Ver. 8.1
OMB #0925-0414 Exp: 5/12

WOMEN'S HEALTH INITIATIVE

# Form 33 - Medical History Update
# WHI Extension

## MARKING INSTRUCTIONS

- Use a 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 ____ ,-20 ____ year

**Do not 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***

1. Date Received: Month ___ Day ___ Year ___

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

○ FCA ○ OU1 ○ OU2

5. Language: ●1 E ○2 S

○■■○○■○■○■■○○■○■■■■■○○○○ 1025702

PLEASE MAKE NO MARKS IN THIS AREA

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

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

2. Since the date on the front of this form, have you been admitted to a hospital for a stay of **2 nights or more?**

   ○0 No ○1 Yes

3. Since the date on the front of this form, have you been **diagnosed or treated** because of heart problems, blocked or narrowed blood vessels, stroke or other problems with your blood circulation (for example, blood clots in the legs or lungs)?

   ○0 No → Go to Question 4 on the next page.
   ○1 Yes

3.1. For which of the following heart or circulation problems were you diagnosed or treated? **(Mark all that apply.)**

- ○1 Heart attack (coronary, myocardial infarction or MI)
- ○2 Heart failure (congestive heart failure or CHF)
- ○3 Chest pain from a heart problem (angina)
- ○4 Heart bypass operation (coronary bypass surgery or CABG)
- ○5 Procedure to unblock narrowed vessels to your heart (opening the arteries of the heart with a balloon or other device, sometimes called a PTCA, coronary angioplasty, coronary stent, or laser)
- ○6 Stroke
- ○7 Transient ischemic attack (TIA)
- ○8 Procedure or operation to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty, or carotid stent)
- ○9 Blood clots in your legs (deep vein thrombosis or DVT)
- ○10 Blood clots in your lungs (pulmonary embolism or PE)
- ○11 Poor blood circulation or blocked or narrowed blood vessels to your legs or feet (claudication, peripheral arterial disease, gangrene, or Buerger's disease)
- ○88 Other heart or circulation problems

3.2. For any item marked above, were you admitted to a hospital for at least one night?

○0 No ○1 Yes

4. 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 malignant tumor?

○0 No ○1 Yes

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

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

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

○0 No ○1 Yes

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

○1 Hip
○2 Upper leg (not hip)
○3 Pelvis
○4 Knee (patella)
○5 Lower leg or ankle
○6 Foot (not toe)
○7 Tailbone (coccyx)
○8 Spine or back (vertebra)
○9 Lower arm or wrist
○10 Hand (not finger)
○11 Elbow
○12 Upper arm or shoulder
○13 Jaw, nose, face, and/or skull
○14 Finger or toe
○15 Ribs and/or chest or breast bone
○16 Cervical spine/neck
○88 Other **(Specify):**_____

6. Since the date 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.")**

○1 Pills for diabetes
○2 Insulin shots for diabetes
○3 Diet and/or physical activity for diabetes
○4 Pills for high blood pressure or hypertension
○5 Treatment for depression (pills or therapy)
○6 Treatment for anxiety, panic, or phobia (pills or therapy)
○7 Pills for osteoporosis other than calcium supplements
○8 Calcium supplements for osteoporosis
○9 Pills for high cholesterol
○10 Estrogen or estrogen combination pills
○99 **None**
I have not been prescribed any of the pills or treatments listed in either column in Question 6 since the date on the front of this form.

**Please Go On to the Next Page**

7. Since the date 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.")**

- ○1 Osteoarthritis or arthritis associated with aging
- ○2 Intestine or colon polyps or adenomas
- ○3 Systemic lupus erythematosus (lupus)
- ○4 Macular degeneration
- ○5 Parkinson's disease
- ○6 Moderate or severe memory problems (for example, dementia or Alzheimer's).

○99 **None**
I have not had any of the conditions listed in Question 7 since the date on the front of this form.

8. Since the date on the front of this form, which of the following exams, tests, or procedures have you had done by a healthcare professional? **(Mark all that apply. If none apply, mark "None.")**

- ○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 Rectal exam
- ○6 Test for the presence of blood in your stool or bowel movement (hemoccult, guaiac)
- ○7 Tube inserted into your bowel to check for bowel problems (sigmoidoscopy, flex. sig., or colonoscopy)
- ○8 Barium enema X-ray
- ○9 Dilation and Curettage (D & C, womb scrape)
- ○10 Removal of the uterus or womb (hysterectomy)
- ○11 Endometrial biopsy
- ○12 Bone density scan (e.g., DEXA)

○99 **None**
I have not had any of the exams, tests, or procedures listed in either column in Question 8 since the date on the front of this form.

9. What is the date that you finished answering this form? (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** 05 06 07 08 09 10

**Use this space if you have additional information about your answers on this form.**

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PLEASE MAKE NO MARKS IN THIS AREA