrogen vaginal cream

NAME OF MOST RECENT MEDICATION

13. How much did you weigh when you were born?

- ○ Less than 4 lbs.
- ○ 4 lbs. to 5 lbs. 8 ozs.
- ○ More than 5 lbs. 8 ozs.
- ○ Don't know

a. If you know the exact weight, please write it in box and fill in ovals.

POUNDS (lbs.)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

OUNCES (ozs.)

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

14. Were you a twin or a triplet?

- ○ Yes ○ No

a.
- ○ Identical
- ○ Fraternal
- ○ Don't know

15. Were you born 3 or more weeks early?

- ○ Yes ○ No ○ Don't know

16. How many cigarettes do you currently smoke each *day*?

- ○ None
- ○ Less than 5
- ○ 5–14
- ○ 15–24
- ○ 25–34
- ○ 35–44
- ○ 45 or more

17. At the following times in your life, were you in the same room with a smoker for at least an hour a day for 12 consecutive months or more?

	YES	NO
Age 0–10 at home	○	○
Age 11–20 at home	○	○
Age 21–30 at home	○	○
Age 21–30 at work	○	○
Age 31–40 at home	○	○
Age 31–40 at work	○	○
Currently at home	○	○
Currently at work	○	○

18. In the last year, on average, how many alcoholic beverages did you have each *week*?

- ○ None
- ○ Less than 1
- ○ 1–3
- ○ 4–6
- ○ 7–13
- ○ 14–20
- ○ 21–27
- ○ 28 or more

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12b	0	1	2	3	4	5	6	7	8	9
	0	1	2	3	4	5	6	7	8	9

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

	YES	NO
Aspirin (Anacin, Bufferin, Bayer, Excedrin, etc.)	○	○
Acetaminophen (Tylenol, Anacin-3, Panadol, etc.)	○	○
Diuretics (water pills) for high blood pressure or other reasons (Diuril, Hydrodiuril, etc.)	○	○
Other blood pressure medication (Vasotec, Minipres, Calan, etc.)	○	○
Injections for diabetes	○	○
Pills for diabetes	○	○
Medication for depression	○	○
Inhalers or pills for asthma	○	○
Multi-vitamins	○	○
Vitamin A (by itself)	○	○
Vitamin B-complex	○	○
Niacin (B-3) (by itself)	○	○
Vitamin B-6 (by itself)	○	○
Vitamin B-12 (by itself)	○	○
Vitamin C (by itself)	○	○
Vitamin E (by itself)	○	○
Beta-carotene (by itself)	○	○
Calcium alone	○	○
Calcium with Vitamin D	○	○
Folic Acid (by itself)	○	○

Please list any *other* medications that you currently take at least 3 days a week (except birth control pills):

_____

_____

_____

_____

20. If a doctor has told you that you had any of the following conditions, please fill in the ovals indicating when it was *first* diagnosed.

	Yes, before March 1, 1995	Yes, after March 1, 1995
High blood pressure not during pregnancy	○	○
High blood pressure during pregnancy	○	○
High cholesterol	○	○
Heart attack	○	○
Angina (chest pain)	○	○
Stroke	○	○
Blood clot in lungs or legs	○	○
Cyst in breast	○	○
Was it confirmed by biopsy?	○	○
Fibroids in uterus	○	○
Endometriosis	○	○
Lupus (Systemic lupus erythematosus)	○	○
Discoid lupus	○	○
Rheumatoid arthritis	○	○
Osteoarthritis	○	○
Sickle cell anemia	○	○
Gingivitis (bleeding gums)	○	○
Depression treated with medication	○	○
Sarcoidosis	○	○
Asthma	○	○
Diabetes not during pregnancy	○	○
Diabetes during pregnancy	○	○
Breast cancer	○	○
Cervical cancer	○	○
Uterine cancer	○	○
Lung cancer	○	○
Colon or rectal cancer	○	○
Other cancer or other serious illness?		
a. *Specify:*	○	○
b. *Specify:*	○	○

21. Please fill in the oval(s) if you have had any of the following:

(Mark all that apply.)

- ○ Arthritis or rheumatism for at least 3 months
- ○ Unusual sensitivity to the cold in your fingers
- ○ Sores in your mouth or nose for 2 weeks or more
- ○ A rash on your cheeks for more than a month
- ○ Skin break out or blister after you have been in the sun (not sunburn)
- ○ Chest pain on breathing (pleurisy)
- ○ Protein in your urine
- ○ Rapid loss of lots of hair
- ○ Epileptic seizure, convulsion or fit
- ○ Low blood count: *If yes*, what type:
  - ○ Low red cell count *(anemia)*
  - ○ Low *white cell* count
  - ○ Low *platelet* count
- ○ None of the above

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20a	20b
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	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
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	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

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22. On average, during *the past year*, how many hours each *day* did you spend:

	None	Less than 1 hour	1–2 hours	3–4 hours	5 or more hours
Watching TV or videos	○	○	○	○	○
Sitting at work	○	○	○	○	○
Sitting in a car or bus	○	○	○	○	○
Other sitting	○	○	○	○	○
Walking at work	○	○	○	○	○

