

Participant ID # \_\_\_\_\_

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_



## The 2004 TREMIN Program Health Report Form

**Instructions:** Before you answer the health report questions please **write your ID number and today's date** in the space provided above (your ID number is on the first line of your address label). Next, fill out the Health Report Form according to the directions provided prior to each question. Return the completed Health Report Form in the addressed envelope that has been provided in this mailing. We remind you that you do not have to answer a particular question if you do not want to. Thank you in advance for taking the time to fill out this form.

1. What is your birth date? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  
2. Indicate your current menstrual status by checking the box next to the most appropriate description (Be sure to read all of the choices first).
  - I began menstruating this year (skip to #4)
  - My periods are regulated by my hormonal birth control method (skip to #4)
  - I am menstruating in my regular pattern (skip to #4)
  - I have had a hysterectomy and no longer menstruate (skip to #4)
  - My periods are changing in amount, length, spacing, etc. (continue with #3)
  - I have not menstruated for 3-12 months (continue with #3)
  - I have not menstruated for 12 months or more (continue with #3)
  
3. Here is a list of reasons why women's periods might change/stop. Read all the choices and then check the box next to every description that applies to you.
  - MENOPAUSE – No bleeding for 12 months or more
  - APPROACHING MENOPAUSE
  - PREGNANT
  - BREASTFEEDING
  - STRENUOUS EXERCISE
  - SERIOUS ILLNESS
  - MEDICATION INDUCED
  - STRESS
  - NOT SURE
  - DIET CHANGE/EATING DISORDER
  - OTHER \_\_\_\_\_

4. Did you use any of the following hormones in 2003? Check the no or yes box for each item. Then, for every hormone that you did use, please record, to the best of your knowledge, the date you began using and the date you stopped using the hormone(s). If you are still using the hormone(s), write "ongoing" for the stop date.

HORMONE	NO	YES	START DATE	STOP DATE
<b>Menopausal Hormones</b>				
Estrogen Dose _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Progestin Dose _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Combination (Estrogen/Progestin)	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Natural Progesterone	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
<b>Birth control</b>				
Depo Provera	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Birth control pill Dose _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Seasonale	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Ortho Evra patch Dose _____	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Mirena IUD/ParaGard-T380A	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
NuvaRing (vaginal ring)	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Emergency contraceptive pill	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
<b>Other</b>				
Testosterone (Androgen)	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Tamoxifen	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____
Raloxifene (Evista)	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____	____/____/____

5. For 2003 indicate how often you experienced each item:

	NEVER	RARELY	OCCASIONALLY	OFTEN
Increased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall health improvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling calm/focused	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling attractive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling satisfied with life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder or back pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. continued...	NEVER	RARELY	OCCASIONALLY	OFTEN
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness/pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes/swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling depressed/having the blues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling frightened/panicked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crying spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling worried/nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired/fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling unattractive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart pounding/racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin crawls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial hair growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. For the years 2002 or 2003, please indicate whether or not you experienced the following conditions by checking the no or yes box. If you did experience the condition please record, to the best of your knowledge, the start and stop dates of the condition. If the condition is ongoing, write "ongoing" for the stop date.

NO	YES	CONDITION	START DATE	STOP DATE
<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Endometrial cancer	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cancer	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Cervical cancer	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Fibroid tumors	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	____/____/____	____/____/____

## 6. continued...

NO	YES	CONDITION	START DATE	STOP DATE
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory illness	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	HIV /AIDS	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted infection (STI)	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Cervical dysplasia	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's disease	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel syndrome	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Periodontal disease	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Ménière's	____/____/____	____/____/____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____	____/____/____	____/____/____

## 7. Overall, how would you rate your physical and emotional health in the last year or two?

## 7a. Physical (circle one):

- 1 VERY POOR
- 2 POOR
- 3 FAIR
- 4 GOOD
- 5 VERY GOOD/EXCELLENT

## 7b. Emotional (circle one):

- 1 VERY POOR
- 2 POOR
- 3 FAIR
- 4 GOOD
- 5 VERY GOOD/EXCELLENT

## 8. In 2002 or 2003 were you pregnant? (check appropriate box)

- NO (skip to #10)
- YES (continue with #9)

9. If in 2002 or 2003 you were pregnant, check the box to the left of the outcome of each pregnancy and record, to the best of your knowledge, the date the outcome occurred.

OUTCOME	OUTCOME DATE
<input type="checkbox"/> STILL PREGNANT	<u>XX / XX / XX</u>
<input type="checkbox"/> LIVE BIRTH 1	<u>   /   /   </u>
<input type="checkbox"/> LIVE BIRTH 2	<u>   /   /   </u>
<input type="checkbox"/> STILL BIRTH 1	<u>   /   /   </u>
<input type="checkbox"/> STILL BIRTH 2	<u>   /   /   </u>
<input type="checkbox"/> MISCARRIAGE 1	<u>   /   /   </u>
<input type="checkbox"/> MISCARRIAGE 2	<u>   /   /   </u>
<input type="checkbox"/> ABORTION 1	<u>   /   /   </u>
<input type="checkbox"/> ABORTION 2	<u>   /   /   </u>
<input type="checkbox"/> ECTOPIC PREGNANCY 1	<u>   /   /   </u>
<input type="checkbox"/> ECTOPIC PREGNANCY 2	<u>   /   /   </u>

10. Check the box next to the description that reflects your highest level of education:

- GRADE SCHOOL
- SOME HIGH SCHOOL
- HIGH SCHOOL DEGREE/GED
- TECHNICAL/VOCATIONAL SCHOOL
- SOME COLLEGE
- COLLEGE DEGREE
- POST-GRADUATE WORK

11. In 2003 what was your total household income (check the box next to the best description)? If you are under 18, check here  , and skip this question.

