

THE 1989 TREMIN TRUST HEALTH REPORT FORM

ALL QUESTIONS PERTAIN TO 1989 ONLY

BACKGROUND INFORMATION

TODAY'S DATE: _____
(mo/day/yr)

WRITE YOUR ID # HERE

What is your height? _____ ft. _____ in.

What is your weight without shoes? _____ lbs.

What was your marital status as of December 31, 1989? _____

If your marital status changed in 1989, describe previous status:

Date of change: _____

MENSTRUAL/ MENOPAUSAL INFORMATION

Check the item which best describes your menstrual status for 1989:

1. Did you **EVER** menstruate during 1989?

_____ No → Skip to Question # 3

_____ Yes → Proceed to Question # 2

2. Which of the following best describes you? Check all that apply:

_____ I am menstruating and DID NOT use birth control pills at any time during 1989.

_____ I am menstruating and DID use birth control pills at some time during 1989.

_____ I am menstruating, but think I began going through menopause in 1989.

_____ I am postmenopausal and took hormones at some time during 1989 which caused me to menstruate.



Skip to Question # 4

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3. Since you DID NOT menstruate during 1989, which of the following best describes you? Check all that apply:

- I had my uterus removed.
- I had my uterus and ovaries removed.
- I am postmenopausal and have been for several years.
- I went through menopause naturally in 1989.
(no bleeding for one year)
- Other: I did not menstruate because of pregnancy, lactation, strenuous exercise, radiation, drugs, etc.
Please specify. _____

Skip to
Question
7

4. Describe a typical menstrual period for you in 1989. (Describe your bleeding, cramps and other things that you felt or experienced.)

5. Was your last menstrual period similar to the one described above?

- Yes → Skip to Question # 7.
- No → Proceed to Question #6.

6. Describe how your last period was different and what you think happened to make it different.

7. What are your thoughts and feelings about menstruation?

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REPRODUCTIVE INFORMATION

8. Whether or not you had sexual intercourse in 1989, check below all types of birth control used by you or your partner with you, and the months of use.

_____ I DID NOT use any birth control.

_____ I DID use birth control. Check the METHOD used, MONTHS used and briefly state your REASON for choosing to use a certain method. Please think carefully over the entire year

Type of Birth Control	[✓]	Months	Reason for choosing method
Tubal Sterilization			
Hysterectomy			
Vasectomy			
Condom			
Diaphragm			
IUD (Brand Name: _____)			
Sponge			
Foam/Jellies/Creams			
Withdrawal			
Rhythm			
Abstinence			
Birth Control Pills: (Brand Name _____)		(Dose _____)	
Other (Please specify: _____)			

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9. Check the outcome of each pregnancy in 1989 and indicate the date the pregnancy ended.

I WAS NOT pregnant.

I WAS pregnant.



Date	I'm still pregnant	Live Birth	Still Birth	Miscarriage	Abortion	Tubal pregnancy

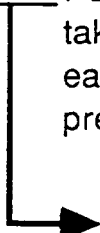
10.

**WHETHER OR NOT YOU ARE MENSTRUATING,
PRE OR POST MENOPAUSAL, READ THE FOLLOWING QUESTION:**

Indicate below by NAME any hormone therapy, for example, estrogen alone (ERT), progesterone alone, or a combination of estrogen and progesterone (HRT), which you took during 1989 for menopause symptoms.

I DID NOT take any hormones for menopausal symptoms during 1989.

I DID TAKE the following medication(s). Indicate below, the HORMONE taken, the DOSE prescribed, the DAYS of the month or how many times each week you took the hormone, and the REASON the hormones were prescribed. Hormone use includes pills, patches and vaginal creams.



Hormone	Dose	Days taken	Reason for taking

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HEALTH INFORMATION

11. List below and name ALL chronic illness(es) or chronic condition(s) which you experienced in 1989. For example: allergies, diabetes, cancer, high blood pressure, heart disease, depression, Parkinson's, etc.

- I DID NOT have any chronic illness(es) or condition(s).
- I DID have the following chronic illness(es) or condition(s).
 Name the ILLNESS/CONDITION and list all prescribed MEDICATIONS.
 Indicate the START and STOP MONTHS.

Illness/Condition	Drug Treatment (Name of drug)	Start Month	Stop Month

12. List below by name ALL surgical procedure(s) performed on you in 1989, major or minor, including dental surgery, appendectomy, hysterectomy, oophorectomy (unilateral or bilateral - please specify), D & C, tubal ligation, and panhysterectomy (uterus and ovaries removed).

- I DID NOT have any surgery performed.
- I DID have surgery performed.
 Name the SURGERY, REASON for the surgery, and the DATE of the surgery.

Surgery	Reason	Date (Month/Day)

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13. Check below all types of radiation exposure you received in 1989 and the date of exposure.

I DID NOT receive any radiation (x-ray) exposure.

I DID receive radiation (x-ray) exposure.

X-Ray	[✓]	Date (Month/Day)
Dental		
Mammogram		
Other (Please specify):		

14. Identify any major source of stress during 1989, such as: job stress, illness, divorce, marriage, change in residence, death of a relative, friend, pet, etc.

I DID NOT experience any major stress.

I DID experience a major stress.

Please describe below, including date(s) of the stress you experienced:
 For example, adjusting to a new job - April to June., death of mother-
 Jan. 14, 1989.

ALL QUESTIONS PERTAIN TO 1989 ONLY

15. Check below the item which best describes the number of cigarettes you smoked per day in 1989.

Cigarettes smoked per day

- None
- Occasional
- 1 to 9
- 10 to 14
- 15 to 19
- 20 to 24
- 25 to 29
- 30 or more

16. Tell us: In your own words, "What does being **HEALTHY** mean to you"?

ALL QUESTIONS PERTAIN TO 1989 ONLY

17. Check [✓] any of the following conditions you experienced in 1989.

CONDITIONS EXPERIENCED IN 1989

- | | | |
|---|---|--|
| <input type="checkbox"/> Weight loss
<input type="checkbox"/> Weight gain
<input type="checkbox"/> Irritability
<input type="checkbox"/> Flooding (vaginal bleeding in a gush)
<input type="checkbox"/> Skin crawls
<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Cold hands/feet
<input type="checkbox"/> Vaginal dryness
<input type="checkbox"/> Can't concentrate
<input type="checkbox"/> Mood changes
<input type="checkbox"/> Crying spells
<input type="checkbox"/> Feeling fright/panic | <input type="checkbox"/> Diarrhea
<input type="checkbox"/> Tiredness
<input type="checkbox"/> Tingling
<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Flooding (with clots)
<input type="checkbox"/> Cold chills
<input type="checkbox"/> Depression
<input type="checkbox"/> Backaches
<input type="checkbox"/> Urinary leakage
<input type="checkbox"/> Excitability
<input type="checkbox"/> Numbness
<input type="checkbox"/> Joint pain | <input type="checkbox"/> Breast pains
<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Feeling suffocated
<input type="checkbox"/> Periodontal disease
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Heart pounding
<input type="checkbox"/> Headaches
<input type="checkbox"/> Bladder infections
<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Worry about nervous breakdown
<input type="checkbox"/> Other, please specify:
_____ |
|---|---|--|

I EXPERIENCED NONE OF THE ABOVE CONDITIONS

CHECK THAT YOUR IDENTIFICATION NUMBER IS ON PG. 1 OF THIS FORM

Thank you for taking time to fill out the 1989 Health Report. We know that we have asked for a lot of information. If you have any concerns about any question, PLEASE write or call. Also, as in the past, your comments are encouraged.

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