

THE 1991 TREMIN TRUST HEALTH REPORT FORM

ALL QUESTIONS PERTAIN TO 1991 ONLY

BACKGROUND INFORMATION

TODAY'S DATE: \_\_\_\_\_  
(mo/day/yr)

WRITE YOUR ID # HERE

What is your height without shoes? \_\_\_\_\_ ft. \_\_\_\_\_ in.

What is your weight without clothing? \_\_\_\_\_ lbs.

What was your marital status as of December 31, 1991? \_\_\_\_\_

If your marital status changed in 1991, describe previous status:

Date of change: \_\_\_\_\_

MENSTRUAL/ MENOPAUSAL  
INFORMATION

Check the item which best describes your menstrual status for 1991:

1. Did you **EVER** menstruate during 1991?

\_\_\_\_\_ 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 1991.

\_\_\_\_\_ I am menstruating and DID use birth control pills at some time during 1991.

\_\_\_\_\_ I am menstruating, but think I began going through menopause in 1991.

\_\_\_\_\_ I am postmenopausal and took hormones at some time during 1991 which caused me to menstruate.

Skip to  
Question  
# 4

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3. Since you DID NOT menstruate during 1991, 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 (no bleeding for one year) naturally in 1990 or 1991. (circle the year)
- I am taking hormones and not bleeding.
- 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 1991. (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 1991, 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 1991 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

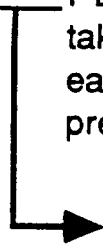
10.

**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 1991 for menopause symptoms.

I DID NOT take any hormones for menopausal symptoms during 1991.

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 1991. For example: allergies, diabetes, cancer, high blood pressure, heart disease, depression, Parkinson's, etc.

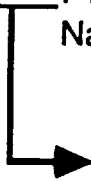
- I DID NOT have any chronic illness(es) or condition(s).
- I DID have the following chronic illness(es) or condition(s).  
Name the ILLNESS/CONDITION and list all prescribed MEDICATIONS. Indicate the START and STOP MONTHS.



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

12. List below by name ALL surgical procedure(s) performed on you in 1991, 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 1991 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 1991, 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, 1991.

ALL QUESTIONS PERTAIN TO 1991 ONLY

15. Check below the item which best describes the number of cigarettes you smoked per day in 1991.

Cigarettes smoked per day
<input type="checkbox"/> None
<input type="checkbox"/> Occasional
<input type="checkbox"/> 1 to 9
<input type="checkbox"/> 10 to 14
<input type="checkbox"/> 15 to 19
<input type="checkbox"/> 20 to 24
<input type="checkbox"/> 25 to 29
<input type="checkbox"/> 30 or more

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

**ALL QUESTIONS PERTAIN TO 1991 ONLY**

17. Check [ ] any of the following conditions you experienced in 1991.

**CONDITIONS EXPERIENCED IN 1991**

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

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 1991 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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