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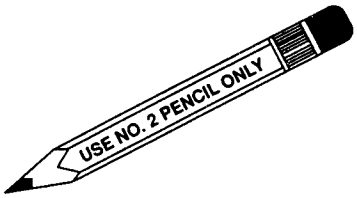
Ver. 2.1
OMB #0925-0414 Exp: 6/97

WOMEN'S HEALTH INITIATIVE

Form 31 - Reproductive History Questionnaire

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
- Darken the oval completely next to the answer you choose.
- Erase cleanly any marks you wish to change.
- Do not make any stray marks on this form.

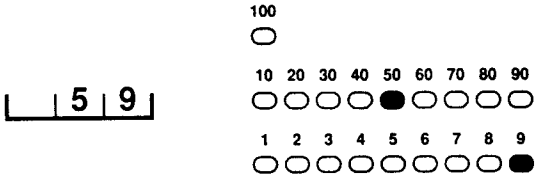


CORRECT MARK

INCORRECT MARKS

- For questions where you write in a number, write the number in the box provided. Then mark the corresponding oval to the right.

Example: If your age is 59:



Public reporting for this collection of information is estimated to average 10 minutes, including the time for reviewing instructions, gathering needed information and completing and reviewing the questionnaire. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: PHS Reports Clearance Officer, Rm. 721-B, Humphrey Building, 200 Independence Ave., SW, Washington, D.C. 20201, ATTN: PRA; and to Office of Management and Budget, Paperwork Reduction Project (0925-0414), Washington, D.C. 20503. Do not return the completed form to either of these addresses.

OFFICE USE ONLY

S _____

AFFIX LABEL BETWEEN LINES

BAR CODE HERE

1. Date Received:

Month - Day - Year

M ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫

D ⑩ ⑳ ㉚ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Y ㊹ ㊺ ㊻ ㊼ ㊽ ㊾

2. Reviewed By:

⓪⓪ ⓪⓪ ⓪⓪ ⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

3. Contact Type:

① Phone
② Mail
③ Visit
⑧ Other

4. Visit Type:

① Screening ⓪ ① ② ③
② Semi-Annual ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
③ Annual ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
④ Non Routine

5. Form Administration:

① Self ② Group ③ Interview ④ Assistance

291403

PLEASE MAKE NO MARKS IN THIS AREA

The following questions ask about your monthly periods (menses) and child bearing history. We are very interested in this information so that we can understand more about women's reproductive lives and their health. Some of the questions ask you to give ages when certain things happened. If you're not sure about the exact age, please give your best guess.

1. How old were you when you had your first menstrual period (menses)?

9 or less	10	11	12	13	14	15	16	17 or older
①	②	③	④	⑤	⑥	⑦	⑧	⑨

2. During most of your life, were your periods regular; that is, did they occur about once a month? **(Do not include any time when you were pregnant or taking birth control pills.)**

⓪ No

① Yes

② Sometimes regular, sometimes irregular

2.1. How old were you when your periods first became regular? **(Your best guess.)**

9 or less	10	11	12	13	14	15	16	17 or older
①	②	③	④	⑤	⑥	⑦	⑧	⑨

3. How old were you when you last had regular menstrual bleeding (a period)? **(Your best guess.)** **(If you are still having regular bleeding or periods, enter your current age.)**

|_|_| years old

10	20	30	40	50	60	70	80
○	○	○	○	○	○	○	○

1	2	3	4	5	6	7	8	9
○	○	○	○	○	○	○	○	○

4. Between the time you had your first period and your last period, did you ever go without any periods for at least one year? **(Do not count times when you were pregnant or breastfeeding.)**

⓪ No ① Yes

4.1. Between your first menstrual period and your last, all together, about how long did you go without having your period? **(Again, do not count times when you were pregnant or breastfeeding.) (Mark one oval.)**

① Less than 12 months

② 12 to 23 months

③ 24 months (2 years) to 48 months (4 years)

④ More than 4 years

5. How old were you when you last had any menstrual bleeding? **(If you are still having menstrual bleeding or periods, enter your current age.)**

|_|_| years old

10 20 30 40 50 60 70 80
○○○○○○○○
1 2 3 4 5 6 7 8 9
○○○○○○○○○

6. Have you ever had menopausal symptoms, such as hot flashes or night sweats? **(Your best guess.)**

⓪ No ① Yes

6.1. How old were you when you first had symptoms such as hot flashes or night sweats? **(Your best guess.)**

|_|_| years old

10 20 30 40 50 60 70 80
○○○○○○○○
1 2 3 4 5 6 7 8 9
○○○○○○○○○

6.2. How old were you when you last had symptoms such as hot flashes or night sweats? **(If you are still having symptoms such as hot flashes or night sweats, enter your current age.)**

|_|_| years old

10 20 30 40 50 60 70 80
○○○○○○○○
1 2 3 4 5 6 7 8 9
○○○○○○○○○

Go to the next page.

291403

PLEASE MAKE NO MARKS IN THIS AREA

7. Have you ever been pregnant? It is very important that we know about all of your pregnancies, including live births, stillbirths, miscarriages, tubals (ectopics), and abortions.

