

THE TREMIN TRUST HEALTH REPORT FORM  
1995

BACKGROUND INFORMATION

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

\* WRITE YOUR ID NUMBER

What is your height without shoes? \_\_\_\_\_ ft. \_\_\_\_\_ in. and weight without clothing? \_\_\_\_\_ lbs.

Did your marital status changed in 1995? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, describe previous status: \_\_\_\_\_ and date of change: \_\_\_\_\_

MENSTRUAL/ MENOPAUSAL  
INFORMATION

Check the item which best describes your menstrual status for 1995:

1. Did you EVER menstruate during 1995?

Yes ➔ Proceed to Question #2

No ➔ Skip to Question #3

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 1995.

I am menstruating and DID use birth control pills at some time during 1995.

I am menstruating, but think I began going through menopause in 1995.

I am postmenopausal and took hormones at some time during 1995 which caused me to menstruate.

Skip to  
Question  
#3 below

3. Since you DID NOT menstruate during 1995, 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 1994 or 1995 (circle the year).

I am taking hormones and not bleeding.

Other: I did not menstruate because of pregnancy, lactation, strenuous exercise, radiation, drug, etc. Please specify: \_\_\_\_\_

Skip to  
Question  
#4 on  
next page

4. Describe a typical menstrual period for you in 1995. Describe your bleeding cramps, and anything else you felt or experienced. You need not restrict your answer to the space below; use a separate sheet of paper if needed.

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

- Yes → **Skip to Question # 7 below**  
 No → **Proceed to Question # 6 below**

6. Describe how your last period was different and what you think happened to make it different. You need not restrict your answer to the space below; use a separate sheet of paper if needed.

7. What are your thoughts and feelings about menstruation? You need not restrict your answer to the space below; use a separate sheet of paper if needed.

REPRODUCTIVE INFORMATION

8. Check the outcome of each pregnancy in 1995 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

9. Whether or not you had sexual intercourse in 1995, 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. —▶ **Skip to Question # 10 below**

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	[ V ]	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):	
Others (Please specify):			

10. 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 1995 for menopause symptoms.

I DID NOT take any hormones for menopausal symptoms during 1995.

—▶ **Skip to Question # 11 on next page**

I DID TAKE the following medication(s). Indicate below, the HORMONE taken, the DOSE prescribed, the DAYS of the month (1-25) or how many times each week you took the hormone (that is 4 days on, 3 days off), and the REASON the hormones were prescribed. Hormone use includes pills, patches and vaginal creams.

Hormone	Dose	Days of month or Days per week taken	Reason for taking

## HEALTH INFORMATION

11. List below and name ALL chronic illness(es) or chronic condition(s) which you experienced in 1995. 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). —▶ **Skip to Question # 12 below**
- 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 or Condition	Drug Treatment (Name of drug)	Start Month	Stop Month

12. List below by name ALL surgical procedure(s) performed on you in 1995, major or minor, including dental surgery, appendectomy, hysterectomy, removal of one or both ovaries (please specify), D & C, tubal ligation, and panhysterectomy (uterus and ovaries removed).

- I DID NOT have any surgery performed. —▶ **Skip to Question # 13 below**
- I DID have surgery performed. Name the SURGERY, REASON for the surgery, and the DATE of the surgery.

Surgery	Reason	Date (Month/Day)

13. Check below all types of radiation exposure you received in 1995 and the date of exposure.

- I DID NOT receive any radiation (x-ray) exposure. —▶ **Skip to Question # 14 on next page**
- I DID receive any radiation (x-ray) exposure.

X-Ray	[ V ]	Date (Month/Day)

14. Check [ V ] any major source of stress during 1995.

I DID NOT experience any major stress. → **Skip to Question # 15 below**

I DID experience a major stress.

Stress	[ V ]		[ V ]
Job Loss		Move	
Job-related		Illness	
Divorce		Financial	
Marriage		Illness of Family Member	
Death of Family Member (please specify): _____		Other (Please specify): _____	

15. Check [ V ] any of the following conditions you experienced in 1995.

Condition	[ V ]	Condition	[ V ]	Condition	[ V ]	Condition	[ V ]
Weight loss		Tiredness		Breast pains		Flooding (vaginal bleeding in a gush)	
Weight gain		Tingling		Vaginal infections		Flooding with clots	
Irritability		Dizzy spells		Feeling suffocated		Feeling fright/panic	
Skin crawls		Cold chills		Periodontal disease		Worry about nervous breakdown	
Forgetfulness		Depression		Insomnia		Other (Please specify):	
Cold hands/feet		Backaches		Heart pounding		I experienced none of the above	
Vaginal dryness		Urinary leakage		Headaches			
Mood changes		Excitability		Bladder infections			
Crying spells		Numbness		Hot flashes			
Diarrhea		Joint pain		Can't concentrate			

16. Estimate to the best of your ability the number of cigarettes you smoked per day in 1995? \_\_\_\_\_

17. Tell us: In your own words, "What does being HEALTHY mean to you"? You need not restrict your answer to the space below; use a separate sheet of paper if needed.

**PLEASE CHECK THAT YOUR IDENTIFICATION NUMBER IS ON PAGE 1 OF THIS FORM.**

Thank you for taking time to fill out the 1995 Health Report. We know that we have asked for a lot of information. As in the past, your comments are encouraged.

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