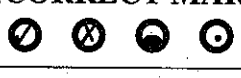
WOMEN'S HEALTH INITIATIVE

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 

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

__ __ - __ __ - __ __
Month 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.

OFFICE USE ONLY

1. **Date Received:** __ __ - __ __ - __ __ **(MM/DD/YY)**

2. **Reviewed By:** __ __ - __ __ __

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

3. **Contact Type:**
   - ○1 Phone
   - ○2 Mail
   - ○8 Other

4. **Visit Type:**
   - ○3 Annual
   - ○4 Non-Routine

○ **RCR** ○ **OU1** ○ **OU2**

5. **Language:** ●1 E ○2 S

1414445

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 ○○○○○○○○○○○○
1 2 3 4 5 6 7 8 9 10 11 12

Day ○○○○○○○○○○○○○○○○○○○○○○○○○○○○○○○
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Year ○○○○○○
11 12 13 14 15 16

2. Who is completing this form?

○1 Self - Women's Health Initiative (WHI) Extension Study participant

○8 Other (on behalf of the WHI participant, specify): _____

3. <u>Since the date on the front of this form,</u> have you had any of the following exams, tests, or procedures done by a doctor or other health care provider? **Mark all that apply.**

○1 Breast exam
○2 Mammogram
○3 Test of breast tissue or fluid for disease (breast biopsy or aspiration)
○4 Other breast examination tests such as MRI or ultrasound
○5 Test for the presence of blood in your stool or bowel movement (Hemoccult®, guaiac)
○6 Tube inserted into your bowel to check for bowel problems (sigmoidoscopy or colonoscopy)
○7 Hysterectomy (surgery to remove the uterus or womb)
○8 Biopsy of the endometrium (lining of the uterus or womb)
○9 Bone density scan (such as DEXA)
○99 **None of the above apply**

Go to the next page ⟶

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.**

- ○ 1 Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis
- ○ 2 Angina or chest pain from a heart condition for which you were hospitalized for one night or more (not a heart attack)
- ○ 3 Transient ischemic attack (not a stroke)
- ○ 4 Osteoarthritis or arthritis associated with aging
- ○ 5 Macular degeneration associated with aging
- ○ 6 Moderate or severe memory problems (dementia or Alzheimer's)
- ○ 7 Parkinson's disease
- ○ 8 Intestine or colon polyps or adenomas
- ○ 9 Systemic lupus erythematosus (lupus)
- ○ 99 **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.**

- ○ 1 Insulin
- ○ 2 Pills or medications other than insulin
- ○ 3 Diet and/or physical activity
- ○ 99 **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**?

○ 0 No ○ 1 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.**

- ○ 0 None
- ○ 1 One time
- ○ 2 Two times
- ○ 3 Three or more times

Go to the next page →

PLEASE DO NOT WRITE IN THIS AREA

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8. **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 a new broken, fractured, or crushed bone?

O1 Yes O0 No → **If No, go to questions 9–16 on next page.** →

8.1 Which bone(s) did you break, fracture, or crush?
Mark all that apply.

- O1 Hip or upper leg (also mark in question 10 on the next page) ___
- O2 Pelvis
- O3 Knee (patella)
- O4 Lower leg or ankle
- O5 Foot (not toe)
- O6 Tailbone (coccyx)
- O7 Spine or back (vertebra)
- O8 Upper arm or shoulder
- O9 Elbow
- O10 Lower arm or wrist
- O11 Hand (not finger)
- O12 Finger or toe
- O13 Jaw, nose, face, and/or skull
- O14 Ribs and/or chest or breast bone
- O88 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, **OR** 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.	O0	O1	Cancer, malignant growth or tumor (include melanoma, do not include other skin cancers)
10.	O0	O1	Broken, fractured, or crushed hip or upper leg bone
11.	O0	O1	Stroke
12.	O0	O1	Heart disease including heart attack, heart failure, atrial fibrillation (afib), or other heart conditions
13.	O0	O1	Procedures or surgeries to unblock narrowed blood vessels to your heart or neck such as CABG (heart bypass), PTCA, carotid endarterectomy, angioplasty, or heart stent
14.	O0	O1	Blood clots in your leg veins or lungs (DVT - deep vein thrombosis or PE - pulmonary embolism)
15.	O0	O1	Blocked or narrowed arteries to the legs or feet causing poor circulation (not varicose veins)
16.	O0	O1	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 all of the items in questions 9 through 16 above, you are done 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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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	
17.	○ 0	○ 1	Stroke
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
18.	○ 0	○ 1	MI, heart attack (coronary, myocardial infarction)
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
19.	○ 0	○ 1	Heart failure (congestive heart failure, CHF or HF)
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
20.	○ 0	○ 1	Heart bypass operation (coronary bypass surgery or CABG)
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
21.	○ 0	○ 1	Heart valve problem or surgery to repair or replace a heart valve
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
22.	○ 0	○ 1	Atrial fibrillation, atrial flutter, or irregular heartbeat, requiring medications OR a procedure (such as electrical shock, cardioversion, ablation, or surgery)
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
23.	○ 0	○ 1	Abdominal aortic aneurysm (AAA) requiring surgery or stent
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
24.	○ 0	○ 1	Blood clots in your lungs (pulmonary embolism or PE)
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes
25.	○ 0	○ 1	Blood clots in the veins of your legs (deep vein thrombosis or DVT)
			→ If Yes, were you in the hospital for 1 night or more? ○ 0 No ○ 1 Yes

