



WOMEN'S HEALTH RESEARCH REGISTRY

Section A: Demographics

A1. Patient's name: \_\_\_\_\_
First MI Last

Preferred Title?

- checkbox Mrs.
checkbox Miss
checkbox Ms.
checkbox Dr.
checkbox Rev.
checkbox Other: \_\_\_\_\_
checkbox None

A2. Address: \_\_\_\_\_
Street number Street Name
Apt. number

A3. City: \_\_\_\_\_

A4. State: \_\_\_\_\_

A5. Zip: \_\_\_\_\_

A6. 1st phone: ( ) \_\_\_\_\_ - \_\_\_\_\_
checkbox Home
checkbox Cell
checkbox Work

A7. 2nd phone: ( ) \_\_\_\_\_ - \_\_\_\_\_
checkbox Home
checkbox Cell
checkbox Work

A8. 3rd phone: ( ) \_\_\_\_\_ - \_\_\_\_\_
checkbox Home
checkbox Cell
checkbox Work

A9. E-mail: \_\_\_\_\_

A10. Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Month/Day/Year

A11. How did you first learn about the Registry: (check all that apply)
Friend or family member
Advertisement
Doctor or health care professional
Internet
Other (specify): \_\_\_\_\_
checkbox Choose not to answer

A12. What ethnicity to you consider yourself to be: (check all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White (*not Hispanic or Latina*)
- Hispanic or Latina
- Other (specify): \_\_\_\_\_
- Choose not to answer

A12i. If you chose more than one response above, please indicate which of those you consider to be your primary ethnic background (choose only one).

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other

A13. Are you currently (check all that apply):

- Employed for wages
- Currently seeking work
- Homemaker
- Student
- Retired
- Disabled/unable to work
- Other: \_\_\_\_\_
- Choose not to answer

A14. Do you live alone?

- Yes->Skip to A16
- No
- Choose not to answer

A15. With whom do you live (check all that apply)?

- Husband/Partner
- Children
- Parents
- Other relatives, friends, roommates
- Choose not to answer

A16. Current legal marital status (check only one):

- Married
- Separated
- Divorced
- Widowed
- Never married
- Choose not to answer

- A17. Sexual Orientation (check only one):
- Heterosexual
  - Bisexual
  - Lesbian
  - Choose not to answer
- A18. Insurance type (check all that apply):
- Private insurance/HMO/PPO/POS
  - Medicare
  - Medicaid/Medi-Cal
  - Do not have insurance
  - Do not know
  - Choose not to answer
- A19. Education (check highest level attained):
- Less than high school
  - Some high school
  - High school diploma
  - Some college
  - Bachelor degree
  - Post graduate training
  - Other: \_\_\_\_\_
  - Choose not to answer
- A20. About how long has it been since you last visited a doctor for a routine checkup?
- Less than 1 year ago
  - 1-2 years ago
  - 3-5 years ago
  - More than 5 years
  - Do not know
  - Choose not to answer

**END OF SECTION A**

**This section of the questionnaire will be separated from the remaining sections.**

**Section B: General History**

- B1. Would you say your health in general is:
- Excellent
  - Very good
  - Good
  - Fair
  - Poor
  - Choose not to answer
- B2. During the PAST 30 DAYS, how many days did POOR physical or mental health prevent you from doing your usual activities, such as self-care, work, or recreation?  
 Days (0 to 30) Choose not to answer
- B3. How much do you weigh without your shoes?  
 \_\_\_\_\_ Pounds Choose not to answer
- B4. How tall are you without your shoes?  
 \_\_\_\_\_ feet \_\_\_\_\_ inches Choose not to answer
- B5. Do you smoke cigarettes?
- Every day
  - Some days
  - Used to smoke but quit
  - Never smoke
  - Choose not to answer
- B6. Do you drink alcoholic beverages?
- Yes
  - No->skip to B7
  - Choose not to answer->skip to B7
- B6i. If 'yes,' how many alcoholic drinks did you have during the past 30 days?  
 \_\_\_\_\_ drinks
- B7. How much time do you spend engaging in **moderate** physical activity during an average week? This might include activities such as walking, gardening, or light home maintenance.  
 \_\_\_\_\_ hours \_\_\_\_\_ minutes
- B8. How much time do you spend engaging in **vigorous** physical activity during an average week? This might include activities such as jogging, biking, or heavy home maintenance.  
 \_\_\_\_\_ hours \_\_\_\_\_ minutes
- B9. Are you currently taking medication?
- Yes
  - No
- B9i. If yes, please list:

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**END OF SECTION B**

**Section C: Gynecological History**

- C1. Are you currently pregnant?
- Yes
  - No->skip to C2
  - Choose not to answer->skip to C2
- C1a. If 'yes,' when is your due date? \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Month/Day/Year

