



*Harvard T.H. Chan School of Public Health  
Department of Nutrition  
677 Huntington Avenue  
Boston, Massachusetts 02115  
(617) 998-1067*

Dear Colleague:

On behalf of our research group, I thank you once more for your invaluable participation in the Health Professionals Follow-Up Study. The response rate to our follow-up questionnaire in 2018 was nearly 90%, ensuring valid data on the relation of diet and other lifestyle factors to heart disease, stroke, cancer, prostatic symptoms, and other major illnesses.

The attached **very brief** questionnaire asks for the most important information necessary for maintaining records. We have made it as short as possible in the hope that you will take just a few minutes to complete the form. If you prefer to fill out the questionnaire online, please find instructions at <https://sites.sph.harvard.edu/hpfs/> and click on "Complete this form to receive an invitation to your 2020 Health Professionals online survey". You will use your ID number printed above when you login and click on "Complete this form to receive an invitation to your 2020 Health Professionals online survey".

As an original member of the Health Professionals Follow-Up Study, you are an indispensable colleague in our research. Whether you are retired or still working, whether your health is excellent or you have been ill, your response is equally important. In short, **no matter what your circumstances, we want to hear from you!** As always, your answers will be kept strictly confidential and used for research purposes only.

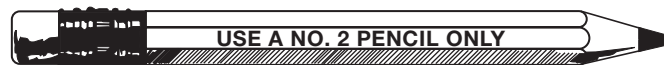
It is with our deepest gratitude that we thank you for your ongoing commitment and care that you have generously provided as we continue to learn more about men's health.

Sincerely,

*Walter Willett*

Walter Willett, M.D.  
Co-Principal Investigator

Lorelei Mucci, ScD.  
Co-Principal Investigator

**INSTRUCTIONS:****INTERNET:**

Go to our website at <https://sites.sph.harvard.edu/hpfs/> and use your ID number (see front of this page) to login. Follow the instructions on the screen to complete the survey online.

**PAPER FORM:**

Please use an ordinary No. 2 pencil to answer all questions. Fill in the appropriate response circles completely. The form is designed to be read by optical-scanning equipment, so it is important that you keep any write-in responses within the spaces provided and erase any incorrect marks completely. If you have comments, please write them on a separate piece of paper.

**USE OF BIOLOGICAL SAMPLES**

In performing specialized analyses on blood, toenails, tissue or urine samples that have been provided by participants in this study, we often collaborate with laboratories outside our university who are capable of doing these. These samples are always sent without any personal identifier to ensure confidentiality. On the basis of these analyses, it is possible that these tests could be found to have value in clinical practice. To make such a test available to health care providers, it is usually necessary that they be developed as a commercial product. Although we would work to facilitate such applications, under no circumstances would members of our research group personally profit financially from this research. Also, you would not receive any compensation for use of these samples. You may withdraw your sample at any time to the extent the data derived from them have not yet been aggregated. As always, our goal is to ensure that research findings are translated into ways that can most effectively benefit men everywhere.

If you have questions about the analysis of samples or other studies, or if you wish not to have your specimens provided to outside laboratories, please send an email to [hpfs@hsph.harvard.edu](mailto:hpfs@hsph.harvard.edu) or write us at HPFS, Walter C. Willett, 677 Huntington Ave., Boston, MA 02115. One of our researchers can answer any questions you may have.

The research team has great respect for your continued study participation, and therefore would like to remind you of several important points, as is standard practice in research. We do so in recognition of the fact that consent is an ongoing process rather than a one-time agreement. Please do not hesitate to contact us if you have any questions regarding this information.