23. On average, during *the past year*, how many hours each *week* did you spend:

	None	Less than 1 hour	1 hour	2 hours	3–4 hours	5–6 hours	7–9 hours	10 or more hours
Walking to and from church, store, school, work	○	○	○	○	○	○	○	○
Walking for exercise	○	○	○	○	○	○	○	○
Moderate activity (such as housework, childcare, gardening, bowling)	○	○	○	○	○	○	○	○
Vigorous exercise (such as basketball, swimming, running, aerobics)	○	○	○	○	○	○	○	○

24. How often do you think about your race?

- ○ Never
- ○ Once a year
- ○ Once a month
- ○ Once a week
- ○ Once a day
- ○ Once an hour
- ○ Once a minute
- ○ Constantly

25. In your day-to-day life, how often have any of the following things happened to you?

a. You receive poorer service than other people at restaurants or stores.

- ○ Never
- ○ A few times a year
- ○ Once a month
- ○ Once a week
- ○ Almost every day

b. People act as if they think you are not intelligent.

- ○ Never
- ○ A few times a year
- ○ Once a month
- ○ Once a week
- ○ Almost every day

c. People act as if they are afraid of you.

- ○ Never
- ○ A few times a year
- ○ Once a month
- ○ Once a week
- ○ Almost every day

d. People act as if they think you are dishonest.

- ○ Never
- ○ A few times a year
- ○ Once a month
- ○ Once a week
- ○ Almost every day

e. People act as if they are better than you.

- ○ Never
- ○ A few times a year
- ○ Once a month
- ○ Once a week
- ○ Almost every day

26. Have you ever been treated unfairly due to your race in any of the following circumstances?

	YES	NO
A. Job (hiring, promotion, firing)	○	○
B. Housing (renting, buying, mortgage)	○	○
C. Police (stopped, searched, threatened)	○	○

27. Have you *ever* used a chemical hair straightener?

○ Yes ○ No → *Go to question 28.*

a. At what age did you *first* use chemical hair straighteners?

- ○ Less than 10 years old
- ○ 10–19 years old
- ○ 20–29 years old
- ○ 30 or more years old

b. How often do you (or did you) use chemical hair straighteners?

- ○ About 1 time per year
- ○ About 2 times per year
- ○ About 3–4 times per year
- ○ About 5–6 times per year
- ○ 7 or more times per year

c. In total, *how many years* have you used hair straighteners?

- ○ Less than 1 year
- ○ 1–4 years
- ○ 5–9 years
- ○ 10–14 years
- ○ 15–19 years
- ○ 20 or more years

d. How many times have you experienced burns (a break in the skin, not just tingling) during the application of chemical straighteners?

- ○ Never
- ○ 1–2 times
- ○ 3–4 times
- ○ 5–9 times
- ○ 10 or more times

e. Which of the following chemical hair straighteners have you used *most often?*

- ○ Lye
- ○ No-lye
- ○ Don't know

28. Please write in your *current* weight in pounds and fill in the ovals.

WEIGHT

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

29. ***Before March 1, 1995*, did you ever give birth to a child (either liveborn or stillborn)?**

○ Yes ○ No → *Go to question 30.*

a. How old were you the *first* time you gave birth?

- ○ Less than 18 years old
- ○ 18–19 years old
- ○ 20–24 years old
- ○ 25–29 years old
- ○ 30–34 years old
- ○ 35 years or older

b. *Before March 1, 1995*, how many times did you give birth to a child (liveborn or stillborn)?

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 or more

c. *Before March 1, 1995*, did you ever give birth to a single child 3 or more weeks before your due date (not a twin, triplet or multiple birth)?

○ Yes ○ No → *Go to question 30.*

d. How many weeks early was this birth?

(If you had more than 1 premature birth, give information on the one that was the most premature.)

- ○ 3 weeks early
- ○ 4 weeks early
- ○ 5 weeks early
- ○ 6 weeks early
- ○ 7 weeks early
- ○ 8 weeks early
- ○ 9 weeks early
- ○ 10 or more weeks early
- ○ Not sure

e. What was the birth weight of that baby?

(Write in box and fill in ovals below.)

POUNDS (lbs.)

	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	⑪	⑫	⑬	⑭	⑮

OUNCES (ozs.)

	0	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	⑪	⑫	⑬	⑭	⑮

30. ***Before March 1, 1995*, how many miscarriages did you have?**

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 or more

31. ***Before March 1, 1995*, how many abortions did you have?**

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7 or more

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32	①	②	③	④	⑤	⑥	⑦	⑧	⑨
33	①	②	③	④	⑤	⑥	⑦	⑧	⑨
36	①	②	③	④	⑤	⑥	⑦	⑧	⑨

THIS SECTION CONCERNS PREGNANCIES THAT OCCURRED **SINCE MARCH 1, 1995.**

32. ***Since March 1, 1995*, have you been pregnant?**

○ Yes ○ No → *Go to page 7.*

a. Mark the number of times since March 1, 1995, you had each of the following:

	0	1	2	3
Miscarriage	○	○	○	○
Abortion	○	○	○	○
Birth of single child	○	○	○	○
Birth of twins or triplets	○	○	○	○
Other *(Specify)*	○	○	○	○

IF YOU HAD A SINGLE BIRTH (LIVEBORN OR STILLBORN) SINCE MARCH 1, 1995, PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THAT PREGNANCY. (IF YOU HAD MORE THAN 1 SINGLE BIRTH PLEASE ANSWER ONLY ABOUT THE MOST RECENT.)

