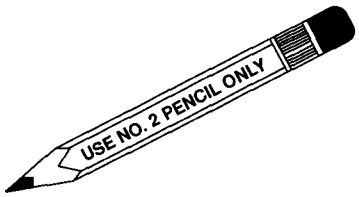
WOMEN'S HEALTH INITIATIVE

Form 30 - Medical History Questionnaire

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 ✓ ⊗ ◐ ◪

- For questions where you write in a number, write the number in the box provided. Then mark the corresponding oval to the right.

Example: If your age is 59:

| 5 | 9 |

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

OFFICE USE ONLY

S _____

AFFIX LABEL BETWEEN LINES

BAR CODE HERE

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 ㉔ ㉕ ㉖ ㉗ ㉘ ㉙

2. Reviewed By:

⓪ ⑳ ㊵
⑩ ⑳ ㉚ ㊵ ㊿ ⑥⓪ ⑦⓪ ⑧⓪ ⑨⓪
① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

3. Contact Type:

① Phone
② Mail
③ Visit
⑧ Other

4. Visit Type:

① Screening ⓪ ① ② ③
② Semi-Annual ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
③ Annual ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
④ Non Routine

5. Form Administration:

① Self ② Group ③ Interview ④ Assistance

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PLEASE MAKE NO MARKS IN THIS AREA

Your Health History

1. Have you been hospitalized overnight at any time during the past two years?

   ⓪ No ① Yes

2. Has a doctor told you that you have any of the following conditions or have you had any of the following procedures? **(Please mark all that apply.)**

   ① Glaucoma

   ② Cataract(s)

   ③ High cholesterol requiring pills

   ④ Asthma

   ⑤ Emphysema or chronic bronchitis

   ⑥ Kidney or bladder stones (renal or urinary calculi)

   ⑦ High blood calcium

   ⑧ Stomach or duodenal ulcer

   ⑨ Diverticulitis

   ⑩ Ulcerative colitis or Crohn's disease

   ⑪ Systemic erythematosus ("lupus" or SLE)

   ⑫ Pancreatitis (inflamed pancreas)

   ⑬ Osteoporosis (weak, thin, or brittle bones)

   ⑭ Hip replacement

   ⑮ Other joint replacement

   ⑯ Part of intestines taken out

   ⑰ Migraine headaches

   ⑱ Alzheimer's disease

   ⑲ Multiple sclerosis

   ⑳ Parkinson's disease

   ㉑ Amyotropic Lateral Sclerosis (ALS, motor neuron disease, or Lou Gehrig's disease)

   ⑨⑨ None of the above

3. Has a doctor ever told you that you had heart problems, problems with your blood circulation, or blood clots?

⓪ No ① Yes

3.1. Please mark the conditions or procedures below that a doctor said you had.

① Cardiac arrest (where your heart stopped and needed to be restarted)

② Heart failure or congestive heart failure

③ Cardiac catheterization (heart catheterization or coronary angiogram)

④ Heart bypass operation or coronary bypass surgery for blocked or clogged arteries in your heart

⑤ Angioplasty of the coronary arteries (opening the arteries of the heart with a balloon or other device, sometimes called a PTCA)

⑥ Carotid endarterectomy or carotid angioplasty (operation for blockage or narrowing of the arteries in your neck)

⑦ Atrial fibrillation (a type of irregular heart beat)

⑧ Aortic aneurysm

⑨ None of the above

4. Did your doctor ever say that you had arthritis?

⓪ No ① Yes

4.1. What type of arthritis do you have?

① Rheumatoid arthritis (not including rheumatism)

⑧ Other/Don't know

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

5. Did a doctor ever say that you had gallbladder disease or gallstones?

⓪ No ① Yes

5.1. Do you now have gallbladder disease or gallstones?
⓪ No ① Yes

5.2. Did you ever have a procedure to remove gallstones?
⓪ No ① Yes

5.3. Did you have your gallbladder removed?
⓪ No ① Yes

6. Did a doctor ever say that you had a thyroid gland problem (not including thyroid cancer)?

⓪ No ① Yes

6.1. Do you have any of the following conditions? **(Please mark "No" or "Yes" for each condition.)**	No	Don't know	Yes	6.2. If yes, do you now have this problem? No	Yes
6.1.1. Goiter (large thyroid gland)	⓪	⑨	① →	⓪	①
6.1.2. Nodule (lumps in the thyroid gland)	⓪	⑨	① →	⓪	①
6.1.3. Overactive thyroid	⓪	⑨	① →	⓪	①
6.1.4. Underactive thyroid	⓪	⑨	① →	⓪	①