- C2. Please describe your pregnancies. How many times have you been pregnant?  
\_\_\_\_\_ If '0,' please skip to C7 Choose not to answer
- C2a. How many of these pregnancies were live births?  
\_\_\_\_\_ If '0,' please skip to C3 Choose not to answer
- C2b. How many of your live births were vaginal births?  
\_\_\_\_\_ Choose not to answer
- C2c. How many of your live births were Cesarean births?  
\_\_\_\_\_ Choose not to answer
- C3. How many of your pregnancies resulted in miscarriages?  
\_\_\_\_\_ Choose not to answer
- C4. How many of your pregnancies resulted in still births?  
\_\_\_\_\_ Choose not to answer
- C5. How many of your pregnancies resulted in elective abortions?  
\_\_\_\_\_ Choose not to answer
- C6. During your pregnancies, did you experience any of the following (check all that apply)?  
Pre-term labor Pre-eclampsia  
Gestational diabetes Post-partum depression  
Multiple pregnancies (twins, triplets, etc.)  
Bleeding during 3<sup>rd</sup> trimester  
None Choose not to answer
- C7. Have you had your uterus removed?  
 Yes  
 No  
 Choose not to answer
- C8. Have you had any of your ovaries removed?  
 Yes, one ovary  
 Yes, both ovaries ->skip to C10  
 No  
 Choose not to answer
- C9. How long has it been since your last period or menstrual cycle?  
 Within the past 2 months  
 From 2 months to 1 year  
 1-2 years ago  
 2-5 years ago  
 More than 5 years ago  
 Never had a period  
 Do not know  
 Choose not to answer
- C10. Are you menopausal?  
 Yes  
 No  
 Do not know/not sure  
 Choose not to answer
- C11. Have you EVER taken menopause hormone therapy?  
 Yes  
 No  
 Choose not to answer

- C12. Do you currently use any of the following treatments (check all that apply)?
- |                               |                        |
|-------------------------------|------------------------|
| Birth control pill            | Birth control patch    |
| Depo Provera                  | Norplant implants      |
| Emergency contraception pills | Oral progesterone only |
| Estrogen                      | Estrogen-Progesterone  |
| Soy or herbal remedies        | Testosterone           |
| Estrogen-Testosterone         | Raloxifene (Evista)    |
| None currently                | Choose not to answer   |
- C13. During the last year, did you experience any of the following symptoms? (check all that apply)
- |   |                             |
|---|-----------------------------|
| Painful menses or period (menstrual cramps) |                             |
| Prolonged/heavy menses or period            | Irregular or absent periods |
| Vulvar pain                                 | Pain with intercourse       |
| Reduced libido                              | Generalized pelvic pain     |
| Mood swings                                 | Vaginal dryness             |
| Severe hot flashes                          |                             |
| None  | Choose not to answer        |
- C14. Have you ever been diagnosed with any of the following gynecological or bladder disorders? (check all that apply)
- |  |                      |
|--|----------------------|
| PMS (Premenstrual Syndrome)/PMDD (Premenstrual Dysphoric Disorder) |                      |
| Fibroids   | Endometriosis        |
| Infertility  | Abnormal Pap Smear   |
| Polycystic ovarian syndrome  | Ectopic pregnancies  |
| Uterine prolapse   | Uterine polyps       |
| Interstitial cystitis  | Pelvic adhesions     |
| Frequent yeast infections (greater than 3 per year)                |                      |
| Frequent vaginal infections (greater than 3 per year)              |                      |
| Hematuria (blood in the urine)                                     |                      |
| Nocturia (waking up at night more than twice just to urinate)      |                      |
| Other (specify): _____   |                      |
| None   | Choose not to answer |
- C15. Within the last year, have you experienced any of the following bladder disorders? (check all that apply)
- |   |                          |
|---|--------------------------|
| Urinary retention   | Urinary incontinence     |
| Urinary frequency   | Bladder spasm or urgency |
| Bladder prolapse  |                          |
| Frequent urinary tract infections (greater than 3 per year) |                          |
| Other (specify): _____                                      |                          |
| None  | Choose not to answer     |
- C16. Have you ever had any of the following sexually transmitted diseases? (check all that apply)
- |  |                        |
|--|------------------------|
| Genital herpes                               |                        |
| Human papilloma virus (HPV) or genital warts |                        |
| Pelvic inflammatory disease                  | Gonorrhea              |
| Chlamydia                                    | Syphilis               |
| Trichomoniasis                               | Other (specify): _____ |
| None   | Choose not to answer   |

**END OF SECTION C**

**Section D: Cancer**

D1. Have you ever had any of the following types of cancer? (check all that apply)

