THE MILLION WOMEN STUDY

A national survey of women invited for breast screening

We need one million women to help us in research that will benefit women all over the world.
Would you become one of these special women?

More and more women are taking hormone replacement therapy (HRT) so it is vital that we find out as much as possible about its benefits and any possible side effects. We have a unique opportunity through the NHS Breast Screening Programme to learn about the way different types of HRT and other lifestyle factors affect a woman's health, particularly her breasts. Britain is the only country in the world that can carry out this study because it is the only one with the combination of a large population and a comprehensive national breast screening programme.

The NHS Breast Screening Programme, the Imperial Cancer Research Fund and the Medical Research Council have joined together to organise The Million Women Study. If one million women answer this questionnaire over the next three years we could have some of the answers to our most important questions about HRT within five years or so.

We would be very grateful if you could set aside some time to answer these questions. It should not take more than 10-15 minutes. You do not have to answer this questionnaire and if you decide not to you will still have your screening done in the normal way.

Please answer every question and do not leave blanks as all the information that you give us is very useful. If you are not sure about exact dates or ages an approximate answer is better than none. If you have any questions you can ring us on freephone **0800 262 872.**

Even if you are not taking HRT it is just as important that you fill in the questionnaire.
Please bring this questionnaire to your breast screening appointment

To help us read your answers please write as clearly as possible and be sure to complete the questionnaire as shown:

Please put a cross in the appropriate box(es) ☒ ☐ ☐

OR put numbers in the appropriate box e.g. *23rd April 1946* 2 3 / 0 4 / 4 6 *age* 4 4 *years*

GENERAL QUESTIONS ABOUT YOU

1. What is your date of birth? *(please put day/month/year)*

☐☐ / ☐☐ / ☐☐

2. How old are you? ☐☐ years

3. How tall are you? *(please give to the nearest inch)*

☐ feet ☐☐ inches

4. About how much do you weigh?

☐☐ stone ☐☐ lbs

5. How old were you when you finished full time schooling? *(please cross one box)*

- ☐ did not go to school
- ☐ 13 or younger
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17 or older

6. What qualification(s) do you have from school, college or the equivalent?
(please put a cross in the most appropriate box(es))

- ☐ clerical or commercial qualifications *(eg secretarial, hairdressing etc)*
- ☐ nursing or teaching
- ☐ "O" level *(or equivalent)*
- ☐ "A" level *(or equivalent)*
- ☐ college/university degree *(or equivalent)*
- ☐ none of these

7. About how many cigarettes do you smoke on average *each day*, now? *(please cross one box)*

- ☐ none
- ☐ less than 5
- ☐ 5-9
- ☐ 10-14
- ☐ 15-19
- ☐ 20-24
- ☐ 25 or more

8. Are you an ex-smoker? ☐ No ☐ Yes

9. About how much wine, beer or spirits do you drink on average *each week*? *(please cross one box for each type)*

Wine (glasses per week)	**Lager/Cider/Beer** (half pints per week)	**Spirits** (tots per week)
☐ none	☐ none	☐ none
☐ less than 1	☐ less than1	☐ less than1
☐ 1-3	☐ 1-3	☐ 1-3
☐ 4-6	☐ 4-6	☐ 4-6
☐ 7-10	☐ 7-10	☐ 7-10
☐ 11-15	☐ 11-15	☐ 11-15
☐ 16-20	☐ 16-20	☐ 16-20
☐ 21+	☐ 21+	☐ 21+

If you drink **wine** is it

- ☐ mostly red
- ☐ mostly white
- ☐ about the same amount of red and white?

10. How often do you do *any* exercise?

- ☐ rarely/never
- ☐ less than once a week
- ☐ once a week
- ☐ 2-3 times a week
- ☐ 4-6 times a week
- ☐ every day

11. How often do you do *strenuous* exercise?

(that is, enough to cause sweating or a fast heart beat.)