7. Did a doctor ever say that you had hypertension or high blood pressure? **(Do not include high blood pressure that you had only when you were pregnant.)**

⓪ No ① Yes

7.1. How old were you when you were told you had high blood pressure? **(Give your best guess.)**

Less than 20	20-29	30-39	40-49	50-59	60-69	70 or older
①	②	③	④	⑤	⑥	⑦

7.2. Did you ever take pills for high blood pressure?
⓪ No ① Yes

7.3. Do you now take pills for high blood pressure?
⓪ No ① Yes

Go to the next page.

8. Did a doctor ever say that you had angina (chest pains from a heart problem)?

⓪ No ① Yes

8.1. Do you now take pills for angina?

⓪ No ① Yes

9. Did a doctor ever say that you had claudication or peripheral arterial disease (poor blood flow to the legs or blocked or narrowed arteries to the legs)? Do not include varicose veins or phlebitis.

⓪ No ① Yes

For the above condition, have you ever had:

	No	Yes
9.1. Angiography (dye in the arteries of the legs)?	⓪	①
9.2. Angioplasty (balloon catheter to open blockage)?	⓪	①
9.3. Surgery to improve blood flow in your legs (do not include surgery for varicose veins)?	⓪	①

10. Have you ever had a colonoscopy or sigmoidoscopy or flex sig (where a doctor inserts a tube in the rectum to check for bowel problems)?

⓪ No ① Yes

10.1. When was the last test?

① Less than 5 years ago ② 5 or more years ago

10.2. Did you ever have any polyps of the colon, intestine, bowel, or rectum removed?

⓪ No ① Yes

11. Have you ever given a sample of your stool (BM, bowel movement, or feces) to be checked or had a rectal stool exam by a doctor or nurse? This is sometimes called a stool guaiac or hemoccult test.

⓪ No ① Yes

11.1. When was the last test?

① Less than 5 years ago ② 5 or more years ago

Go to the next page.

12. Did a doctor ever say that you had cancer, a malignant growth, or tumor? **(This does not include "fibroids" of the uterus.)**

⓪ No ① Yes

Go to the next page.

12.1. What kind of cancer did you have? **(Mark "No" or "Yes" for each type of cancer.)**	No	Yes	12.2. How old were you when a doctor first told you that you had this cancer? Less than 55	55 or older
1. Breast	⓪	①	①	②
2. Ovary	⓪	①	①	②
3. Endometrium (lining of the uterus or womb)	⓪	①	①	②
4. Colon, rectum, bowel, or intestine	⓪	①	①	②
5. Thyroid	⓪	①	①	②
6. Cervix (opening to the uterus or womb)	⓪	①		
7. Skin cancer (not melanoma)	⓪	①		
8. Melanoma	⓪	①		
9. Liver	⓪	①		
10. Lung	⓪	①		
11. Brain	⓪	①		
12. Bone	⓪	①		
13. Stomach	⓪	①		
14. Blood (leukemia)	⓪	①		
15. Bladder	⓪	①		
16. Lymphoma	⓪	①		
17. Hodgkin's	⓪	①		
18. Other **(Specify):** _____ _____	⓪	①		

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PLEASE MAKE NO MARKS IN THIS AREA

13. During the past 12 months, how many times did you fall and land on the floor or ground?

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

14. During the past 12 months, have you fainted, blacked out, passed out, or lost consciousness?

⓪ No ① Yes

15. Did a doctor, nurse, or physician assistant ever say you had a broken, fractured, or crushed bone?

⓪ No ① Yes

15.1. Which bone(s) did you break and how old were you when the bone(s) first broke? **(Please mark all that apply. If you don't know the exact age, please guess as close as you can.)**	15.2. How old were you when you first broke this bone? Less than 55	55 or older
① Hip	①	②
② Spine or back (vertebra)	①	②
③ Upper arm (humerus)	①	②
④ Lower arm or wrist	①	②
⑤ Hand (not finger)	①	②
⑥ Lower leg or ankle	①	②
⑦ Foot (not toe)	①	②
⑧ Other **(Specify):** _____ _____	①	②

16. What is the date you finished 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

Thank you. Please take a moment to review any questions you may have missed. Feel free to write any comments here:

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