COMMENTS

- Affix label here-

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name _____M.I._____

Last Name _____

1. Date of Contact: ⌊__⌋-⌊__⌋-⌊__⌋ (M/D/Y)
2. Completed By: ⌊__⌋
3. Contact Type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other
4. Visit Type:
   - ☐ 1 Screening # ⌊_⌋
   - ☐ 4 Non-Routine

5. Date Washout Started: ⌊__⌋-⌊__⌋-⌊__⌋ (M/D/Y)
6. Date Washout Reviewed: ⌊__⌋-⌊__⌋-⌊__⌋ (M/D/Y)
7. Did washout start at least 3 calendar months ago?

   ___ No, participant willing to continue. → Stop form and recontact participant when washout is ³ 3 calendar months from washout start date.

   ☐ 0 No, participant not willing to continue. **HRT ineligible**

   ☐ 1 Yes

8. **"After you went off hormones did you have post-menopausal symptoms such as hot flashes and night sweats?"**

   ☐ 0 No → Schedule SV1

   ☐ 1 Yes

   8.1. **"Are you still having symptoms?"**

   ☐ 0 No → Schedule SV1

   ☐ 1 Yes

   8.2. **"How severe are the symptoms?"**

   ☐ 1 Mild

   ☐ 2 Moderate

   8.3. **"You may be randomized to a placebo and the symptoms could continue for the rest of the study. Are you interested in participating in the study?"**

   ☐ 0 No **HRT ineligible**

   ☐ 1 Yes → Schedule SV1

   ☐ 3 Severe → **HRT ineligible**

K _____ V _____