- ☐ rarely/never
- ☐ less than once a week
- ☐ once a week
- ☐ 2-3 times a week
- ☐ 4-6 times a week
- ☐ every day

QUESTIONS ABOUT YOU AND YOUR FAMILY

12. Have you ever had any children? ☐ No ☐ Yes

- if No, please go on to question 15

13. How many children have you had? ☐☐

(please include stillbirths; it is not necessary to include miscarriages)

14. When was each child born, and for how many months did you breastfeed each child, if at all?

	DATE OF BIRTH (If you had twins or triplets please repeat the same date for each child) day / month / year	BREASTFEEDING (Months that you breastfed each child; put "0" if you did not breastfeed that child an "1" if you breastfed for a month or less)
1st child	☐☐ / ☐☐ / ☐☐	☐☐ months
2nd child	☐☐ / ☐☐ / ☐☐	☐☐ months
3rd child	☐☐ / ☐☐ / ☐☐	☐☐ months
4th child	☐☐ / ☐☐ / ☐☐	☐☐ months
5th child	☐☐ / ☐☐ / ☐☐	☐☐ months
6th child	☐☐ / ☐☐ / ☐☐	☐☐ months
7th child	☐☐ / ☐☐ / ☐☐	☐☐ months
8th child	☐☐ / ☐☐ / ☐☐	☐☐ months
9th child	☐☐ / ☐☐ / ☐☐	☐☐ months
10th child	☐☐ / ☐☐ / ☐☐	☐☐ months

15. Have you ever been for breast screening before?

- ☐ No
- ☐ Yes- If **Yes**, about how many years ago was your last screen? ☐☐ years ago

16. Have you ever had a breast lump removed or any operations on your breast(s)?

- ☐ No
- ☐ Yes- If **Yes**, how old were you? ☐☐ years

(If you have had more than one operation please write your age at the first operation)

17. Have you ever had breast cancer diagnosed?

- ☐ No
- ☐ Yes- If **Yes**, how old were you when the cancer was first diagnosed? ☐☐ years

18. Has your mother ever had breast cancer diagnosed?

- ☐ No ☐ Don't know
- ☐ Yes- If **Yes**, how old was she when the cancer was first diagnosed? ☐☐ years

19. How many sisters do you have? ☐☐ sisters

(put"0" if you do not have any sisters, please include any sisters who have died)

20. Have any of your sisters ever had breast cancer diagnosed?

- ☐ No/No sisters ☐ Don't know
- ☐ Yes- If **Yes**, how old were they when the cancer was first diagnosed?

1st sister ☐☐ years **2nd sister** ☐☐ years

QUESTIONS ABOUT YOUR HEALTH

21. Have you ever had any other cancer?

☐ Yes ☐ No

Please describe

22. Have you EVER had:

(please cross "Yes" or "No" for each condition)

High blood pressure - when pregnant	☐ Yes	☐ No
High blood pressure - when not pregnant	☐ Yes	☐ No
Heart disease *(eg heart attack/angina)*	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
High blood cholesterol	☐ Yes	☐ No
Blood clot *(thrombosis)*	☐ Yes	☐ No

23. Are you NOW being treated for:

High blood pressure *(hypertension)*	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
High blood cholesterol	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Clotting problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Depression/Anxiety	☐ Yes	☐ No

24. Are you *NOW* being treated for any other *serious* illness?

☐ Yes ☐ No

Please describe this illness

Please describe the treatment

QUESTIONS ABOUT PAST OPERATIONS

25. Have you had a hysterectomy?

☐ No

☐ Yes- If **Yes**, how old were you? ☐☐ years

26. Have you had BOTH ovaries removed?

☐ No ☐ Not sure

☐ Yes- If **Yes**, how old were you? ☐☐ years

27. Have you been sterilised *(had your tubes tied)***?**

☐ No

☐ Yes- If **Yes**, how old were you? ☐☐ years

QUESTIONS ABOUT YOUR USE OF THE PILL

28. Have you ever used the pill *(oral contraceptive)*?

☐ Yes

☐ No ***- if No, please go to question 32***

29. About how old were you when you *first went on* the pill? ☐☐ years

30. About how old were you when you *last came off* the pill? ☐☐ years

31. For how many years *in total* did you take the pill? ☐☐ years

(Add together the years and months when you actually took the pill -do not count the years and months when you were not taking it. Please write "0" if you used the pill for less than a year in total)

QUESTIONS ABOUT YOUR USE OF HORMONE REPLACEMENT THERAPY (HRT)

