Date Received: ___-___-___ (M/D/Y) Reviewed By: ___-___	**- Affix label here-** Participant ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
Contact Type: ☐1 Phone ☐2 Mail ☐8 Other Visit Type: ☐3 Annual ☐4 Non-Routine	
OFFICE USE ONLY	

In *Form 33 - Medical History Update*, you said you had some medical problems that are important for us to know about in more detail.

The questions on this form ask about hospital admissions, medical problems, and medical tests that you have had since:

_____ ___, **20**___
month day 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.

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):**_____

_____

→ Please answer the following questions <u>about</u> the WHI Extension Study participant.

Go to the next page.

Information on New Broken, Fractured, or Crushed Bone

2. Since the date on the front of this form, has a doctor told you that you had a broken, fractured, or crushed **hip** or **upper leg** bone?

☐1 Yes ☐0 No → **Go to Question 3 on the next page.**

↓

2.1 Where was the fracture? **(Mark all that apply.)**

☐1 Hip

☐2 Upper leg

2.2. Was this broken, fractured, or crushed hip or upper leg bone first diagnosed or treated during a hospital stay?

☐1 Yes ☐0 No → **Go to Question 2.6 below.**

↓

2.3. What is the name, address, and phone number of the medical facility where you were treated for the broken, fractured, or crushed hip or upper leg bone?

Place name: _____

Street address: _____

_____

City State Zip Code

Phone number: ( ) _____

Office Use Only
Provider ID
⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋

2.4. Date you entered the hospital: ⌊ ⌋⌊ ⌋ - ⌊ ⌋⌊ ⌋ - ⌊ ⌋⌊ ⌋
month day year

2.5. Date you left the hospital: ⌊ ⌋⌊ ⌋ - ⌊ ⌋⌊ ⌋ - ⌊ ⌋⌊ ⌋
month day year

2.6. Was an X-ray or imaging scan (MRI) taken to diagnose the broken, fractured, or crushed hip or upper leg bone?

☐1 Yes ☐0 No → **Go to Question 3 on the next page.**

↓

2.7. Where was your X-ray or imaging scan (MRI) taken?

Place name: _____

Street address: _____

_____

City State Zip Code

Phone number: ( ) _____

Office Use Only
Provider ID
⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋⌊ ⌋
Do not key enter if identical to provider ID in 2.3

2.8. What was the date of the visit? **(If you had more than one visit, give the date of the first visit.)** ⌊ ⌋⌊ ⌋ - ⌊ ⌋⌊ ⌋ - ⌊ ⌋⌊ ⌋
month day year

Information on New Cancers or Malignant Tumors

3. Since the date on the front of this form, has a doctor told you that you have a new cancer or malignant growth or tumor? **(Do not include benign tumors or cancers first diagnosed before the date on the front of this form.)**

☐1 Yes ☐0 No → **Go to Question 4 on page 5.**

3.1. What kind of cancer or malignant tumor was it? **(Mark all that apply.)**

- ☐1 Breast
- ☐2 Ovary
- ☐3 Endometrium (lining of the uterus or womb)
- ☐4 Cervix (opening to the uterus or womb)
- ☐5 Colon, rectum, bowel, or intestine
- ☐6 Skin cancer **(not melanoma)**
- ☐7 Melanoma
- ☐8 Lung
- ☐9 Liver
- ☐10 Bone
- ☐11 Lymphoma or Hodgkin's disease
- ☐12 Leukemia
- ☐13 Meningioma
- ☐88 Other cancer or malignant tumor **(Specify):** _____

If you have checked more than one new cancer or malignant tumor above, write the medical provider information below for the first cancer you were treated for.

If additional cancer sites were treated at different medical facilities, record the additional provider information in the comments section on the last page.

3.2. Was this cancer or malignant tumor diagnosed or treated during a hospital stay of one or more nights?

☐1 Yes ☐0 No → **Go to Question 3.6 on the next page.**

3.3. What is the name, address, and phone number of the place where the medical records of the cancer are kept?

Place name: _____

Street address: _____

_____

City State Zip Code

Phone number: ( ) _____

Office Use Only
Provider ID

3.4. Date you entered the hospital: ___ - ___ - ___
month day year

3.5. Date you left the hospital: ___ - ___ - ___
month day year

Go to the next page.