33. **Did the pregnancy result from:**

- ○ IVF (in-vitro fertilization)
- ○ GIFT (gamete intrafallopian transfer)
- ○ Other assisted reproductive technology *(Specify)*
- ○ None of the above

34. **How much weight did you gain during this pregnancy?**

- ○ Less than 10 lbs.
- ○ 10–14 lbs.
- ○ 15–19 lbs.
- ○ 20–24 lbs.
- ○ 25–29 lbs.
- ○ 30–34 lbs.
- ○ 35-39 lbs.
- ○ More than 39 lbs.

35. **Had you planned to get pregnant at that time?**

○ Yes, planned ○ No, unplanned

36. **What is the race of the father?**

- ○ Black
- ○ White
- ○ Other race *(Specify)*

37. **Did you take multi-vitamins during this pregnancy?**

○ Yes ○ No

a. When did you take them?

(Mark all that apply.)

- ○ Before the pregnancy
- ○ During 1st trimester
- ○ During 2nd trimester
- ○ During 3rd trimester

38. **Did you use vaginal douching during this pregnancy?**

(Mark all that apply.)

- ○ No, never douched during this pregnancy
- ○ Yes, during 1st trimester, *less than* once per week
- ○ Yes, during 1st trimester, *at least* once per week
- ○ Yes, during 2nd trimester, *less than* once per week
- ○ Yes, during 2nd trimester, *at least* once per week
- ○ Yes, during 3rd trimester, *less than* once per week
- ○ Yes, during 3rd trimester, *at least* once per week

39. Did you smoke during this pregnancy?

○ Yes ○ No → *Go to question 40.*

a. When did you smoke? *(Mark all that apply.)*

- ○ Before the pregnancy
- ○ During 1st trimester
- ○ During 2nd trimester
- ○ During 3rd trimester

b. How many cigarettes did you smoke on average during this pregnancy?

- ○ Less than 5 per day
- ○ 5–14 per day
- ○ 15–24 per day
- ○ 25 or more per day

40. When did you see a doctor or a nurse for prenatal care?

(Mark all that apply.)

- ○ 1st trimester
- ○ 2nd trimester
- ○ 3rd trimester
- ○ Never

41. How much did this baby weigh at birth?

(Please write in the child's birth weight in pounds and ounces and fill in the ovals. If not certain, give approximate weight.)

POUNDS (lbs.)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

OUNCES (ozs.)

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

42. What was the due date?

(If due date changed during the pregnancy, give last one doctor told you.)

MONTH	DAY	YEAR
○ Jan		
○ Feb		
○ Mar	0 0	95
○ Apr	1 1	96
○ May	2 2	97
○ June	3 3	
○ July	4	
○ Aug	5	
○ Sept	6	
○ Oct	7	
○ Nov	8	
○ Dec	9	

43. What was the child's birth date?

MONTH	DAY	YEAR
○ Jan		
○ Feb		
○ Mar	0 0	95
○ Apr	1 1	96
○ May	2 2	97
○ June	3 3	
○ July	4	
○ Aug	5	
○ Sept	6	
○ Oct	7	
○ Nov	8	
○ Dec	9	

44. Did the doctor say this child was born at least 3 weeks early?

○ Yes ○ No → *Go to page 7.*

a. How early?

- ○ 3 weeks
- ○ 4 weeks
- ○ 5 weeks
- ○ 6 weeks
- ○ 7 weeks
- ○ 8 weeks
- ○ 9 weeks
- ○ 10 weeks or more
- ○ Unsure

b. Were you told the birth was early for any of the following reasons?

- ○ Labor began early for no known reason
- ○ Membranes ruptured (water broke) early and baby was delivered to prevent infection
- ○ Labor was induced or had c-section because . . .

(Mark all that apply.)

- ○ Blood pressure was too high (preeclampsia, toxemia)
- ○ Baby was too big
- ○ Placenta detached or in wrong position (bleeding)
- ○ Breech birth or other abnormal position
- ○ Baby too small or not growing properly (or had birth defect)
- ○ Baby having a problem (fetal distress)
- ○ For some other reason *(Specify)*

- ○ Doctor not sure or did not say

45. Did this child stay in a neonatal intensive care unit before going home?

- ○ Yes, less than 1 day
- ○ Yes, 1–4 days
- ○ Yes, 5–9 days
- ○ Yes, 10 or more days
- ○ No

46. Is this child alive?

○ Yes ○ No **Died because of:**

- ○ Prematurity
- ○ Accident
- ○ Sudden Infant Death Syndrome (SIDS)
- ○ Other *(Specify)*

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44	1	2	3	4	5	6	7	8	9
46	1	2	3	4	5	6	7	8	9

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