- LESS THAN \$15,000
- \$15,000-25,000
- \$25,001-50,000
- \$50,001-75,000
- \$75,001-100,000
- \$100,001-125,000
- \$125,001-150,000
- MORE THAN \$150,000

12. Check the box next to the answer(s) that best describe(s) you:

- NATIVE AMERICAN
- ALASKAN NATIVE
- AFRICAN AMERICAN/BLACK
- ASIAN/PACIFIC
- LATINA/HISPANIC
- NON-HISPANIC WHITE
- OTHER \_\_\_\_\_

13. Check the box next to the description that best reflects your current status:

- MARRIED
- SINGLE (NEVER MARRIED)
- DIVORCED / SEPARATED
- WIDOWED

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For those of you 18 and over, please continue with the next questions. **If you are under 18**, you have completed the 2004 TREMIN Health Report Form. Please stop here. We are very grateful to you for taking the time to answer this survey. If there is anything else you'd like to tell us, feel free to attach additional sheets. Please place this Form into the pre-addressed envelope with your Confidential Information and Referral Form and your 2003-2004 Menstrual Calendar Card, affix a 60 cent stamp, and mail them to us.

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14. Have you been in any relationship (marital, sexual, and/or romantic) in the **past month**?

- NO (skip to #19)
- YES (continue with #15)

15. Indicate the start and stop date of your primary or only relationship. If the relationship is ongoing, write "ongoing" for the stop date.

START DATE  
\_\_\_\_/\_\_\_\_/\_\_\_\_

STOP DATE  
\_\_\_\_/\_\_\_\_/\_\_\_\_

16. Is/was this partner (check one)?

- MALE
- FEMALE

17. Do you live/did you live with this partner (check one)?

- NO
- YES

18. How satisfied are/were you overall in your relationship (check one)?

- VERY DISSATISFIED
- SOMEWHAT DISSATISFIED
- NEITHER DISSATISFIED NOR SATISFIED
- SOMEWHAT SATISFIED
- VERY SATISFIED

19. Below is a list of different sexual responses people may have, even if they are not in a relationship, categorized by type of activity. Circle the number that best describes the *strength of your feelings* in responding to each form of sexual expression. Imagine the scale being a continuum with '1' being nonexistent feelings, '5' being moderate feelings, and '9' being very strong feelings. Circle 'N/A,' not applicable, if the statement does not apply to you.

<b>RATING SCALE</b>									
1	2	3	4	5	6	7	8	9	N/A
NONEXISTENT.....				MODERATE.....			VERY STRONG		

**TYPE OF ACTIVITY**

**STRENGTH OF FEELINGS**

**1. Nongenital sexual activity with a partner**

**(hugging, kissing, caressing, etc.)**

- |                                   |   |   |   |   |   |   |   |   |   |     |
|-----------------------------------|---|---|---|---|---|---|---|---|---|-----|
| a. Desire it                      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| b. Aroused (turned on) by it      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| c. Enjoy it                       | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| d. Intensity of orgasm from it    | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| e. Physical satisfaction from it  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| f. Emotional satisfaction from it | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |

**2. Genital sexual activity with a partner**

- |                                   |   |   |   |   |   |   |   |   |   |     |
|-----------------------------------|---|---|---|---|---|---|---|---|---|-----|
| g. Desire it                      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| h. Aroused (turned on) by it      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| i. Enjoy it                       | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| j. Intensity of orgasm from it    | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| k. Physical satisfaction from it  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| l. Emotional satisfaction from it | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |

**3. Fantasies without a partner**

- |                                     |   |   |   |   |   |   |   |   |   |     |
|-------------------------------------|---|---|---|---|---|---|---|---|---|-----|
| m. Desire them                      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| n. Aroused (turned on) by them      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| o. Enjoy them                       | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| p. Intensity of orgasm from them    | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| q. Physical satisfaction from them  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| r. Emotional satisfaction from them | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |

**4. Masturbation without a partner**

- |                                   |   |   |   |   |   |   |   |   |   |     |
|-----------------------------------|---|---|---|---|---|---|---|---|---|-----|
| s. Desire it                      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| t. Aroused (turned on) by it      | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| u. Enjoy it                       | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| v. Intensity of orgasm from it    | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| w. Physical satisfaction from it  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |
| x. Emotional satisfaction from it | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | N/A |

20. Do you experience pain during genital sex (check the box next to the appropriate answer)?

- NOT APPLICABLE-DO NOT HAVE GENITAL SEX
- NO
- SOME
- MODERATE
- SEVERE

21. Thinking about when you were involved in genital activities with your partner in the last month:

**How often did you have an orgasm?**

- NOT APPLICABLE-DID NOT HAVE GENITAL ACTIVITIES
- ALMOST NEVER/NEVER
- LESS THAN 1/2 THE TIME
- ABOUT 1/2 THE TIME
- MORE THAN 1/2 THE TIME
- ALMOST ALWAYS/ALWAYS

**How easy or difficult was it to have an orgasm?**

- NOT APPLICABLE-DID NOT HAVE GENITAL ACTIVITIES
- VERY DIFFICULT
- SOMEWHAT DIFFICULT
- NEITHER DIFFICULT OR EASY
- SOMEWHAT EASY
- VERY EASY

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**\*\*Congratulations! You have completed the TREMIN 2004 Health Report Form. We are very grateful to you for taking the time to answer this survey. If there is anything else you'd like to tell us, feel free to use the space below or attach additional sheets. Now that you are finished, place this Form into the pre-addressed envelope with your Confidential Information and Referral Form and your 2003-2004 Menstrual Calendar Card, affix a 60 cent stamp, and mail them to us.**

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