3.6. What is the date when your cancer or malignant tumor was first diagnosed? ___ - ___ - ___
month day year

3.7. What is the name, address, and phone number of the place where your cancer or malignant tumor was first diagnosed?

Place name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( ) _____

Office Use Only
Provider ID
____
Do not key enter if identical to provider ID in 3.3

3.8. What is the name, address, and phone number of the place where any other tests or procedures for your cancer or malignant tumor were done?

Place name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( ) _____

Office Use Only
Provider ID
____
Do not key enter if identical to provider ID in 3.3 or 3.7

Go to the next page.

Information on Hysterectomy

4. Since the date on the front of this form, have you had a hysterectomy (operation to remove the uterus or womb)?

☐$_1$ Yes ☐$_0$ No → **Go to Question 5 on the next page.**

↓

4.1. What was the date of the operation? ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋
month day year

4.2. What is the name, address, and phone number of the place where the operation was done?

Place name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( ) _____

Office Use Only
Provider ID ⌊__⌋⌊__⌋⌊__⌋⌊__⌋

4.3. What is the name of the doctor who did the operation?

Doctor's name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( ) _____

Office Use Only
Provider ID ⌊__⌋⌊__⌋⌊__⌋⌊__⌋
Do not key enter if identical to provider ID in 4.2

Go to the next page.

Information on heart problems, blocked or narrowed blood vessels, stroke, blood clots in the legs or lungs, and other blood circulation problems or related operations and/or procedures.

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

☐1 Yes ☐0 No → **Go to Question 9 on page 10.**

5.1. Since the date on the front of this form, was this heart problem, blocked or narrowed blood vessels, stroke, or other problems with your circulation (for example, blood clots in your legs or lungs) diagnosed or treated during a hospital stay of **one or more nights**?

☐1 Yes ☐0 No → **Go to Question 6 on page 8.**

5.2. For which of the following heart or circulation problems or procedures were you admitted? **(Mark all that apply.)**

☐1 Heart attack (coronary, myocardial infarction or MI)

☐2 Heart bypass operation (coronary bypass surgery or CABG)

☐3 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)

☐4 Procedure or operation to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty, or carotid stent)

☐5 Stroke

☐6 Blood clots in your legs (deep vein thrombosis or DVT)

☐7 Blood clots in your lungs (pulmonary embolism or PE)

☐8 Poor blood circulation or blocked or narrowed blood vessels to your legs or feet (claudication, peripheral arterial disease, gangrene, or Buerger's disease)

☐9 Heart failure (congestive heart failure)

☐88 Other heart or circulation problems

Go to the next page.

Please give the details of the first two hospital stay(s) where you were admitted for the heart problems, blocked or narrowed blood vessels, stroke, blood clots in the legs (DVT) or lungs (PE), or other blood circulation problems since the date on the front of this form.

Record additional provider information in the comments section on the last page.

5.3. **First hospital admission of one or more nights for heart or circulation problems or procedures.**

Hospital name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( )_____

Office Use Only
Provider ID

5.4. Date you entered the hospital: ___ - ___ - ___
month day year

5.5. Date you left the hospital: ___ - ___ - ___
month day year

5.6. **Second hospital admission of one or more nights for heart or circulation problems or procedures.**

Hospital name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( )_____

Office Use Only
Provider ID

5.7. Date you entered the hospital: ___ - ___ - ___
month day year

5.8. Date you left the hospital: ___ - ___ - ___
month day year

Go to the next page.

Heart, Stroke, Blood Clots in the Legs (DVT) (Outpatient)

6. Since the date on the front of this form, have you ever been treated by a doctor or a nurse **with shots at home or as an outpatient (usually followed by blood thinning pills such as Coumadin or warfarin)** for blood clots in your legs, called deep vein thrombosis or DVT?

☐1 Yes ☐0 No → **Go to Question 7 on the next page.**

6.1. On what date did the shots start (shots such as as Lovenox, Arixtra, or heparin)? ___ - ___ - ___
month day year

6.2. What is the name, address, and phone number of the doctor who treated you for blood clots in your leg?

Doctor's name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( )_____

Office Use Only
Provider ID
___

6.3. Since the date on the front of this form, have you ever had **outpatient** test(s) performed for blood clots in your legs (called deep vein thrombosis or DVT)?

