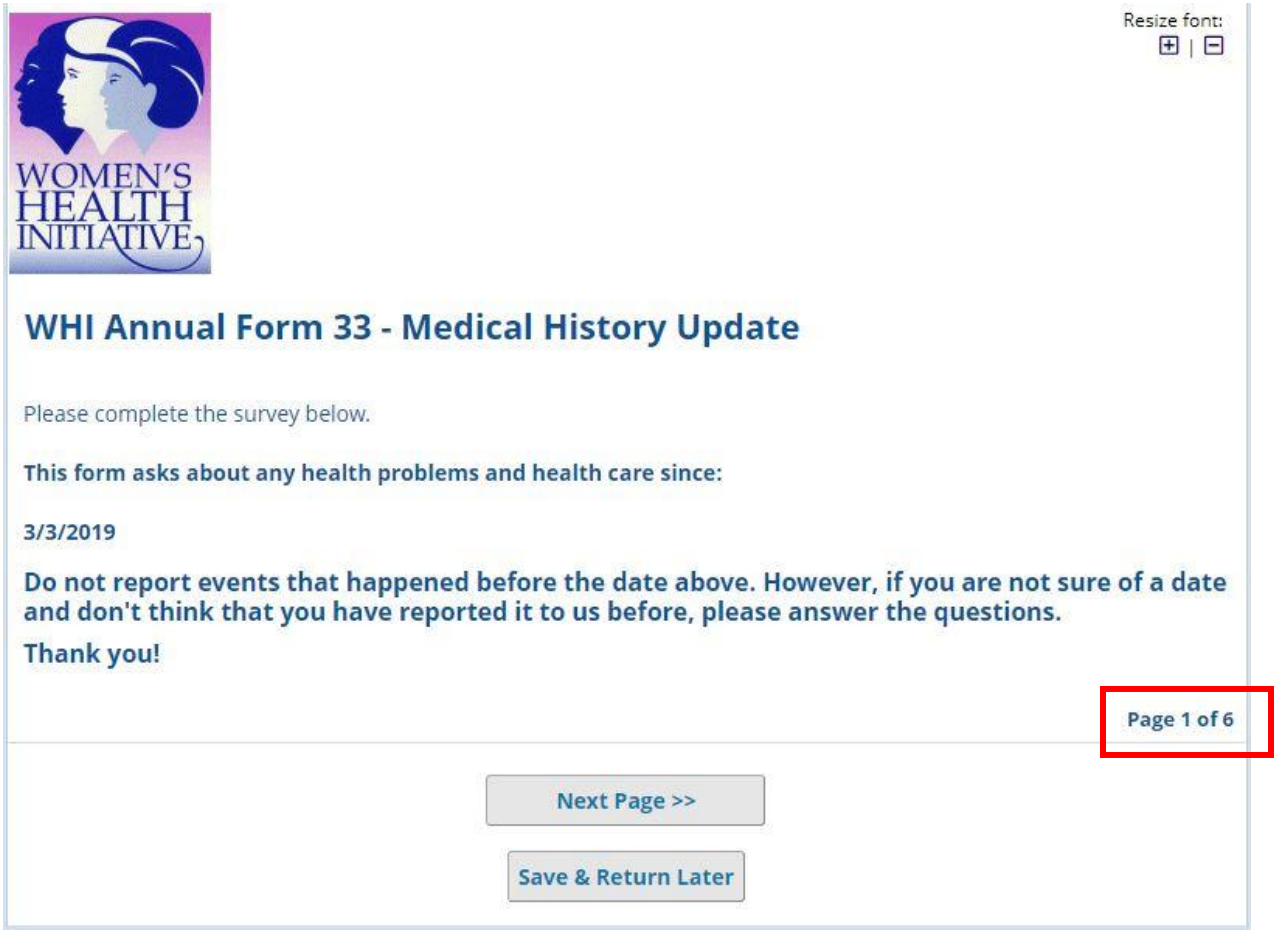
Form 33 REDCap, v13.3,

Form 33 REDCap, v13.3: track changes noted in red.



