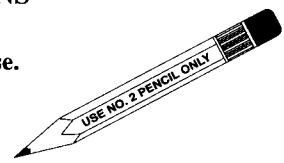
WOMEN'S HEALTH INITIATIVE

Form 33 - Medical History Update

MARKING INSTRUCTIONS

- Use a No. 2 pencil only.
- Darken the oval 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 ,-20 ☐☐ year

Do <u>not</u> report hospital admissions, medical problems or tests that happened before this date. However, if you are not sure of the date and don't think that you have reported the problem to us before, please do answer the questions about that problem.

OFFICE USE ONLY

S_____

1. Date Received:

☐☐/☐☐/☐☐ Month Day Year

M 1 2 3 4 5 6 7 8 9 10 11 12
D 10 20 30 1 2 3 4 5 6 7 8 9
Y 94 95 96 97 98 99 00 01 02 03 04 05 06 07

2. Reviewed By:

☐☐☐

100 200 300
10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

3. Contact Type:

1 Phone
2 Mail
3 Visit
8 Other

4. Visit Type:

2 Semi-Annual 1 2 3 4 5 6 7 8 9 10 11 12
3 Annual 1 2 3 4 5 6 7 8 9 10 11 12
4 Non-Routine

5. Form Administration:

1 Self 2 Group 3 Interview 4 Assistance

6. Language:

● 2
E S

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PLEASE MAKE NO MARKS IN THIS AREA

1. First, please tell us who is completing this form:

   1 Women's Health Initiative (WHI) participant (self)
   2 Family or friend of WHI participant
   3 Health care provider for WHI participant
   8 Other **(Specify):**_____

   → Please answer the following questions about the WHI participant.

2. Since the date on the front of this form, have you fainted, blacked out, or lost consciousness?

   0 No 1 Yes

3. 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 activities such as snow- or water-skiing or horseback riding.)**

   0 None 1 1 time 2 2 times 3 3 or more times

4. Since the date on the front of this form, have you been admitted to a hospital overnight? **(Do not include day surgery or visits to an emergency room.)**

   0 No 1 Yes →

   4.1. What was the reason? **(Mark all that apply.)**

   1 Problems with the heart or circulation
   2 Stroke or transient ischemic attack (TIA)
   3 Broken, crushed, or fractured bone
   4 Cancer or a malignant tumor
   8 Other reasons **(Specify):**_____

5. Since the date on the front of this form, have you been treated in an emergency room, had day surgery, or been seen on an outpatient basis?

   0 No 1 Yes →

   5.1. What was the reason? **(Mark all that apply.)**

   1 Problems with the heart or circulation
   2 Stroke or transient ischemic attack (TIA)
   3 Broken, crushed, or fractured bone
   4 Cancer or a malignant tumor
   8 Other reasons **(Specify):**_____

6. Since the date on the front of this form, has a doctor told you for the first time that you have a new broken, crushed, or fractured bone?

0 No
1 Yes

6.1. Which bones did you break? **(Mark all that apply.)**

1 Jaw, nose, face, and/or skull
2 Finger, and/or toe
3 Ribs and/or chest or breast bone
8 Other broken bone

7. Since the date on the front of this form, has a doctor told you for the first time that you have a new cancer or a malignant tumor?

0 No
1 Yes

7.1. What type of cancer? **(Mark all that apply.)**

1 Skin cancer (not melanoma)
8 Other cancer or malignant tumor

8. Since the date given on the front of this form, has a doctor told you for the first time that you have any of the following specific conditions? **(Mark all that apply. If none apply, mark "None of the above.")**

1 Glaucoma
2 Osteoporosis (weak, thin, or brittle bones)
3 Osteoarthritis or arthritis associated with old age
4 Rheumatoid arthritis (not including rheumatism)
5 Intestine or colon polyps or adenomas
6 Gallbladder disease or gallstones
7 Systemic lupus erythematosus ("lupus")
8 Kidney or bladder stones (renal or urinary calculi)
10 Cataracts
9 **None of the above**

9. Since the date given on the front of this form, has a doctor prescribed for the first time any of the following pills or treatments? **(Mark all that apply. If none apply, mark "None of the above.")**

1 Pills for diabetes
2 Insulin shots for diabetes
3 Pills for high blood pressure or hypertension
9 **None of the above**

Please Go On to the Next Page

10. Since the date on the front of this form, which of the following exams, tests, or procedures have you had done by a doctor or a nurse at a place other than your Women's Health Initiative Clinic? **(Mark all that apply. If none apply, mark "No.")**

General

1 Physical exam or check-up

2 Eye exam

Breast

11 Breast exam

12 Mammogram

13 Test of breast tissue or fluid for disease (Breast biopsy or aspiration)

Bowel

14 Rectal exam

15 Test for the presence of blood in your stool or bowel movement (Hemoccult, guaiac)

16 Tube inserted into your bowel from below to check for bowel problems (Sigmoidoscopy, flex. sig., or colonoscopy)

17 Barium enema x-ray

Heart and circulation

3 Blood pressure check

4 Blood cholesterol test

5 Electrocardiogram (ECG)

6 Procedure to unblock narrowed blood vessels to your heart muscle (opening the arteries of the heart with a balloon or other device, sometimes called PTCA, coronary angioplasty, or coronary stent)

18 Shots at home for blood clots in legs followed by blood thinning medications (such as Coumadin, Warfarin)

Women's procedures

7 Pap smear

8 Dilation and Curettage (D & C, womb scrape)

9 Endometrial biopsy

10 Removal of the uterus or womb (Hysterectomy)

99 **No, I have not had any of the exams, tests, or procedures listed above.**

11. What is the date that you finished answering this form?

Month Day Year

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

D 10 20 30 / 1 2 3 4 5 6 7 8 9

Y 94 95 96 97 98 99 00 01 02 03 04 05 06 07

Thank you. Please take a moment to review any questions you may have missed.

* U.S. GOVERNMENT PRINTING OFFICE:2003-589-322/40017

PLEASE MAKE NO MARKS IN THIS AREA

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