

Form 33 - Medical History Update

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
- Darken the circle completely next to the answer you choose.
- Erase cleanly any marks you wish to change.
- Do not make any stray marks on this form.

CORRECT MARK

INCORRECT MARKS

 $\circ \bullet \circ \circ$

0000

This form asks about any health problems and health care since:

	-	_	
Mont	h Day	Year	* *:

Do not report hospital admissions, medical conditions or tests that happened before this date. However, if you are not sure of the date and don't think that you have reported it to us before, please answer the questions.

Public reporting burden for this collection of information is estimated to average 7 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0414). Do not return the completed form to this address.

OFFICE USE ONLY	1. Date Received:
	LITELI (MM/DD/YY)
o o	2. Reviewed By:
CODE HERE	3. Contact Type: O¹ Phone O³ Annual O² Mail O³ Other 4. Visit Type: O³ Annual O³ Annual O³ Other
AFFIX LABE BAR	O RCR ○ OU1 ○ OU2 5. Language:
•	PLEASE MAKE NO MARKS IN THIS AREA

1.	What is today's date? (Write the date in the space provided and mark the corresponding bubbles below.)
	Month Day Year
	Please mark only one bubble per line:
	Month 000000000000000000000000000000000000
	Pay 5 00000000000000000000000000000000000
	Year 00000 11 12 13 14 15 16
3.	Os Other (on behalf of the WHI participant, specify): Since the date on the front of this form, have you had any of the following exams, tests,
100 mg/s	or procedures done by a doctor or other health care provider? Mark all that apply. Or Breast exam Or Mammogram Or Test of breast-tissue or fluid for disease (breast biopsy or aspiration)
A.	O4 Other breast examination tests such as MRI or ultrasound
10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -	Os Test for the presence of blood in your stool of bowel movement (Hemoccult®, guaiac)
	O Tube inserted into your bowel to check for bowel problems (sigmoidoscopy or colonoscopy)
	O Hysterectomy (surgery to remove the uterus or womb)
	Os Biopsy of the endometrium (lining of the uterus or womb)
::: ::::::::::::::::::::::::::::::::::	O Bone density scan (such as DEXA)

O³⁹ None of the above apply

4.	Since the date on the front of this form, has a doctor or other health care provider told you for the first time that you have any of the following conditions? Mark all that apply.
	O. Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis
	O ₂ Angina or chest pain from a heart condition for which you were hospitalized for one night or more (not a heart attack)
, .	O Transient ischemic attack (not a stroke)
	O4 Osteoarthritis or arthritis associated with aging
	On Macular degeneration associated with aging
	O Moderate or severe memory problems (dementia or Alzheimer's)
	Or Parkinson's disease
	O* Intestine or colon polyps or adenomas
;	O. Systemic lupus crythematosus (lupus)
•	O ³⁹ None of the above apply
5.	Since the date on the front of this form, has a doctor or other health care provider prescribed for the first time any of the following treatments for diabetes? Mark all that apply.
5. Spatia	O Insulin
	O ² Pills or medications other than insulin
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	O Diet and/or physical activity
	Oss None of the above apply
6.	Since the date on the front of this form, has a doctor or other health care provider prescribed for the first time pills for high blood pressure or hypertension?
	O No O Yes
7.	Since the date on the front of this form, how many times did you fall and land on the floor or ground? Do not include falls due to sports. Mark only one.
	O None O Two times
	O¹ One time O³ Three or more times Go to the next page —>
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	rovider told you for the first time that you have a new broken, fractured, crushed bone?				
01 3	Yes	O° No If No, go to questions 9–16 on next page			
8.1		ch bone(s) did you break, fracture, or crush?			
	O ₁	Hip or upper leg (also mark in question 10 on the next page)			
	O^2	Pelvis			
	O ₃	Knee (patella)			
•	O4	Lower leg or ankle			
	O 5	Foot (not toe)			
	O _E	Tailbone (coccyx)			
	O 7	Spine or back (vertebra)			
	O ⁸	Upper arm or shoulder			
	0,9	Elbow			
	O ₁₀	Lower arm or wrist			
	O ₁₁	Hand (not finger)			
	O ₁₂	Finger or toe			
•	O 13	Jaw, nose, face, and/or skull			
	O14	Ribs and/or chest or breast bone			
	O 88	Other (Specify):			

➤ Go to questions 9–16 on next page.

Questions 9-16

Since the date on the front of this form, have you been hospitalized for one night or more for any reason, <u>OR</u> has a doctor or other health care provider diagnosed or treated you for the first time for any of the following? Please answer No or Yes to each item.

