

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.

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

1. Date Received:

Month Day Year

2. Reviewed By:

3. Contact Type:

- ☐ 1 Phone
- ☐ 2 Mail
- ☐ 8 Other

4. Visit Type:

- ☐ 3 Annual
- ☐ 4 Non-Routine

5. Language:

- ☐ FCA ☐ OU1 ☐ OU2

FIG. 1

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PLEASE MAKE NO MARKS IN THIS AREA

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
☐ ⁴ 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.)

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

→
Please Go On to the Next Page

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?

☐ No ☐ Yes

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

- ☐ Skin cancer (not melanoma)
☐ 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?

☐ No ☐ Yes

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

- | | |
|--|--|
| <input type="radio"/> Hip | <input type="radio"/> Hand (not finger) |
| <input type="radio"/> Upper leg (not hip) | <input type="radio"/> Elbow |
| <input type="radio"/> Pelvis | <input type="radio"/> Upper arm or shoulder |
| <input type="radio"/> Knee (patella) | <input type="radio"/> Jaw, nose, face, and/or skull |
| <input type="radio"/> Lower leg or ankle | <input type="radio"/> Finger or toe |
| <input type="radio"/> Foot (not toe) | <input type="radio"/> Ribs and/or chest or breast bone |
| <input type="radio"/> Tailbone (coccyx) | <input type="radio"/> Cervical spine/neck |
| <input type="radio"/> Spine or back (vertebra) | <input type="radio"/> Other (Specify): _____ |
| <input type="radio"/> Lower arm or wrist | |

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.")

- | | |
|--|---|
| <input type="radio"/> Pills for diabetes | <input type="radio"/> Pills for osteoporosis other than calcium supplements |
| <input type="radio"/> Insulin shots for diabetes | <input type="radio"/> Calcium supplements for osteoporosis |
| <input type="radio"/> Diet and/or physical activity for diabetes | <input type="radio"/> Pills for high cholesterol |
| <input type="radio"/> Pills for high blood pressure or hypertension | <input type="radio"/> Estrogen or estrogen combination pills |
| <input type="radio"/> Treatment for depression (pills or therapy) | <input type="radio"/> None |
| <input type="radio"/> Treatment for anxiety, panic, or phobia (pills or therapy) | 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)
☐ ⁹ Dilation and Curettage (D & C, womb scrape)
☐ ¹⁰ Removal of the uterus or womb (hysterectomy)
☐ ¹¹ Endometrial biopsy
☐ 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

☐ 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

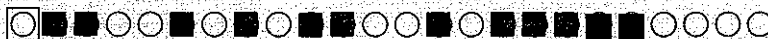
Please mark only one bubble per line:

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.



PLEASE MAKE NO MARKS IN THIS AREA.

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