☐1 Yes ☐0 No → **Go to Question 7 on the next page.**

6.4. On what date was the test performed? ___ - ___ - ___
month day year

6.5. What is the name, address, and phone number of the place where you had the outpatient test performed for blood clots in your legs?

Place name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( )_____

Office Use Only
Provider ID
___
Do not key enter if identical to provider ID in 6.2.

Go to the next page.

7. Since the date on the front of this form, have you been diagnosed or treated as an **outpatient** for a stroke?

☐1 Yes ☐0 No → **Go to Question 8 below.**

7.1. What was the date you were diagnosed or treated? ___ - ___ - ___
month day year

7.2. What is the name, address, and phone number of the place where you were first diagnosed or treated for a stroke?

Place name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( )_____

Office Use Only
Provider ID
____

8. Since the date on the front of this form, have you had an **outpatient or day surgery 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)?

☐1 Yes ☐0 No → **Go to Question 9 on the next page.**

8.1. What was the date of the procedure or surgery? ___ - ___ - ___
month day year

8.2. What is the name, address, and phone number of the place where the procedure or surgery was performed?

Place name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( )_____

Office Use Only
Provider ID
____

Go to the next page.

Hospital Stay of <u>Two or More Nights</u> and Not Already Reported on this Form.

9. <u>Since the date on the front of this form</u>, have you been admitted to the hospital for **two or more nights**? (Do not include an overnight stay that you have already reported on this form.)

☐1 Yes ☐0 No → **Go to Question 10 on the last page.**

↓

Please give the details of the first three hospital stays where you were admitted for two or more nights since the date on the front of this form.

Please record additional provider information in the comments section on the last page.

9.1. First hospital admission of **two or more nights**.

Hospital name: _____

Street address: _____

_____

City State Zip Code

Phone number: ( ) _____

Office Use Only
Provider ID
|_|_|_|_|

9.2. Date you <u>entered</u> the hospital: |_|_| - |_|_| - |_|_|
month day year

9.3. Date you <u>left</u> the hospital: |_|_| - |_|_| - |_|_|
month day year

9.4. Reason for this hospital admission: **(Mark all that apply.)**

☐1 Non cancer gynecologic surgeries: e.g., bladder suspension, vaginal/uterine/rectal prolapse, stress incontinence

☐2 Gallbladder attack or gallbladder surgery

☐3 Cataract surgery

☐4 Joint repair or replacement

☐88 Other reasons: (Specify) _____

9.5. ☐5 Office use only

Go to the next page.

9.6. Second hospital admission of **two or more nights**.

Hospital name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( ) _____

Office Use Only
Provider ID

9.7. Date you entered the hospital: ___ - ___ - ___
month day year

9.8. Date you left the hospital: ___ - ___ - ___
month day year

9.9. Reason for this hospital admission: **(Mark all that apply.)**

☐ 1 Non cancer gynecologic surgeries: e.g., bladder suspension, vaginal/uterine/rectal prolapse, stress incontinence
☐ 2 Gallbladder attack or gallbladder surgery
☐ 3 Cataract surgery
☐ 4 Joint repair or replacement
☐ 88 Other reasons: (Specify) _____

9.10. ☐ 5 Office use only

9.11. Third hospital admission of **two or more nights**.

Hospital name: _____
Street address: _____
_____
City State Zip Code
Phone number: ( ) _____

Office Use Only
Provider ID

9.12. Date you entered the hospital: ___ - ___ - ___
month day year

9.13. Date you left the hospital: ___ - ___ - ___
month day year

9.14. Reason for this hospital admission: **(Mark all that apply.)**

☐ 1 Non cancer gynecologic surgeries: e.g., bladder suspension, vaginal/uterine/rectal prolapse, stress incontinence
☐ 2 Gallbladder attack or gallbladder surgery
☐ 3 Cataract surgery
☐ 4 Joint repair or replacement
☐ 88 Other reasons: (Specify) _____

9.15. ☐ 5 Office use only

Go to the next page.

10. What was the date that you finished answering this form? ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋
month day year

Please report comments and additional provider information below.

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