No Yes

9. O Cancer, malignant growth or tumor (include melanoma, do not include other skin cancers)

PROMERNICAL SECTION OF THE SECTION O

- 10. O¹ Broken, fractured, or crushed hip or upper leg bone
- 11. O O Stroke
- 12. O Heart disease including heart attack, heart failure, atrial fibrillation (afib), or other heart conditions
- 13. O O! Procedures or surgeries to unblock narrowed blood vessels to your heart or neck such as CABG (heart bypass); PTCA; carotid endarterectomy, angioplasty, or heart steat
- 14. O^o O¹ Blood clots in your leg veins or lungs (DVT deep vein thrombosis or PE pulmonary embolism)
- 15. O O Blocked or narrowed afteries to the legs or feet causing poor circulation (not varicose veins)
- 16. O O Hospitalized for one night or more for any reason

If you answered YES to one or more of the items in questions 9 through 16 above, please go to the next page.

If you answered NO to <u>all</u> of the items in questions 9 through 16 above, <u>you are done</u> with this form.

Please take a moment to review any questions you may have missed. Feel free to write any comments in the Comments section at the end of the form.

Thank you.

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Form 33 - Medical History Update Information on New Stroke, Heart, and Circulation Problems

Questions 17-29

Since the date on the front of this form, have you been diagnosed or treated for any of the following conditions or procedures? Please mark No or Yes to each item. For each item you mark Yes, also indicate if you were in the hospital for one night or more.

No	Yes	en in in de la companya di manana di man Manana di manana di m				
17. @•		Stroke If Yes, were you in the hospital for 1 night or more?	O۰	No	0	Yes
18. O	O ₁	MI, heart attack (coronary, myocardial infarction)	2 17 1 14.7%	era kilotik i	123	
	L	If Yes, were you in the hospital for 1 night or more?	0.	No	O 1	Yes
19. O º	O	Heart failure (congestive heart failure, CHF or HF)				
		If Yes, were you in the hospital for 1 night or more?	O•	No	0,	Yes
20. O	O۱	Heart bypass operation (coronary bypass surgery or CA)	BG)	,,	,	
٠	· L	If Yes, were you in the hospital for 1 night or more?	0.	No	O¹	Yes
21. O°	O	Heart valve problem or surgery to repair or replace a hea	art valve			
		If Yes, were you in the hospital for 1 night or more?	O.	No	O	Yes
22. O°	O 1	Atrial fibrillation, atrial flutter, or irregular heartbeat, recon a procedure (such as electrical shock, cardioversion)	quiring r , ablation	nedio 1, or	cation surge	ıs ry)
	L	If Yes, were you in the hospital for 1 night or more?	0°	No	O ₁	Yes
23. O°	Ø ,	Abdominal aortic aneurysm (AAA) requiring surgery or	stent			
	,	If Yes, were you in the hospital for 1 night or more?	, . Ö.,	No	0	Yes
24. Oº	01	Blood clots in your lungs (pulmonary embolism or PE)			, ,	
-	L,	If Yes, were you in the hospital for 1 night or more?	Ó۰	No	O 1	Yes
25. O°	O 1	Blood clots in the veins of your legs (deep vein thrombosi	s or DV	F)		
	4	If Yes, were you in the hospital for 1 night or more?	0.	No	O¹	Yes

27. (
28. (
29. (

No	·Yes				•	٠
O º	O ¹	Procedure to unblock narrowed blood vessels to your hea (opening the arteries of the heart with a stent, balloon, las other device). Also called PTCA, angioplasty, or percuta coronary intervention (PCI).	ser, or			
	-	If Yes, were you in the hospital for 1 night or more?	O•]	No	O¹	Yes
O۰	O ₁	Procedure or surgery to unblock narrowed blood vessels neck (carotid endarterectomy, carotid angioplasty, or caro	in your otid sten	ir)		
		If Yes, were you in the hospital for 1 might or more?	O	No	O -	Yes
O º	0,	Poor blood circulation or any procedure to unblock narro arteries to your legs or feet (claudication, peripheral arter disease, PAD, or gangrene). Do not include varicose veir	ial			
	-	If Yes, were you in the hospital for 1 night or more?	O ®	No	O ₁	Yes
O۰	0	Other heart or circulation conditions (Specify):				
		If Yes, were you in the hospital for 1 night or more?	. 0i	No	O ¹	Yes
	mlete	the health care provider information for the first four	heart o	or cir	cula	tion
		marked Yes in questions 17–29.				
	s you	marked Yes in questions 17-29. Hospital or MD office where you were diagnosed, treated	d, or adı	mitted	d.	
item	s you 1st		d, or adı	mitted	d.	
item	s you 1st	Hospital or MD office where you were diagnosed, treated	d, or adı		d.	
item	1st Nan Date	Hospital or MD office where you were diagnosed, treatedne:	d, or add			