⓪ No ① Yes

7.1. How many times have you been pregnant?

1	2	3	4	5	6	7	8 or more
①	②	③	④	⑤	⑥	⑦	⑧

7.2. Did you ever have a pregnancy that lasted at least 6 months?

⓪ No ① Yes

7.3. How many of these pregnancies did you have?

1	2	3	4	5	6	7	8 or more
①	②	③	④	⑤	⑥	⑦	⑧

7.4. How old were you at the end of the first of these pregnancies?

Less than 20	20-24	25-29	30-34	35-39	40-44	45 or older
①	②	③	④	⑤	⑥	⑦

7.5. How old were you at the end of the last of these pregnancies?

Less than 20	20-24	25-29	30-34	35-39	40-44	45 or older
①	②	③	④	⑤	⑥	⑦

Go on to Question 7.6.

For these next questions, please mark "None" if they don't apply to you.

7.6. How many live births did you have?

None	1	2	3	4	5	6	7	8 or more
⓪	①	②	③	④	⑤	⑥	⑦	⑧

7.7. How many stillbirths (from a pregnancy lasting 6 months or more) did you have?

None	1	2	3	4	5	6	7	8 or more
⓪	①	②	③	④	⑤	⑥	⑦	⑧

7.8. How many spontaneous miscarriages did you have?

None	1	2	3	4	5	6	7	8 or more
⓪	①	②	③	④	⑤	⑥	⑦	⑧

7.9. How many tubal (ectopic) pregnancies did you have?

None	1	2	3	4	5	6	7	8 or more
⓪	①	②	③	④	⑤	⑥	⑦	⑧

Go to the next page.

8. Have you ever tried to become pregnant for more than 1 year without becoming pregnant?

⓪ No ① Yes ⑨ Don't know

8.1. Did you visit a doctor or clinic because you didn't get pregnant?

⓪ No ① Yes

8.2. Was a reason found for why you did not become pregnant?

⓪ No ⑨ Don't know ① Yes

8.3. What was the reason you did not become pregnant? **(Mark all that apply.)**

① Problem with your hormones or ovulation (producing eggs)

② Problem with your tubes or uterus

③ Endometriosis

④ Other problem with you **(Specify):** _____

_____

⑤ Problem in your partner

⑨ Don't know

Go to the next page.

Go to the next page.

9. Did you breastfeed or nurse any children for at least one month?

⓪ No ① Yes

9.1. How many children did you breastfeed?

1	2	3	4	5	6	7	8 or more
①	②	③	④	⑤	⑥	⑦	⑧

9.2. How old were you when you first breastfed a child?

Less than 20	20-24	25-29	30-34	35-39	40-44	45 or older
①	②	③	④	⑤	⑥	⑦

9.3. How old were you when you last breastfed a child?

Less than 20	20-24	25-29	30-34	35-39	40-44	45 or older
①	②	③	④	⑤	⑥	⑦

9.4. Thinking about all the children you breastfed, how many months total did you breastfeed? **(Your best guess.)**

① 1-3 months
② 4-6 months
③ 7-12 months
④ 13-23 months
⑤ 2-4 years (24-48 months)
⑥ More than 4 years

10. Did you ever have an operation to have one or both of your ovaries taken out? **(Mark one oval.)**

⓪ No
① Yes, one was taken out
② Yes, both were taken out
③ Yes, unknown number taken out
④ Yes, part of an ovary was taken out
⑨ Don't know

10.1. How old were you when you had your last operation to remove an ovary?

Less than 30	30-34	35-39	40-44	45-49	50-54	55-59	60 or older
①	②	③	④	⑤	⑥	⑦	⑧

11. Did you ever have an operation to have your tubes tied to prevent pregnancy?

⓪ No ① Yes

11.1. How old were you when you had your tubes tied?

Less than 30	30-34	35-39	40-44	45 or older
①	②	③	④	⑤

Go to the next page.

12. Have you ever had a needle aspiration (where a doctor puts a needle in a lump in your breast and withdraws fluid or material)?

⓪ No ① Yes

12.1. How many of these needle aspirations have you had?

1 ① 2 ② 3 ③ 4 or more ④

13. Have you ever had a breast biopsy (where a doctor removes part or all of a breast lump to check for cancer)?

⓪ No ① Yes

13.1. How many of these biopsies have you had?

1 ① 2 ② 3 ③ 4 or more ④

14. Did you ever have an operation to increase your breast size (breast augmentation) or have breast reconstruction using a breast implant?

⓪ No ① Yes

14.1. How old were you when you first had that operation?

Less than 30 ① 30-34 ② 35-39 ③ 40-44 ④ 45-49 ⑤ 50-54 ⑥ 55 or older ⑦

14.2. Was this operation for the right breast, left breast, or both?

① Right breast
② Left breast
③ Both breasts

14.3. What type of breast implant did you receive?

① Silicone or silicone gel-filled
② Saline-filled
⑧ Other **(Specify):** _____
⑨ Don't know

Go to the next page.

15. Have you ever had any other operations on your breasts?

⓪ No ① Yes

15.1. What type of other breast operations did you have? **(Mark all that apply.)**

① Removal of part of breast or breast reduction
② Removal of one breast
③ Removal of both breasts
⑨ Other **(Specify):** _____

16. What is the date you finished this form?

|_|_|-|_|_|-|_|_|
Month Day Year

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

D 10 20 30
1 2 3 4 5 6 7 8 9

Y 94 95 96 97 98 99

Thank you. Please take a moment to review any questions you may have missed. Feel free to write any comments here:

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PLEASE MAKE NO MARKS IN THIS AREA