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8. **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 bone?

<sup>1</sup> Yes    <sup>0</sup> No → **If No, go to questions 9–16 on the next page.** →



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

- <sup>1</sup> Hip or upper leg (also mark in question 10 on the next page)
- <sup>2</sup> Pelvis
- <sup>3</sup> Knee (patella)
- <sup>4</sup> Lower leg or ankle
- <sup>5</sup> Foot (not toe)
- <sup>6</sup> Tailbone (coccyx)
- <sup>7</sup> Spine or back (vertebra)
- <sup>8</sup> Upper arm or shoulder
- <sup>9</sup> Elbow
- <sup>10</sup> Lower arm or wrist
- <sup>11</sup> Hand (not finger)
- <sup>12</sup> Finger or toe
- <sup>13</sup> Jaw, nose, face, and/or skull
- <sup>14</sup> Ribs and/or chest or breast bone
- <sup>88</sup> Other (Specify): \_\_\_\_\_

→ **Go to questions 9–16 on the next page.** →





**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.  No     Yes    Stroke

↳ If Yes, were you in the hospital for 1 night or more?     No     Yes

18.  No     Yes    MI, heart attack (coronary, myocardial infarction)

↳ If Yes, were you in the hospital for 1 night or more?     No     Yes

19.  No     Yes    Heart failure (congestive heart failure, CHF or HF)

↳ If Yes, were you in the hospital for 1 night or more?     No     Yes

20.  No     Yes    Heart bypass operation (coronary bypass surgery or CABG)

↳ If Yes, were you in the hospital for 1 night or more?     No     Yes

21.  No     Yes    Heart valve problem or surgery to repair or replace a heart valve

↳ If Yes, were you in the hospital for 1 night or more?     No     Yes

22.  No     Yes    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?     No     Yes

23.  No     Yes    Abdominal aortic aneurysm (AAA) requiring surgery or stent

↳ If Yes, were you in the hospital for 1 night or more?     No     Yes

24.  No     Yes    Blood clots in your lungs (pulmonary embolism or PE)

↳ If Yes, were you in the hospital for 1 night or more?     No     Yes

25.  No     Yes    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?     No     Yes



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

No Yes

26. 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? No Yes

27. 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? No Yes

28. 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? No Yes

29. Other heart or circulation conditions (Specify):

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

Complete the health care provider information for the 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 more than four hospital stays for stroke, heart, or circulation conditions?

<sub>1</sub> Yes <sub>0</sub> No → If No, go to the next page.



42.1 How many other hospital stays? <sub>1</sub> One stay <sub>2</sub> Two stays <sub>3</sub> 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 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.

<sup>1</sup> Yes      <sup>0</sup> 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.**

<input type="radio"/> <sup>1</sup> Breast	<input type="radio"/> <sup>13</sup> Kidney
<input type="radio"/> <sup>2</sup> Ovary	<input type="radio"/> <sup>14</sup> Leukemia
<input type="radio"/> <sup>3</sup> Endometrium (lining of the uterus or womb)	<input type="radio"/> <sup>15</sup> Liver
<input type="radio"/> <sup>4</sup> Cervix	<input type="radio"/> <sup>16</sup> Lung
<input type="radio"/> <sup>5</sup> Other female genital organs (not ovary, endometrium, or cervix)	<input type="radio"/> <sup>17</sup> Melanoma
<input type="radio"/> <sup>6</sup> Colon or rectum	<input type="radio"/> <sup>18</sup> Multiple myeloma
<input type="radio"/> <sup>7</sup> Bladder or urinary tract	<input type="radio"/> <sup>19</sup> Pancreas
<input type="radio"/> <sup>8</sup> Brain	<input type="radio"/> <sup>20</sup> Skin cancer (not melanoma)
<input type="radio"/> <sup>9</sup> Esophagus	<input type="radio"/> <sup>21</sup> Stomach
<input type="radio"/> <sup>10</sup> Gallbladder or bile ducts	<input type="radio"/> <sup>22</sup> Thyroid
<input type="radio"/> <sup>11</sup> Hodgkin's Lymphoma	<input type="radio"/> <sup>88</sup> Other or unknown cancer (Specify):
<input type="radio"/> <sup>12</sup> Non-Hodgkin's Lymphoma	_____
	_____
	_____

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 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?

Yes  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?

Yes  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

Center Per





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?

<sup>1</sup> Yes      <sup>0</sup> No →

45.1 If No, are any planned?

<sup>1</sup> Yes

<sup>0</sup> 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?

<sup>1</sup> Yes

<sup>0</sup> 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, 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?  One  Two or more

47.8 Reason for this hospital stay (Specify): \_\_\_\_\_

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

Yes  No —> If No, go to Final Instructions below.



48.1 How many additional hospital stays did you have?

One  Two  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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**Release records 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  
Please contact the Buffalo  
Regional Center at the  
numbers provided.

**SE Regional Center Sites**

- Wake Forest School of Medicine  
PHS-SSHP, WHI  
Bldg 90 South, 3rd FL  
PO Box 573152  
Winston Salem, NC 27157  
336-713-4221, 877-736-4962
- University of Florida  
1600 SW Archer Rd.  
PO Box 100277  
Dental Tower; Rm D8-26  
Gainesville, FL 32610  
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
- The University of Iowa  
411 Laurel St., Suite 3262  
Des Moines, IA 50314  
515-643-4840, Fax: 515-643-4841

**Western Regional Center Sites**

- Stanford University  
1070 Arastradero Road  
Suite 100, WHI  
Palo Alto, CA 94304-1334  
888-729-8442
- The University of Arizona  
Amelia Lobos, WHI  
3950 S Country Club Rd. #330  
Tucson, AZ 85714  
520-626-5487, 800-341-7672

**Clinical Coordinating Center**

- Fred Hutch (WHI)—M3-A410  
1100 Fairview Avenue N  
Seattle, WA 98109  
800-514-0325

**AUTHORIZATION TO RELEASE MEDICAL RECORDS  
(Protected Health Information)**

(WHI OFFICE USE ONLY) Release records from:

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.
- Although not being asked by WHI, information released may include all aspects of treatment, including testing and/or treatment of sexually transmitted diseases, AIDS or HIV infection, alcohol and/or drug abuse, and mental health conditions.
- 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 not affect information already released and will not affect my enrollment or participation in WHI or my treatment, payment, enrollment, or eligibility for benefits at this 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. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule 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.

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

\_\_\_\_\_  
Signature of WHI Participant  
(or Authorized Representative)

Today's Date: \_\_\_\_ - \_\_\_\_ - 20 \_\_\_\_  
Month Day Year

\_\_\_\_\_  
Printed Name of WHI Participant  
(or Authorized Representative and  
relationship to participant)

Participant's  
Date of Birth: \_\_\_\_ - \_\_\_\_ - 19 \_\_\_\_  
Month Day Year

Phone #: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

**Comments**

**Please report comments/additional provider information below. Provider information includes: Hospital/physician name; city and state; date of admission; length of stay, and reason for stay**

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