32. Have you ever used hormone replacement therapy (HRT)? ☐ No ***- if No - please go to question 39***

☐ Yes

33. How old were you when you *first started* using HRT? ☐☐ years

34. Had your periods stopped before you started using HRT? *(Cross "Yes" if you had a hysterectomy before starting HRT)*

☐ No

☐ Yes **- if Yes**, how old were you when your periods stopped? ☐☐ years

35. For about how many years *in total* have you used HRT? ☐☐ years

(Add together the years and months when you used HRT - do not count the years and months when you were not using HRT. Please write "0" if you used HRT for less than a year in total)

36. Are you *now* using HRT?

☐ Yes

☐ No **- if No**, how old were you when you **last** used HRT? ☐☐ years

37. What is the name of the most RECENT HRT you have used?

☐ Prempak C 0.625mg
☐ Prempak C 1.25mg
☐ Tridestra
☐ Trisequens
☐ Trisequens Forte
☐ Cycloprogynova 1mg
☐ Cycloprogynova 2mg
☐ Estrapak
☐ Estracombi
☐ Climaval 1mg
☐ Climaval 2mg
☐ Premique Cycle
☐ Premique
☐ Nuvelle
☐ Kliofem
☐ Livial
☐ Premarin 0.625mg
☐ Premarin 1.25mg
☐ Evorel 25mcg/50mcg
☐ Evorel 75mcg/100mcg
☐ Progynova 1mg
☐ Progynova 2mg
☐ Estraderm 25mcg
☐ Estraderm 50mcg
☐ Estraderm 100mcg
☐ Zumenon 1mg
☐ Zumenon 2mg
☐ Ethinyloestradiol
☐ Micronor
☐ Provera
☐ Duphaston

☐ Do not know ☐ Implants ☐ Oestrogel

Other *(please write here)*

38. For how many years in total did you use the most *recent* type of HRT? ☐☐ years

(Please write "0" if you used this recent HRT for less than a year in total)

QUESTIONS ABOUT YOUR PERIODS

39. About how old were you when your periods started? ☐☐ years

40. Have your periods NOW stopped?

*Cross "**Yes**"-if you are not having periods now, either because of your menopause, after a hysterectomy or after stopping HRT.*
*Cross "**No**"- if you are still having regular periods now, even if they are because you are taking HRT.*
*Cross "**Irregular**"-if your periods have been irregular and you think it might be because of the menopause.*

☐ **Yes**- If **Yes**, how old were you when they **stopped**? ☐☐ years

☐ **No**

☐ **Irregular**

FINAL SECTION

41. So that we can find out about your health in the future we may need to contact you again or look at your screening or medical records. We would be grateful if you gave us permission to contact you again or to use information from those records. **We guarantee that all information obtained will be treated with absolute confidentiality and used for medical research only.** Of course, you do not have to give permission. Your response to this request will not affect your screening or the treatment you receive in any way.

If you give permission, please sign here and print your name, address and other details in the section below. Please print in BLOCK CAPITALS as clearly as possible.

Signature: ☐ today's date: ☐☐/☐☐/☐☐

Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Given name(s): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

House number and street: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

District: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Town: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

County: ☐☐☐☐☐☐☐☐☐☐ Postcode: ☐☐☐☐☐☐☐☐☐☐

Surname at birth: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Town of birth: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

NHS (National Health Service)Number: ☐☐☐☐☐☐☐☐☐☐
(The number on your medical card)

Breast Screening Number: ☐☐☐☐☐☐☐☐☐☐
*(This is in the top left hand corner of your **screening invitation letter** and starts with the letters LGL)*

Please bring this questionnaire to your breast screening appointment

If you would like to post this questionnaire back to us, please send it to:
THE MILLION WOMEN STUDY CO-ORDINATING CENTRE
ICRF-CEU, GIBSON BUILDING,
RADCLIFFE INFIRMARY,
OXFORD OX2 6HE

FREEPHONE: 0800 262 872

Breast Screening Unit
Linton House
Thirlestaine Road
Cheltenham
GL53 7AS

LGL ☐

THANK YOU VERY MUCH FOR YOUR HELP