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

No Yes

26. O0 O1 Procedure to unblock narrowed blood vessels to your heart (opening the arteries of the heart with a stent, balloon, laser, or other device). Also called PTCA, angioplasty, or percutaneous coronary intervention (PCI).

→ If Yes, were you in the hospital for 1 night or more? O0 No O1 Yes

27. O0 O1 Procedure or surgery to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty, or carotid stent)

→ If Yes, were you in the hospital for 1 night or more? O0 No O1 Yes

28. O0 O1 Poor blood circulation or any procedure to unblock narrowed arteries to your legs or feet (claudication, peripheral arterial disease, PAD, or gangrene). Do not include varicose veins.

→ If Yes, were you in the hospital for 1 night or more? O0 No O1 Yes

29. O0 O1 Other heart or circulation conditions (Specify): _____

→ If Yes, were you in the hospital for 1 night or more? O0 No O1 Yes

Complete the health care provider information for the first four heart or circulation items you marked Yes in questions 17–29.

30. 1st Hospital or MD office where you were diagnosed, treated, or admitted.

Name: _____

_____

Street City State

31. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure): __ __ - __ __ - __ __
Month Day Year

32. 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 New Stroke, Heart, and Circulation Problems, continued

33. 2nd Hospital or MD office where you were diagnosed, treated, or admitted.

Name: _____

_____

Street City State

34. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure): __ __ - __ __ - __ __ __ __
Month Day Year

35. How many nights were you in the hospital? __ __ Nights (write "0" if no nights)

36. 3rd Hospital or MD office where you were diagnosed, treated, or admitted.

Name: _____

_____

Street City State

37. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure): __ __ - __ __ - __ __ __ __
Month Day Year

38. How many nights were you in the hospital? __ __ Nights (write "0" if no nights)

39. 4th Hospital or MD office where you were diagnosed, treated, or admitted.

Name: _____

_____

Street City State

40. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure): __ __ - __ __ - __ __ __ __
Month Day Year

41. How many nights were you in the hospital? __ __ Nights (write "0" if no nights)

42. Did you have any other hospital stays for stroke, heart, or circulation conditions?

○1 Yes ○0 No → **If No, go to the next page.**

42.1 How many other hospital stays? ○1 One stay ○2 Two stays ○3 Three stays or more

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

Questions on New Broken, Fractured, or Crushed Bone

43. **Since the date on the front of this form,** has a doctor or other health care provider told you that you have a new broken, fractured, or crushed hip or upper leg bone?

O¹ Yes O⁰ 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)

43.2 **Was this broken, fractured, or crushed** hip or upper leg bone first diagnosed or treated during a hospital stay?

O¹ Yes O⁰ No → **If No, go to question 43.6 below.**

43.3 In what hospital or medical facility were you diagnosed or treated for the broken, fractured, or crushed hip or upper leg bone?

Name: _____

_____

Street City State

43.4 Date you entered the hospital (estimate if unsure): __ __ - __ __ - __ __

Month Day Year

43.5 Did you stay overnight? O⁰ No O¹ Yes

43.6 **Was an outpatient X-ray or imaging scan** (CT or MRI) taken to diagnose the broken, fractured, or crushed hip or upper leg bone at a facility not reported above?