- |  |                  |
|--|------------------|
| Bladder                                    | Bone             |
| Brain                                      | Breast           |
| Cervical                                   | Colon            |
| Endometrial                                | Esophagus        |
| Head (not brain), neck, oral cavity tumors |                  |
| Kidney                                     | Leukemia         |
| Liver                                      | Lung             |
| Lymphoma                                   | Multiple myeloma |
| Ovarian                                    | Pancreatic       |
| Skin                                       | Stomach          |
| Thyroid                                    | Uterine          |
- Other (specify): \_\_\_\_\_

- Choose not to answer  
None->Skip to E1

D2. Have you ever had any of the following cancer treatments? (check all that apply)

- Radiation
- Surgical treatment
- Bone marrow transplant
- Chemotherapy
- Other (specify): \_\_\_\_\_
- Do not know
- Choose not to answer

**END OF SECTION D**

**Section E: Allergies**

E1. Do you have allergies to any of the following items? (check all that apply)

- Food (specify) \_\_\_\_\_
- Drugs
- Animal
- Latex
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer

**END OF SECTION E**

**Section F: Respiratory**

F1. Have you ever had any of the following respiratory disorders? (check all that apply)

- Asthma
- Chronic bronchitis
- Emphysema
- Chronic obstructive pulmonary disease (COPD)
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer

**END OF SECTION F**

**Section G: Liver**

- G1. Have you ever had any of the following liver disorders? (check all that apply)
- Hepatitis A
  - Hepatitis B
  - Hepatitis C
  - Other type of hepatitis: \_\_\_\_\_
  - Jaundice (as an adult) \_\_\_\_\_
  - Cirrhosis
  - Elevated liver enzymes
  - Other (specify): \_\_\_\_\_
  - None
  - Choose not to answer

**END OF SECTION G**

**Section H: Cardiovascular**

- H1. Have you ever had any of the following cardiovascular problems? (check all that apply)
- High blood pressure
  - High cholesterol/triglycerides
  - Angina
  - Heart attack
  - Heart failure
  - Irregular heart beat
  - Mitral valve prolapse
  - Rheumatic fever
  - Murmur or abnormal heart valve
  - Aortic aneurysm
  - Peripheral vascular disease or claudication
  - Congenital heart disease
  - Other (specify): \_\_\_\_\_
  - None->Skip to I1
  - Choose not to answer
- H2. Have you ever had any of the following surgeries or treatments? (check all that apply)
- Coronary artery bypass graft/angioplasty
  - Pacemaker placement
  - Heart catheterization
  - Heart valve replacement
  - None
  - Choose not to answer

**END OF SECTION H**

**Section I: Blood/Clotting Disorders**

- I1. Have you ever had any of the following blood/clotting disorders? (check all that apply)
- Anemia (except when related to pregnancy)
  - Sickle cell anemia
  - White cell disorders
  - Von Willebrands disease
  - Factor deficiency
  - Platelet disorders
  - Deep vein thrombosis (DVT)
  - Pulmonary embolism
  - Other (specify): \_\_\_\_\_
  - None
  - Choose not to answer

**END OF SECTION I**

**Section J: Gastrointestinal**

J1. Have you ever had any of the following gastrointestinal disorders? (check all that apply)

- |                        |                          |
|------------------------|--------------------------|
| Ulcers                 | Gastritis                |
| Chronic constipation   | Chronic acid reflux      |
| Chronic diarrhea       | Irritable bowel syndrome |
| Gallstones             | Pancreatitis             |
| Crohns disease/colitis | Colonic polyps           |
| Other (specify): _____ |                          |
| None-> Skip to K1      | Choose not to answer     |

J2. Have you ever had any of the following surgeries or treatments?

- Gallbladder removal
- Splenectomy
- Appendectomy
- Bowel resection
- Gastric bypass surgery
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer

**END OF SECTION J**

**Section K: Endocrine**

K1. Have you ever had any of the following endocrine disorders? (check all that apply)

- |                             |                      |
|-----------------------------|----------------------|
| Hyperthyroid/Graves disease | Hypothyroid          |
| Parathyroid disease         | Goiter               |
| Pituitary disorder          | Adrenal disorder     |
| Hyperprolactemia            |                      |
| Other (specify): _____      |                      |
| None                        | Choose not to answer |

K2. Have you had your thyroid removed?

- Yes
- No
- Choose not to answer

K3. Do you have diabetes?

