



Contact Information Update Form

Please return this form even if there are no changes to report.

Help us keep in touch with you by reporting changes to your contact information. If you've moved, are about to move, or changed your phone number or email address, please provide your updated information.

Today's date: / / 20
(month) (day) (year)

There have been no changes to any of my contact information. (Check box and go to next page.)

Name and Primary Address

Name: «FirstName»
 «MiddleInitial»
 «LastName»

Update or Correction

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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If you have more than one residence, provide information for your primary address, where you live most of the year.

Street Address: «Address1»
 «Address2»
 «City», «State»
 «Zip»

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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If you have moved, what was the date of your move? OR,
 If you are moving in 2-3 months, what date will you move?

/ / 20
(month) (day) (year)

Mailing Address:

«Address1»
 «Address2»
 «City», «State»
 «Zip»

Same as street address

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Telephone Numbers We Can Use to Reach You:

Home phone: «HomePhoneNumber»

() -

Work phone: «WorkPhoneNumber» «WorkPhoneExt»

() - ext.

Cell phone: «OtherPhoneNumber»

() -

Email Address We Can Use to Reach You:

Email: «Email1»

@ .

PAGE ONE - PLEASE CONTINUE TO NEXT PAGE

ID#: SIS 



Please return this form even if there are no changes to report.

We request the names of two people who do not live with you, but who will always know how to reach you. Please be sure their information is up to date. You may replace a contact person with someone else by filling in the new information. If we do not have two contacts for you, please provide the information below.

There have been no changes to any of the information for my contact people. (Check box and return form.)

First Contact

Update/Correction/New Contact

Name: «FirstName»
«LastName»

Grid for name input

Relationship to you: «Relationship»

Grid for relationship input

Address: «StreetNumber» «StreetName»
«ApartmentNumber»
«City», «State»
«Zip»

Grid for address input

Phone Number: «PhoneNumber»

Grid for phone number input

What is the reason for the changes you made?

Reason for changes checkboxes: updating old or outdated information, correcting errors in current information, replacing old contact with a new contact person

Second Contact

Update/Correction/New Contact

Name: «FirstName»
«LastName»

Grid for name input

Relationship to you: «Relationship»

Grid for relationship input

Address: «StreetNumber» «StreetName»
«ApartmentNumber»
«City», «State»
«Zip»

Grid for address input

Phone Number: «PhoneNumber»

Grid for phone number input

What is the reason for the changes you made?

Reason for changes checkboxes: updating old or outdated information, correcting errors in current information, replacing old contact with a new contact person

After completing both pages of this form, please mail it to the address below. A postage-paid envelope is provided. Thank you!

The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703
phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org

Sister Study Health Update: Year 7



*** Please fill out this form even if there are no changes to report. ***

It is important to the Sister Study that we stay updated on your health. Please take a few minutes to fill out this form and let us know if you have been diagnosed with any of the following conditions since August 2012.

Today's date / /
month day year

ID #



«StudyID»

1. Since August 2012, has a doctor or other health professional told you that you had any of the following conditions?

Please mark No or Yes for each question.		If YES, give the month and year of diagnosis.	
	NO	YES	MONTH / YEAR
a	Breast cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
b	DCIS (ductal [breast] carcinoma in situ) <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
c	LCIS (lobular [breast] carcinoma in situ) <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
d	Lung cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
e	Ovarian cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
f	Cancer of the uterus or endometrium (please do not include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer) <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
g	Cancer of the colon or rectum <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
h	Melanoma <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
i	Any other type of cancer except non-melanoma skin cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> What kind? _____
j	Heart attack (myocardial infarction – MI) <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> Were you a patient in a hospital overnight? NO <input type="checkbox"/> YES <input type="checkbox"/>
k	Other heart disease (e.g. angina, congestive heart failure, arrhythmias) <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> What kind? _____
l	Stroke, mini-stroke, TIA <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
m	Thyroid disease (e.g. Graves' disease, overactive thyroid/hyperthyroidism, thyroiditis, underactive thyroid/hypothyroidism, or other) <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> What kind? _____
n	Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma, multiple sclerosis, or other) <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> What kind? _____
o	Parkinson's disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
p	Hypertension (high blood pressure) <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
q	Diabetes <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>
r	Hip, wrist or other fracture <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> What kind? _____
s	Any other major illness <input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> What kind? _____

PLEASE CONTINUE ON THE BACK →

2. Have you gone through menopause?

- No
- Don't Know
- Yes

3. What month and year did you have your last menstrual period or how old were you when you had your last menstrual period?

/ **OR**
MONTH YEAR AGE

4. Have you ever smoked at least one cigarette per day for six months or longer?

- No → **GO TO QUESTION 7**
- Yes

5. What best describes your smoking status?

- Stopped smoking cigarettes
- Currently smoking cigarettes

6. During the years you smoked, how many cigarettes do/did you usually smoke per day?

- Less than one pack per day
- One pack per day
- More than one pack per day

7. Are you currently using hormones for hormone replacement (HRT)? Please include pills and patches. Common brand and generic names are Prempro, Premarin, Estrace, estradiol, Provera, medroxyprogesterone, etc.

- No
- Yes

*Thank you for your continued participation in the Sister Study. Please mail this form to:
The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703. A postage-paid envelope is provided.
Phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org*

Public reporting burden for this collection of information is estimated to average 10 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 (0925-0522). Do not return the completed form to this address.