

# \*\*\*\*\* Follow-up Reproductive History \*\*\*\*\*

Record ID

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Site: 39 ADCID

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Subject ID: PTID

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Form Date: (Y-M-D)

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Visit Number: 2 or up

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Examiner's initials:  
INITIALS

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Data Entry Date: (Y-M-D)

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Data Entry By:

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Administered Status

- 1 Yes  
 95 - No, Physical Problem  
 96 - No, Cognitive/Behavior Program  
 97 - No, Other Problem  
 98 - No, Verbal Refusal  
 99 - Not Administered

Reproductive History (women only), follow-up visit

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1. Since your last visit with us, have you had one or both ovaries removed? (Y/N/DK)  
(Skip, if this was previously answered as YES, two ovaries.)

0 No    1 Yes    9 Don't Know

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1ai. If ONE or DON'T KNOW, what was your age when your ovary was removed? (years)

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1aii. If TWO, both at the same time? (Y/N/DK)

0 No    1 Yes    9 Don't Know

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1aii(A). If YES or DON'T KNOW, what was your age when your ovaries were removed?  
(years)

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1aii(B1). If NO, what was your age when your first ovary was removed? (years)

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1a. If NO, what was your age when your second ovary was removed? (years)

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2. Since your last visit with us, have you had a hysterectomy (partial hysterectomy or total hysterectomy)? / (or, Have you ever had your uterus removed?) (Y/N/DK)  
(Skip, if this was previously answered as YES.)

0 No  1 Yes  9 Don't Know

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2a. If YES, how old were you when you had a hysterectomy? (years)

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2b. (For women who answered YES to question #4 and question #5): If YES, was this at the same time that (your ovary was removed)/ (your ovaries were removed)? (Y/N/DK)

0 No  1 Yes  9 Don't Know

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3. Are you currently using (hormonal) birth control? (Y/N/DK)  
(Hormonal birth control refers to an estrogen or a progestin or both. These can be taken or delivered by mouth, by injection, by transdermal patch, by a vaginal ring, or by a subcutaneous implant. It does not include intrauterine devices or other forms of contraception. OK to assume "NO" for ages 60+.)

0 No  1 Yes  9 Don't Know

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4. Since your last visit with us, have you used hormone therapy (menopausal hormone therapy)? (Y/N/DK)  
(Hormone therapy is an estrogen, with or without a progestogen, taken by mouth, or delivered by injection or transdermal patch. Include estrogen prescribed to prevent migraine headache. Do not include vaginal (topical) estrogen.)

0 No  1 Yes  9 Don't Know

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4a. If YES, are you currently taking hormone therapy? (Y/N/DK)

0 No  1 Yes  9 Don't Know

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4b. If YES, how old were you when you most recently started (or most recently restarted) hormone therapy? (years)

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5. Are you still menstruating?/ (or, Have you had a menstrual period within the past 12 months?) (Y/N/DK/Not asked) (DON'T KNOW may apply when a woman started hormone therapy prior to a final menstrual period.)  
(Skip, if this was previously answered as NO and the participant is age 65 or older.)

0 No  1 Yes  9 Don't Know  88 Not asked

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5a. If YES, have you had a menstrual period within the past 60 days? (Y/N/DK)

0 No  1 Yes  9 Don't Know

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5b. If YES, would you describe your current menstrual cycle (menstrual periods) as 1) regular without a change in flow or length, 2) regular but with mild changes in flow or length, or 3) variable with a persistent, 7 or more day difference in the length of consecutive cycles (periods)? (Regular/ Mild changes/ Variable)

- 1 Regular: regular without a change in flow or length  
 2 Mild changes: regular but with mild changes in flow or length  
 3 Variable: variable with a persistent, 7 or more day difference in the length of consecutive cycles (periods)
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5c. If NO, how old were you when you had your last period? (years)  
(This age must be at least 1 year less than the current age.)

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