Study ID#: _____

Date of Interview: /__/__/ /__/__/ /__/__/__/__/
(Month) (Day) (Year)

Interviewer: _____

MEDICAL AND REPRODUCTIVE HISTORY QUESTIONNAIRE

(HORMONE MEDICATION HISTORY)

OF THE

BREAST CANCER COMPREHENSIVE PROJECT

Prepared for the National Action Plan on Breast Cancer
of the Office on Women's Health
U.S. Department of Health and Human Services

by

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MAY 1998

HORMONE MEDICATION HISTORY

Now I have some questions about hormone medications that you many have used before, during, or after menopause. Do not include any birth control pills, shots, or implants we've already discussed.

Q1. Before (REFERENCE DATE), did you ever use any prescription medications for (SYMPTOM)?	Q2. What was the name of the hormone medication you used? (SHOW CARD)	Q3. What was the month and year when you first used (HORMONE)?	Q4. Did you take (HORMONE) as a pill, shot, skin patch, or vaginal cream or suppository?	Q5. If Q4=1, Did you take (HORMONE) ever day or in cycles?	Q6. If Q4=2, How many times per week, month, or year, did you get a shot?	Q7. If Q4=3, How many times per week, month, or year, did you change your patch?
a. Irregular menstrual bleeding? YES … 1 ➜ NO … 5 (Q1b.)	_____ HORMONE	☐☐ ☐☐ MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
b. heavy menstrual bleeding? YES … 1 ➜ NO … 5 (Q1c.)	_____ HORMONE	☐☐ ☐☐ MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
c. delay of menopause or the change of life? YES … 1 ➜ NO … 5 (Q1d.)	_____ HORMONE	☐☐ ☐☐ MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
d. hot flashes? YES … 1 ➜ NO … 5 (Q1e.)	_____ HORMONE	☐☐ ☐☐ MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3

Q1. Before (REFERENCE DATE), did you ever use any prescription medications for (SYMPTOM)?	Q2. What was the name of the hormone medication you used? (SHOW CARD)	Q3. What was the month and year when you first used (HORMONE)?	Q4. Did you take (HORMONE) as a pill, shot, skin patch, or vaginal cream or suppository?	Q5. If Q4=1, Did you take (HORMONE) ever day or in cycles?	Q6. If Q4=2, How many times per week, month, or year, did you get a shot?	Q7. If Q4=3, How many times per week, month, or year, did you change your patch?
e. sweating? YES … 1 ➜ NO … 5 (Q1f.)	_____ HORMONE	☐☐ ☐☐ MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
f. vaginal dryness? YES … 1 ➜ NO … 5 (Q1g.)	_____ HORMONE	☐☐ ☐☐ MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
g. bladder problems? YES … 1 ➜ NO … 5 (Q1h.)	_____ HORMONE	☐☐ ☐☐ MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
h. depression, anxiety, or emotional distress? YES … 1 ➜ NO … 5 (Q1i.)	_____ HORMONE	☐☐ ☐☐ MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3

Q1. Before (REFERENCE DATE), did you ever use any prescription medications for (SYMPTOM)?	Q2. What was the name of the hormone medication you used? (SHOW CARD)	Q3. What was the month and year when you first used (HORMONE)?	Q4. Did you take (HORMONE) as a pill, shot, skin patch, or vaginal cream or suppository?	Q5. If Q4=1, Did you take (HORMONE) ever day or in cycles?	Q6. If Q4=2, How many times per week, month, or year, did you get a shot?	Q7. If Q4=3, How many times per week, month, or year, did you change your patch?
i. a medication after hysterectomy or removal of the ovaries? YES … 1 ➜ NO … 5 (Q1j.)	_____ HORMONE	MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
j. prevention or treatment of bone loss or osteoporosis? YES … 1 ➜ NO … 5 (Q1k.)	_____ HORMONE	MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/ SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
k. prevention or treatment of heart disease or cardiovascular disease? YES … 1 ➜ NO … 5 (Q1l.)	_____ HORMONE	MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3
l. other uses just before menopause, during menopause, or after menopause? YES … 1 ➜ NO … 5 (Q1m.)	_____ HORMONE	MONTH YEAR	PILL ... 1 SHOT … 2 SKIN PATCH … 3 VAG. CREAM/SUPP. … 4	EVERYDAY … 1 IN CYCLES … 2 (SPECIFY) _____ _____	NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3

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HORMONE MEDICATION HISTORY

Now I have some questions about hormone medications that you many have used before, during, or after menopause. Do not include any birth control pills, shots, or implants we've already discussed.