Go to the next page

PLEASE DO NOT WRITE IN THIS AREA

Information on New Stroke, Heart, and Circulation Problems, continued

13. 2nd Hospital or MD office where you we Name:	re diagnos	ed, treated;	or admitted.
Street	City		State
4. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure):			
	Month	Day Ye	
5. How many nights were you in the hospital			rite "0" if no nig
6. 3rd Hospital or MD office where you were Name:	e diagnose	ed, treated, o	or admitted.
		-	
Street	City		State
7. Date you were diagnosed, treated, or			
admitted to a hospital (estimate if unsure):	Month	Day Yea	·
	Wohin	Day 162	u
8. How many nights were you in the hospital?	·	_ Nights (w	rite "0" if no nig
9. 4th Hospital or MD office where you were	diagnoga	A tensinal is	
Name:	o uragnoso	u, acaleu, o	raemnueu.
Street	City		State
l. Date you were diagnosed, treated, or			· · · · · · · · · · · · · · · · · · ·
admitted to a hospital (estimate if unsure);			
	Month	Day Yea	
. How many nights were you in the hospital?	·	_ Nights (w	rite "0" if no nigl
•	, , , , , , , , , , , , , , , , , , ,		
you have any other hospital stays for stroke	, heart, or	circulation of	conditions?
Yes O∘ No → If No, go to the ne	ext page.		
Hove money other beautiful stands	ne	O ² Two	O ₃ Three stay
	tay	stays	or more

42.

Form 33 - Medical History Update Questions on <u>New</u> Broken, Fractured, or Crushed Bone

\downarrow	Yes O∘ No → If No, go to the next page →
43.1	Which bone(s) did you break, fracture, or crush? Mark all that apply.
	O¹ Hip O² Upper leg (not hip)
	this broken, fractured, or crushed hip or upper leg bone first diagnosed or treag a hospital stay?
O¹ `	Yes O∘ No → If No, go to question 43.6 below.
43.3	In what hospital or medical facility were you diagnosed or treated for the broke fractured, or crushed hip or upper leg bone?
	Names
43.4	Street City State Date you entered the hospital (estimate if unsure):
	Did you stay overnight? Oo No O1 Yes
43.5	Did you but you wanted
Was a fractu	an outpatient X-ray or imaging scan (CT or MRI) taken to diagnose the broke ared, or crushed hip or upper leg bone at a facility not reported above? Yes Oo No
Was a	an outpatient X-ray or imaging scan (CT or MRI) taken to diagnose the broke ared, or crushed hip or upper leg bone at a facility not reported above? Yes Oo No
Was a fractu	an outpatient X-ray or imaging scan (CT or MRI) taken to diagnose the broke ared, or crushed hip or upper leg bone at a facility not reported above? Yes Oo No — If No, go to the next page — In what hospital or medical facility were you diagnosed or treated for the broke
Was a fractu	an outpatient X-ray or imaging scan (CT or MRI) taken to diagnose the broke ared, or crushed hip or upper leg bone at a facility not reported above? Yes O∘ No → If No, go to the next page → In what hospital or medical facility were you diagnosed or treated for the broke fractured, or crushed hip or upper leg bone? Name:
Was a fracture O ↑ ↓ ↓ 43.7	an outpatient X-ray or imaging scan (CT or MRI) taken to diagnose the broke ared, or crushed hip or upper leg bone at a facility not reported above? Yes Oo No — If No, go to the next page — In what hospital or medical facility were you diagnosed or treated for the broke fractured, or crushed hip or upper leg bone?

Since the date on the front of this form, has a doctor or other health care provider 44. told you that you have a new cancer, malignant growth, or tumor? Do not include benign tumors. O No - If No, skip to question 46 on page 13. -O Yes 44.1 Which cancers, malignant growths, or tumors were you told you had? Mark all that apply. O Breast O¹³ Kidney O² Ovary O¹⁴ Leukemia Endometrium (lining of the O¹⁵ Liver uterus or womb) O16 Lung Cervix O17 Melanoma O⁵ Other female genital organs

O⁶ Colon or rectum

or cervix)

Bladder or urinary tract

(not ovary, endometrium.