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 WHI participant

1.1 Name and relationship to participant:

Best phone number to reach the person completing this 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
- Test of breast tissue or fluid for disease (breast biopsy or aspiration)
- Other breast examination tests such as MRI or ultrasound
- Test for the presence of blood in your stool or bowel movement (Hemoccult, guaiac, Cologuard)
- Tube inserted into your bowel to check for bowel problems (sigmoidoscopy or colonoscopy)
- Hysterectomy (surgery to remove the uterus or womb)
- Biopsy of the endometrium (lining of the uterus or womb)
- **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
- Angina or chest pain from a heart condition for which you were hospitalized for one night or more (not a heart attack)
- Transient ischemic attack (not a stroke)
- Osteoarthritis or arthritis associated with aging
- Macular degeneration associated with aging
- Moderate or severe memory problems
- Dementia or Alzheimer's
- Parkinson's disease
- Intestine or colon polyps 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 for the first time pills for high blood pressure or hypertension?
- No
- Yes

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

6.1 Were you injured as a result of any falls?
- No
- Yes

<< Previous Page | Next Page >>

Save & Return Later

Form 33 REDCap, v13.3,

WHI Annual Form 33 - Medical History Update

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

7. Stroke	○ No ○ Yes
8. MI, heart attack (coronary, myocardial infarction)	○ No ○ Yes
9. Heart failure (congestive heart failure, CHF or HF)	○ No ○ Yes
10. Heart bypass operation (coronary bypass surgery or CABG)	○ No ○ Yes
11. Heart valve problem or surgery to repair or replace a heart valve	○ No ○ Yes
12. Abdominal aortic aneurysm (AAA) requiring surgery or stent	○ No ○ Yes
13. Procedure or surgery to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty, or carotid stent)	○ No ○ Yes
14. 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.	○ No ○ Yes

Form 33 REDCap, v13.3,

15. Blood clots in your lungs (pulmonary embolism or PE)

- ○ No
- ○ Yes

reset

16. Blood clots in the veins of your legs (deep vein thrombosis or DVT)

- ○ No
- ○ Yes

reset

17. Atrial fibrillation, atrial flutter, or irregular heartbeat, requiring medications OR a procedure (such as electrical shock, cardioversion, ablation, or surgery)

- ○ No
- ○ Yes

reset

18. 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).

- ○ No
- ○ Yes

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19. Other heart or circulation conditions

- ○ No
- ○ Yes

reset

<< Previous Page **Next Page >>**

Save & Return Later

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.

---

20. Name of **1st hospital or MD office** where you were diagnosed, treated, or admitted.

Street address:

City:

State:

21. Date you were diagnosed, treated, or admitted to a hospital: (Estimate if unsure.) M-D-Y

21.1. For what condition:

22. Were you hospitalized?

- ○ No
- ○ Yes

reset

22.1. How many nights? (Enter "0" if no nights.)

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): M-D-Y

24.1. For what condition:

25. Were you hospitalized?

- ○ No
- ○ Yes

reset

25.1. How many nights? (Enter "0" if no nights.)

<< Previous Page

Next Page >>

Save & Return Later

WHI Annual Form 33 - Medical History Update

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

reset

26.1. What type of new cancer?
Mark all that apply.

- ☐ 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)? M-D-Y

26.3. Name of doctor or other health care provider who diagnosed this cancer and at what facility was this cancer first diagnosed.	
Street:	
City:	
State:	
26.4. What is the name of your oncologist?	
26.5. Was an outpatient X-ray or imaging scan (CT, MRI, mammogram, bone or PET scan) taken to diagnose the cancer?	○ No • Yes reset
Place name:	
Street address:	
City:	
State:	
Date of x-ray or scan (estimate if unsure):	M-D-Y

Form 33 REDCap, v13.3,

Cancer-related surgeries for the first new cancer.

27. Since 3/3/2019, have you had any cancer-related surgeries following the diagnosis of the first cancer?

- ○ No
- • Yes

reset

Number of cancer-related surgeries you had:

Name of facility where this first cancer-related surgery was done:

Street address:

City:

State:

Date of first cancer-related surgery (estimate if unsure):

M-D-Y

<< Previous Page

Next Page >>

Save & Return Later

28.7. Name of hospital or medical facility were you 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 3/3/2019, has a doctor or other health care provider told you that you have a new broken, fractured, or crushed bone **other than** hip or 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 toe)
- ☐ 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
- ☐ Ribs, 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 clarify your answers on this form.

Comments or Additional Provider Information:
Please write comments/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.

255 characters remaining

<< Previous Page

Submit

Save & Return Later

Form 33 REDCap, v13.3,

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
- ◉ Yes

reset

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
- ◉ Yes

reset

28.3. Name of hospital or medical facility were you 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
- ○ Yes

reset

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
- ◉ Yes

reset

Form 33 REDCap, v13.3,

Close survey

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 {1-800-218-8415} 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.