Q8. If Q4=4, How many times per week, month, or year did you use (HORMONE)?	Q9. And, how many applicatorfuls did you use each time? Was it less than, equal to or greater than 1 applicator?	Q10. In what month and year did you stop using (HORMONE), or change its dose or pattern of use?	Q11. Why did you stop using (HORMONE)?	Q12. Did you have any complications or side effects when using (HORMONE)?	Q13. If Q4=1, Did you use (HORMONE) in combination with one of these other hormones?
☐☐ NO. TIMES PER WEEK … 1 PER MONTH … 2 PER YEAR … 3	LESS THAN 1…….1 GREATER THAN 1...2 EQUAL TO 1……..…3	☐☐ ☐☐ MONTH YEAR CURRENT…95 (Q12)	COMPL/SIDE EFFECTS……. 1 FEAR……2 NO LONGER NEEDED/ TREATMENT COMPLETED…. 3 TOO EXPENSIVE/NO LONGER AVAILABLE……..4 DISEASE (SPECIFY)._____ 5 DIDN'T LIKE…… 6 NEEDED DIFFERENT DOSAGE OR BRAND…….....7 OTHER (SPECIFY)…….. 88 _____ [__ __] DK……99	NO COMPL/SIDE EFFECTS……... 1 VAGINAL BLEEDING…..……..... 2 BREAST TENDER/ DISCHARGE... 3 HEADACHE/DIZZY……..... 4 WEIGHT CHANGES…… 5 DEPRESSION/IRRITABILITY …... 6 WATER RETEN/SWELLING IN HANDS/FEET/FACE…… 7 NAUSEA…….. 8 OTHER (SPECIFY)…….88 _____ [__ __] DK……....99	YES…1 → Which one? _____ HORMONE (COMPLETE ATTACHED CHART) NO…5
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MONTHLY CYCLE CALENDAR

Q14. ASK FOR EACH Q13 = 1 (YES). During the (first/next) time period when you were using two hormones during the same month, on which days did you usually use the (ESTROGEN) and on which days did you usually use the (PROGESTIN)? CIRCLE FIRST AND LAST LETTERS FOR EACH HORMONE. THEN CONNECT FIRST TO LAST WITH A LINE.

DAY OF THE MONTH	ESTROGEN CODE PROGESTIN CODE		ESTROGEN CODE PROGESTIN CODE		ESTROGEN CODE PROGESTIN CODE		ESTROGEN CODE PROGESTIN CODE	
	CONTIN **E** **P** USE DAY: BEGIN ___ ___ ___ ___ END___ ___ ___ ___		CONTIN **E** **P** USE DAY: BEGIN ___ ___ ___ ___ END___ ___ ___ ___		CONTIN **E** **P** USE DAY: BEGIN ___ ___ ___ ___ END___ ___ ___ ___		CONTIN **E** **P** USE DAY: BEGIN___ ___ ___ ___ END___ ___ ___ ___	
1	E	P	E	P	E	P	E	P
2	E	P	E	P	E	P	E	P
3	E	P	E	P	E	P	E	P
4	E	P	E	P	E	P	E	P
5	E	P	E	P	E	P	E	P
6	E	P	E	P	E	P	E	P
7	E	P	E	P	E	P	E	P
8	E	P	E	P	E	P	E	P
9	E	P	E	P	E	P	E	P
10	E	P	E	P	E	P	E	P
11	E	P	E	P	E	P	E	P
12	E	P	E	P	E	P	E	P
13	E	P	E	P	E	P	E	P
14	E	P	E	P	E	P	E	P
15	E	P	E	P	E	P	E	P
16	E	P	E	P	E	P	E	P
17	E	P	E	P	E	P	E	P
18	E	P	E	P	E	P	E	P
19	E	P	E	P	E	P	E	P
20	E	P	E	P	E	P	E	P
21	E	P	E	P	E	P	E	P
22	E	P	E	P	E	P	E	P
23	E	P	E	P	E	P	E	P
24	E	P	E	P	E	P	E	P
25	E	P	E	P	E	P	E	P
26	E	P	E	P	E	P	E	P
27	E	P	E	P	E	P	E	P
28	E	P	E	P	E	P	E	P
29	E	P	E	P	E	P	E	P
30	E	P	E	P	E	P	E	P
31	E	P	E	P	E	P	E	P

HORMONE MEDICATIONS*

Amen	Estratest	Norlutin
Amnestrogen	Estrocon	Nor-Q-D
Aygestin	Estrogen	Ogen
Conjugated estrogen	Estrovis	Ortho-Est
Curretab	Evex	PMB
Cycrin	Gynetone	Premarin
Delalutin	Gynorest	Progesterone
Depo-provera (DMPA)	Hormonin	Provera
DES (Diethylstilbestrol)	Mediatric	Provest
Estinyl	Medroxyprogesterone (MPA)	SK-Estrogen
Estrace	Menest	Stilbestrol
Estraderm	Menrium	Tace
Estratab	Norlutate	Zeste
		Other hormone (SPECIFY)

*Use of trade names is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services or the Public Health Service.

Medications To Help You Become Pregnant

Clomid

Clomiphene Citrate

Danazol

Danocrine

HCG

Lupron Depot

Milophene

Nolvadex (Tamoxifen)

Pergonal

Serophene

Synarel Nasal Solution

Other (SPECIFY)

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