Brain

O. Esophagus

O¹⁰ Gallbladder or bile ducts

On Hodgkin's Lymphoma

O12 Non-Hodgkin's Lymphoma

O¹8 Multiple myeloma

Pancreas

Skin cancer (not melanoma)

O²¹ Stomach

O²² Thyroid

Oss Other or unknown cancer (Specify):

Go to the next page -

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Questions on New Cancer, Malignant Growth, or Tumor, continued

Please provide information for the doctor or other health care provider who diagnosed the cancer. If you have been diagnosed with more than one cancer since the date on the front of this form, write the provider information below for the first cancer.

Diagnosis Information for the First Cancer since the date on the front of this form

44.2	When was th	is cancer diagnosed (estimate if unsure)?	
		Month Day	Year
44.3	Who was the	doctor or other health care provider who diagnosed this c	ancer?
	Doctor or pro	ovider name:	
	Double of pro		
	Street	City	State
44.4	At what facil	ity was this cancer first diagnosed?	
	· ·		
	Street	City	State
44.5		cer diagnosed during an overnight hospital stay?	State
			•
	O¹ Yes	Oº No	•
	▼ [(
		lliger for the state of the sta	
	44.6 Date y	ou were admitted (estimate if unsure):	Zoon
•	AN SHAN A STAND OF SEALS	Month Day Y	ieai · · · ·
44.7	Was an outna	tient X-ray or imaging scan (CT, MRI, mammogram, bon	o or DET
770/	scan) taken to	diagnose the cancer at a place other than what you repor	ted above?
	·		
	O¹ Yes	O° No If No, go to the next page	
	*	·	
44.8	Place name:		,
	Street	City	State
		•	
44.9	Date of X-ray	or scan (estimate if unsure):	
		Month Day Year	

Questions on New Cancers, Malignant Growths or Tumors, continued

Cancer-related Surgeries for the First Cancer

45. Since the date on the front of this form, have you had any cancer-related surgeries following the diagnosis of the first cancer?

O 1 Y	Yes O∘ No → 45.1	O¹ Yes —	Go to the next page
∀	the date on the front of this fo	rm:	
	Number of cancer-related sur		
45.3	Type(s) of cancer-related surg	gery (Specify):	
45.4	At what facility was this first	cancer-related surgery	done?
	Place name:		
	Street	City	State
45.5	Date of first cancer-related surgery (estimate if unsure):		_
		Month Day Year	
45.6	Was this cancer treated during O₁ Yes Oゅ No →		

Record the provider information for any additional cancers in the Comments section at the end of this form, then continue to the next page.

45.7 How many nights were you in the hospital? ____ Nights (write "0" if no nights)

Go to the next page -

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Information on Hospital Stays (not already reported on this form)

- 46. Since the date on the front of this form, have you been admitted to a hospital for one night or more for any of the following? Do not include an overnight stay that you have already reported on this form.
 - Appendectomy or removal of appendix; bowel or intestinal obstruction (not cancer); gallbladder attack or gallbladder surgery; hernia repair
 - Back surgery such as laminectomy or spinal fusion
 - Fracture (not hip or upper leg)
 - Joint repair or replacement
 - Surgery for vaginal, uterine, or rectal prolapse; bladder suspension; stress incontinence
 - O¹ Yes Oº No
- 47. Since the date on the front of this form, have you been admitted to a hospital for one night or more for any other reason? Do not include an overnight stay that you have already reported on this form.
 - O Yes O No --- If No, go to Final Instructions at the end of the next page. ---

Please give the details of your first two hospital stay(s) not already reported on this form.

47 1 1	st hospital stay of one night or more.
	Hospital name:
	CARANTANIAN PARAMBANAN PARAMBAN PARAMBAN PARAMBAN PARAMBAN PARAMBAN PARAMBAN PARAMBAN PARAMBAN PARAMBAN PARAMB Paramban Paramban Pa
	Street City State
47.2 I	Date you entered the hospital (estimate if unsure)
47.3 I	How many nights were you in the ospital? O One O Two or more
47.4 F	Reason for this hospital stay (Specify):
\$2 (# 8 2 a) <u></u>	and the control of the first transfers asserted as the first and the first statement of the

Go to the next page —

Information on Hospital Stays, continued (not already reported on this form)

47.5	2nd hospital stay of one night or more.				
	Hospital name:				
	Street City State				
47.6	Date you entered the hospital (estimate if unsure): Month Day Year				
47.7	How many nights were you in the hospital? O: One O: Two or more				
47.8	Reason for this hospital stay (Specify):				
O1 3	you have any other hospital stays not yet reported? Yes O∘ No → If No, go to Final Instructions below.				
48.1	How many additional hospital stays did you have?				
	O¹ One O² Two O³ Three or more				
	Record the additional provider information in the Comments section at				

Final Instructions

Please read, then sign and date the Authorization to Release Medical Records on the next page. By signing this form you are giving permission for your provider to release a copy of your medical records to WHI.