- a. You are participating in a research study that focuses on how to decrease the risk of cancer, heart disease, impaired cognitive function and other major chronic diseases in men. Participation involves the completion of questionnaires.
- b. Your participation is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled.
- c. There is a small risk of breach of confidentiality; however we have taken many steps to minimize this risk.
- d. Samples are sometimes shared with entities outside of Harvard as part of research collaborations; in such cases, we use a separate ID number to ensure confidentiality.
- e. You will not receive monetary compensation for participating.
- f. There are no direct benefits to you from study participation.
- g. If you wish to speak with someone not directly involved in this research study about your rights as a research participant, please contact the Harvard School of Public Health's Office for Human Research Administration at [617-432-2143](tel:617-432-2143) (local calls) or [866-606-0573](tel:866-606-0573) (long distance calls) or email at [irb@hsph.harvard.edu](mailto:irb@hsph.harvard.edu).
- h. If you have any questions regarding the study itself, please call the study Project Coordinator, Betsy Frost-Hawes at [866-762-6609](tel:866-762-6609).

If your name and address as printed on this questionnaire are no longer correct or are incomplete, or if you are providing your email address, please make any necessary changes on the letter and return it to us.

**Thank you for completing the 2020 Health Professionals Follow-Up Study short questionnaire.**



# HEALTH PROFESSIONALS FOLLOW-UP STUDY

HPFS SH 20

1. Please WRITE in your date of birth:

MONTH	DAY	YEAR

2. Your CURRENT weight:

lbs.									

3. Do you currently smoke a pipe, cigar or cigarettes?

No  Yes

0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4					
0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4
3																								

4. Since January 1, 2018, have you had any of the following clinician diagnosed conditions or procedures?

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	BEFORE 2018	2018	2019	2020 OR LATER	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	④
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	①
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	②
Myocardial infarction (heart attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	③
↳ Hospitalized for this MI? <input type="checkbox"/> No <input type="checkbox"/> Yes					④
Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a
↳ Confirmed by an angiogram? <input type="checkbox"/> No <input type="checkbox"/> Yes					⑤
Coronary bypass, angioplasty, or stent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑥
Congestive heart failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑦
Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑧
Pulmonary embolus or deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑨
TIA (Transient Ischemic Attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑩
Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑪
Carotid surgery (endarterectomy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑫
Peripheral artery disease or claudication of legs (not varicose veins)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑬
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑭
Cataract extraction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑮
Macular degeneration of retina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑯
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑰
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑱
Vertebral (spine) fracture, x-ray confirmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑲
Hip fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑳
Hip replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉑
Knee replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉒

LEAVE BLANK FOR "NO," MARK HERE FOR "YES"	YEAR OF DIAGNOSIS				
	BEFORE 2018	2018	2019	2020 OR LATER	
Colon or rectal polyp (benign)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑲
Cancer of the colon or rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	⑳
Basal cell skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉑
Squamous cell skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉒
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉓
Prostatic enlargement treated by drugs, surgery, or laser	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉔
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉕
Lymphoma or leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉖
Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉗
↳ Please specify site and year: _____					a
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉘
Depression, clinician-diagnosed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉙
Ulcerative colitis or microscopic colitis/Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉚
Barrett's esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉛
Diverticulitis or Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉜
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉝
Gall bladder removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉞
Fatty liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㉟
↳ Confirmed by liver biopsy? <input type="checkbox"/> No <input type="checkbox"/> Yes					a
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㊱
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㊲
Colonoscopy or Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㊳
Other major illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	㊴
↳ DIAGNOSIS _____ DATE _____					a
PSA test within past 2 years? <input type="checkbox"/> No <input type="checkbox"/> Yes					a
If yes, was it elevated? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes					b

CENTER

PERF

1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
4	4	4	4	4	4	4	4
8	8	8	8	8	8	8	8
P	P	P	P	P	P	P	P

➔ Please indicate the name of someone at a **DIFFERENT PERMANENT ADDRESS** to whom we might write in the event we are unable to contact you: ○

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone/Email: \_\_\_\_\_

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PLEASE DO NOT WRITE IN SHADED AREA

**THANK YOU  
FOR YOUR CONTINUED  
PARTICIPATION**