WHI Annual Form 33 - Medical History Update

Please complete the survey below.

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

3/3/2019

Do not report events that happened before the date above. However, if you are not sure of a date and don’t think that you have reported it to us before, please answer the questions.

Thank you!
Form 33 REDCap, v13.3,

### WHI Annual Form 33 - Medical History Update

This form asks about any health problems and health care since 3/3/2019

#### 1. Who is completing this form?
- [ ] Self (WHI Study participant)
- [ ] Other, on behalf of self (participant)

#### 1.1 Name and relationship to participant:

**Best phone number to reach the person completing the form:**

#### 2. Since 3/3/2019, have you had any of the following exams, tests, or procedures done by a doctor or other health care provider? Mark all that apply.

- Breast exam
- Mammogram
- Two or more blood tests
- Breast exam or fluid for disease (breast biopsy or aspiration)
- Other breast examination or tests such as MRI or ultrasound
- Test for the presence of blood in your stool or bowel movement
- Hemorrhoids, greater or less granuloma
- Tumors inserted into your bowel to check for bowel problems
- Hysterectomy (surgical removal of uterus or womb)
- Bloody or black stool (color of stool or vomiting)
- None of the above apply

#### 3. Since 3/3/2019, has a doctor or other health care provider told you that you have any of the following conditions? Mark all that apply.

- Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis
- Anemia or other type of anemia
- Angina or chest pain from a heart condition for which you were hospitalized for one night or more (after a heart attack)
- Transient ischemic attack (TIA or stroke)
- Osteoporosis or arthritis associated with any other health condition
- Medical condition associated with aging
- Benign or severe memory problems
- Dementia or Alzheimer’s
- Parkinson’s disease
- Tissue or skin problems or adenomas
- None of the above apply

#### 4. Since 3/3/2019, has a doctor or other health care provider prescribed any of the following treatments for diabetes? Mark all that apply.

- Insulin
- Pills or medications other than insulin
- Diet and/or physical activity
- None of the above apply (I do not have, or no longer have diabetes.)

#### 5. Since 3/3/2019, has a doctor or other health care provider prescribed the first time, pills for high blood pressure or hyperglycemia?

- Yes
- No

#### 6. Since 3/3/2019, how many times did you fall and land on the floor or ground? Do not include falls due to sports. Mark only once.

- None
- One time
- Two times
- Three or more times

#### 6.1 Were you injured as a result of any fall?

- Yes
- No

[Save & Return Later]

[Next Page]
### WHI Annual Form 33 - Medical History Update

Since 3/5/2019, have you been diagnosed or treated for any of the following conditions or procedures? Mark No or Yes for each item.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Stroke</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>8. MI, heart attack (coronary, myocardial infarction)</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>9. Heart failure (congestive heart failure, CHF or HF)</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>10. Heart bypass operation (coronary bypass surgery or CABG)</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>11. Heart valve problem or surgery to repair or replace a heart valve</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>12. Abdominal aortic aneurysm (AAA) requiring surgery or stent</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>13. Procedure or surgery to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty, or carotid stent)</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>14. Poor blood circulation or any procedure to unblock narrowed arteries to your leg or feet (caduication, peripheral arterial disease, PAD, or gangrene). Do not include varicose veins.</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Option 1</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>15</td>
<td>Blood clots in your lungs (pulmonary embolism or PE)</td>
<td>No</td>
</tr>
<tr>
<td>16</td>
<td>Blood clots in the veins of your legs (deep vein thrombosis or DVT)</td>
<td>No</td>
</tr>
<tr>
<td>17</td>
<td>Atrial fibrillation, atrial flutter, or irregular heartbeat, requiring medications OR a procedure (such as electrical shock cardioversion, ablation, or surgery)</td>
<td>No</td>
</tr>
<tr>
<td>18</td>
<td>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).</td>
<td>No</td>
</tr>
<tr>
<td>19</td>
<td>Other heart or circulation conditions</td>
<td>No</td>
</tr>
</tbody>
</table>
WHI Annual Form 33 - Medical History Update

Since you marked Yes to one or more of the heart or circulation items in questions 7-19, please complete the NEW health care provider information below.

Record any additional provider information in the Comments section at the end of this form.

<table>
<thead>
<tr>
<th>20. Name of 1st hospital or MD office where you were diagnosed, treated, or admitted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>21. Date you were diagnosed, treated, or admitted to a hospital: (Estimate if unsure.)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>21.1. For what condition:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>22. Were you hospitalized?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22.1. How many nights? (Enter &quot;0&quot; if no nights.)</th>
</tr>
</thead>
</table>
23. Name of 2nd hospital or MD office where you were diagnosed, treated, or admitted.