You may receive a follow-up call to clarify your answers on this form.

Please take a moment to review any questions you may have missed. Feel free to write any comments in the Comments section at the end of the form.

Go to the next page ----

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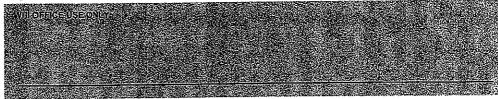


Mail to: Women's Health Initiative

NE Regional Center Sites
University at Buffalo 65 Farber Hall Buffalo, NY 14214
716-829-3128, 855-944-2255
WHI Brigham & Women's Hospit Division of Preventive Medicine 900 Commonwealth Ave E, Floor Boston, MA 02215 617-278-0791, 800-510-4858
MedStar Research Institute Attn: Women's Health Initiative 6525 Belcrest Rd., Suite 700 Hyattsville, MD 20782 301-560-2924
SE Regional Center Sites
Wake Forest Univ Schl of Med. PHS-SSHP Med. Center Blvd. Winston Salem, NC 27157 336-713-4221, 877-736-4962
University of Florida 1329 SW 16th Street PO Box 100277 Ste 5251 CB-5256F Gainesville, FL 32603 352-294-5211, 800-944-4594
Midwest Regional Center Sites
OSU at Wexner Medical Center 1581 Dodd Dr., Suite 140 Columbus, OH 43210 614-688-3563, 800-251-1175
University of Pittsburgh 130 N Bellefield Ave., Rm 550 Pittsburgh, PA 15213 800-552-8140
University of Iowa MMP II, Box 24 1215 Pleasant St., Suite 302 Des Moines, IA 50309 515-241-8989, 800-347-8164
Western Regional Center Sites
Stanford University 1070 Arastradero Road Suite 100 Palo Alto, CA 94304-1334 650-736-0809
University of Arizona Attn: Amelia Lobos 1601 N Tucson Blvd., Ste 23 Tucson, AZ 85716 520-321-7440, 800-341-7672
Clinical Conditioning Conton

AUTHORIZATION TO RELEASE MEDICAL RECORDS (Protected Health Information

I give permission for any and all facilities and providers to release my health information.



The Women's Health Initiative (WHI) Extension Study is a national study sponsored by the National Institutes of Health (NIH) whose ongoing purpose is to learn about the health of post-menopausal women. By signing this form, I give permission to these facilities to give information about my health care and health conditions to: the investigators at the WHI Clinical Coordinating Center (CCC) and the Regional Center affiliates.

The information released will only be used for research purposes by the WHI and will be held in strict confidence. Examples of medical information to be requested.

Discharge summary	Operative reports	Consultations
History and physical	Procedure reports	Outpatient/short
Radiology/imaging	Lab tests and results	stay records
Pathology reports/	Diagnostic/	MD notes/
specimens	procedure codes	progress notes
ER records	Other:	

By signing, I acknowledge that I have read and understood the following:

- Signing this authorization is voluntary.
- I have the right to revoke (cancel) this authorization at any time by notifying the WHI and the facility in writing. If I do this, it will be in effect immediately as soon as it is received and no further information about my health care and health conditions will be requested. If I revoke this authorization, it will have no effect whatsoever on my enrollment or participation in WHI or on my medical treatment at the facility.
- The above medical records may be shared with researchers at the WHI CCC at the Fred Hutchinson Cancer Research Center, WHI Regional Centers and their affiliates, the NIH (study sponsor), and regulatory agencies and review boards who watch over the safety, effectiveness and conduct of the research. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule may no longer protect the information but the WHI, as a nationally funded research study, has established continued protection for the disclosed information.

Fred Hutchinson Cancer

1100 Fairview Avenue N Seattle, WA 98109

800-514-0325

Research Center - M3-A410

WHI cannot further use or disclose the information in my medical records without my consent unless required by law. This authorization shall remain valid for the duration of the WHI Extension Study. I have the right to receive a copy of this authorization. A photocopy or facsimile of this document is as valid as the original. Today's Date: Month Day Signature of WHI Participant (or Authorized Representative) Participant's Date of Birth: Month Day Signature of WHI Participant (or Authorized Representative and relationship to participant) Comments Please report comments and additional provider information below. Provider information includes: Hospital/physician name; street, city and state; date of admission; length of stay; and reason for stay