- Insulin resistance, glucose intolerance, or pre-diabetes
- Type I diabetes
- Type II diabetes, diet controlled only
- Type II diabetes, taking oral medication (no insulin)
- Type II diabetes, on insulin
- No
- Choose not to answer

**END OF SECTION K**



**Section N: Eyes and Ears**

N1. Do you currently have any of the following hearing disorders? (check all that apply)

- Deafness
- Hard of hearing/hearing loss
- Vertigo/dizziness
- Ringing
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer

N2. Do you have any of the following eye disorders? (check all that apply)

- Cataracts
- Double vision
- Macular degeneration
- Retinal detachment
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer
- Glaucoma
- Lazy eye
- Dry eyes

N3. Are you legally blind?

- Yes
- No
- Choose not to answer

N4. Have you ever had any of the following procedures or surgeries? (check all that apply)

- Refractive surgery (LASIK, PRK)
- Cataract surgery
- Glaucoma surgery
- Laser treatment for retinal detachment
- Buckle surgery for retinal detachment
- None
- Choose not to answer

**END OF SECTION N**

**Section O: Neurological**

O1. Have you had any of the following neurological disorders (check all that apply)?

- Memory problems
- Stroke
- Parkinson's disease
- Encephalitis
- Tremors
- Brain aneurysm
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer
- Seizures/epilepsy
- Multiple sclerosis
- Alzheimer's disease
- Transient ischemic attack (TIA)
- Neuropathy (pain/numbness/tingling)
- Spinal cord injury

**END OF SECTION O**

**Section P: Mental Health**

- P1. Have you ever had any of the following mental health disorders? (check all that apply)
- |  |   |
|--|---|
| Bipolar disorder                         | Mild depression or subclinical depression |
| Severe depression or clinical depression | Seasonal affective disorder (SAD)         |
| Panic disorder                           | Anxiety disorder or generalized anxiety   |
| Dementia                                 | Personality disorder                      |
| Schizophrenia                            | Obsessive-compulsive disorder (OCD)       |
| Adjustment disorder                      | Post-traumatic stress disorder (PTSD)     |
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer
- P2. Have you ever had any of the following eating disorders? (check all that apply)
- Anorexia nervosa
- Bulimia
- Compulsive overeating or binge eating disorder
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer
- P3. Have you ever received treatment for any of the mental health disorders listed above? (check all that apply)
- Medication
- Psychotherapy
- Electroshock therapy
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer
- P4. Have you ever experienced any of the following forms of abuse? (check all that apply)
- Emotional abuse
- Physical abuse
- Sexual abuse
- Sexual assault or rape
- Other (specify): \_\_\_\_\_
- None->Skip to Q1
- Choose not to answer
- P5. Have you ever received professional treatment or assistance for any of the following forms of abuse? (check all that apply)
- Emotional abuse
- Physical abuse
- Sexual abuse
- Sexual assault or rape
- Other (specify): \_\_\_\_\_
- None
- Choose not to answer

**END OF SECTION P**

**Section Q: Other chronic conditions**

- Q1. Have you ever had any of the following chronic head or neck conditions? (check all that apply)
- Migraines
- Cluster headaches
- Chronic sinusitis
- None
- Choose not to answer
- Q2. Have you ever had any of the following chronic skin conditions? (check all that apply)
- Psoriasis
- Acne

Eczema

Rosacea

None

Choose not to answer

Q3. Have you ever had any of the following chronic infectious diseases? (check all that apply)

Lyme disease

Tuberculosis

HIV/AIDS

Polio

None

Choose not to answer

Q4. Have you ever had any of the following chronic autoimmune conditions? (check all that apply)

Lupus

Sjogrens

Raynauds disease

None

Choose not to answer

Q5. Have you ever had any of the following chronic sleep disorders? (check all that apply)

Sleep apnea

Narcolepsy

Insomnia

None

Choose not to answer

**END OF SECTION Q**

**Section R: Transplant history**

R1. Have you ever been a donor or transplant recipient for any of the following organs? (check all that apply)  
Recipient                  Donor

Kidney

Liver

Bone marrow

Lung

Skin

Pancreas

Heart

Cornea

None

Choose not to answer

**END OF SECTION R**

**Section S: Family history**

S1. Does your family have a history of any of the following? (check all that apply). "Family" includes your immediate family such as your parents and siblings.

Breast, ovarian, uterine cancer

Colon cancer

Prostate cancer (father, brother, or son)

Heart disease

Diabetes

Osteoporosis

Depression

None

Choose not to answer

**END OF SURVEY**

Thank you for completing the Women's Health Research Registry questionnaire and for your commitment to women's health. The information you have provided will be stored in a secure database. You will be contacted if your information matches the criteria for a gender-based research study being conducted at Cedars-Sinai Medical Center. If you have any questions, please contact the Women's Health Resource Center at (310) 423-9860 or e-mail [WomensServices@cshs.org](mailto:WomensServices@cshs.org).