Street address: 

City: 

State: 

24. Date you were diagnosed, treated, or admitted to a hospital (estimate if unsure):

24.1. For what condition:

25. Were you hospitalized?  
   ○ No  
   ○ Yes

25.1. How many nights? (Enter "0" if no nights.)
26. Since 3/3/2019, 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.

- No
- Yes


- Breast
- Ovary
- Endometrium (lining of the uterus or womb)
- Cervix
- Other female genital organs (not ovary, endometrium, or cervix)
- Colon or rectum
- Bladder or urinary tract
- Brain
- Esophagus
- Gallbladder or bile ducts
- Hodgkin's Lymphoma
- Non-Hodgkin's Lymphoma
- Kidney
- Leukemia
- Liver
- Lung
- Melanoma
- Multiple myeloma
- Pancreas
- Skin cancer (not melanoma)
- Stomach
- Thyroid
- Other or unknown cancer

Complete the diagnosis information for the first new cancer.

26.2. When was this cancer diagnosed (estimate if unsure)?
### 26.3. Name of doctor or other health care provider who diagnosed this cancer and at what facility was this cancer first diagnosed.

<table>
<thead>
<tr>
<th>Street:</th>
</tr>
</thead>
<tbody>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
</tbody>
</table>

### 26.4. What is the name of your oncologist?

<table>
<thead>
<tr>
<th>Place name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address:</td>
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<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
</tbody>
</table>

### 26.5. Was an outpatient X-ray or imaging scan (CT, MRI, mammogram, bone or PET scan) taken to diagnose the cancer?

- [ ] No
- [ ] Yes

| Date of X-ray or scan (estimate if unsure): | }
**Cancer-related surgeries for the first new cancer.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Since 3/3/2019, have you had any cancer-related surgeries following the diagnosis of the first cancer?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of cancer-related surgeries you had</td>
<td></td>
</tr>
<tr>
<td>Name of facility where this first cancer-related surgery was done</td>
<td></td>
</tr>
<tr>
<td>Street address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Date of first cancer-related surgery (estimate if unsure)</td>
<td></td>
</tr>
</tbody>
</table>

**Links:**
- **Previous Page**
- **Next Page**
- **Save & Return Later**
28.7. Name of hospital or medical facility where you were diagnosed or treated for the broken, fractured, or crushed hip or upper leg bone.

Street address: 

City: 

State: 

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

29. Since 3/23/2019, has a doctor or other healthcare provider told you that you have a new broken, fractured, or crushed bone other than in the upper leg?

- No
- Yes

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

- Pelvis
- Knee (patella)
- Lower leg or ankle
- Foot (not toes)
- Tailbone (coccyx)
- Spine or back (vertebra)
- Upper arm or shoulder
- Elbow
- Lower arm or wrist
- Hand (not finger)
- Finger or toe
- Jaw, nose, face, and/or skull
- Rib(s), chest, or breast bone
- Another fracture not listed

Final Instructions

This is the last page of the form. Once you click the Submit button below, your responses will be sent to the WHI Clinical Coordinating Center. Therefore, please take a moment to review your answers and any questions you may have missed. Feel free to write any comments in the Comments section below.

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

Comments or Additional Provider Information:

Please write comments or additional provider information in the box. Provider information includes: Hospital/physician name, city and state, date of admission, length of stay, and reason for stay.

Use characters remaining:

<< Previous Page

Submit

Save & Return Later
### WHI Annual Form 33 - Medical History Update

28. Since 3/3/2019, has a doctor or other health care provider told you that you have a **new** broken, fractured, or crushed hip or upper leg bone?
   - [ ] No
   - [x] Yes

#### 28.1. Which bone(s) did you break, fracture, or crush?
Mark all that apply.
   - [ ] Hip
   - [ ] Upper leg (not hip)

#### 28.2. Was this broken, fractured, or crushed hip or upper leg bone first diagnosed or treated during a hospital stay?
   - [ ] No
   - [x] Yes

28.3. Name of hospital or medical facility where you were diagnosed or treated for the broken, fractured, or crushed hip or upper leg bone:

   Street address:

   City:

   State:

28.4. Date you entered the hospital (estimate if unsure):

28.5. Did you stay overnight?
   - [ ] No
   - [x] Yes

28.6. 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?
   - [ ] No
   - [x] Yes
Thank you for submitting your form. If you are unsure about or wish to change an answer, please contact the WHI Clinical Coordinating Center at (1-800-218-8413) or email us at participant@whi.org

*Has your phone number changed in the last year?*
*If it has, please contact your Regional Center, Stanford University at (888) 729-8442.*