O¹ Yes O⁰ No → **If No, go to the next page** →

43.7 In what hospital or medical facility were you diagnosed or treated for the broken, fractured, or crushed hip or upper leg bone?

Name: _____

_____

Street City State

43.8 Date of X-ray or other imaging scan (CT or MRI) (estimate if unsure): __ __ - __ __ - __ __

Month Day Year

Questions on New Cancer, Malignant Growth, or Tumor

44. **Since the date on the front of this form,** has a doctor or other health care provider told you that you have a new cancer, malignant growth, or tumor? Do not include benign tumors.

O1 Yes O0 No → **If No, skip to question 46 on page 13.** →

44.1 Which cancers, malignant growths, or tumors were you told you had? **Mark all that apply.**

- O1 Breast
- O2 Ovary
- O3 Endometrium (lining of the uterus or womb)
- O4 Cervix
- O5 Other female genital organs (not ovary, endometrium, or cervix)
- O6 Colon or rectum
- O7 Bladder or urinary tract
- O8 Brain
- O9 Esophagus
- O10 Gallbladder or bile ducts
- O11 Hodgkin's Lymphoma
- O12 Non-Hodgkin's Lymphoma
- O13 Kidney
- O14 Leukemia
- O15 Liver
- O16 Lung
- O17 Melanoma
- O18 Multiple myeloma
- O19 Pancreas
- O20 Skin cancer **(not melanoma)**
- O21 Stomach
- O22 Thyroid
- O88 Other or unknown cancer **(Specify):**

_____

_____

_____

Go to the next page →

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 this cancer diagnosed (estimate if unsure)? __ __ - __ __ - __ __
Month Day Year

44.3 Who was the doctor or other health care provider who diagnosed this cancer?

Doctor or provider name: _____

_____
Street City State

44.4 At what facility was this cancer first diagnosed?

Place name: _____

_____
Street City State

44.5 Was this cancer diagnosed during an overnight hospital stay?

O 1 Yes O 0 No

↓

44.6 Date you were admitted (estimate if unsure): __ __ - __ __ - __ __
Month Day Year

44.7 Was an outpatient X-ray or imaging scan (CT, MRI, mammogram, bone or PET scan) taken to diagnose the cancer at a place other than what you reported above?

O 1 Yes O 0 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

Go to the next page →

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?

○1 Yes ○0 No → **45.1** If No, are any planned?

○1 Yes
○0 No
→ **Go to the next page** →

Since the date on the front of this form:

45.2 Number of cancer-related surgeries you had: ___ ___

45.3 Type(s) of cancer-related surgery **(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 an overnight hospital stay?

○1 Yes ○0 No → **If No, go to the next page.** →

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

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

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

O[1] Yes O[0] 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[1] Yes O[0] 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 1st hospital stay of one night or more.

Hospital name: _____

_____

Street City State

47.2 Date you entered the hospital (estimate if unsure): ___ ___ / ___ ___ / ___ ___

Month Day Year

47.3 How many nights were you in the hospital? O[1] One O[2] Two or more

47.4 Reason for this hospital stay **(Specify):** _____

_____

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? ○1 One ○2 Two or more

47.8 Reason for this hospital stay **(Specify)**: _____

_____

48. Did you have any other hospital stays not yet reported?

○1 Yes ○0 No → **If No, go to Final Instructions below.**

48.1 How many additional hospital stays did you have?

○1 One ○2 Two ○3 Three or more

Record the additional provider information in the Comments section at the end of the form, then continue to the Final Instructions below.

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 Hospital**
Division of Preventive Medicine
900 Commonwealth Ave E, Floor 3
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 32608
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 Coordinating Center

☐ **Fred Hutchinson Cancer**
Research Center – M3-A410
1100 Fairview Avenue N
Seattle, WA 98109
800-514-0325

AUTHORIZATION TO RELEASE MEDICAL RECORDS
(Protected Health Information

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

WHI OFFICE USE ONLY

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 stay records
Radiology/imaging	Lab tests and results	
Pathology reports/ specimens	Diagnostic/ procedure codes	MD notes/ 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.

- 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: ___ ___ - ___ ___ - ___ ___
Signature of WHI Participant Month Day Year
(or Authorized Representative)

Participant's
_____ Date of Birth: ___ ___ - ___ ___ - ___ ___
Signature of WHI Participant Month Day Year
(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