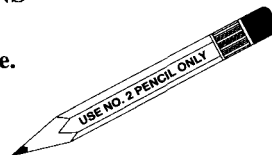




Form 33 - Medical History Update

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 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.

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0414). Do not return the completed form to this address.

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											
Y	1	2	3	4	5	6	7	8	9					
	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						

3. Contact Type:

- 1 Phone
- 2 Mail
- 3 Visit
- 4 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

AFFIX LABEL BETWEEN LINES
BAR CODE HERE



PLEASE MAKE NO MARKS IN THIS AREA

1901851

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

4

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

5

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

5

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
10 20 30
D 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.

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PLEASE MAKE NO MARKS IN THIS AREA

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