WHI **Form 2 - Eligibility Screen** **Ver. 3**

OMB#_____ Exp. _____

Date: ☐☐-☐☐-☐☐ (M/D/Y) Contacted By: ☐☐☐	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
Contact Type: ☐1 Phone ☐2 Mail ☐3 Visit ☐8 Other	Visit Type: ☐1 Screening # ☐ ☐4 Non-Routine Form Administration ☐1 Self ☐2 Group ☐4 Assistance
OFFICE USE ONLY	

We would like some information from you so that we can find out if you can take part in the study. Please print the information in the space provided and follow instructions for filling in the ovals.

These first questions will just help us stay in touch with you.

1. What is your full name?

   _____ _____ _____ _____
   (Mrs., Ms., Miss) First Middle Initial Last

2. What is your current mailing address?

   _____

   _____
   City State Zip

3. What is your home phone number? Home: (__ __ __) __ __ __ - __ __ __ __

4. Do you have a work number?

   ☐ No ☐ Yes ↓

   4.1. May we call you at work?
   ☐ No ☐ Yes ↓

   4.2 What is your work number ?

   Work:(__ __ __) __ __ __ - __ __ __ __

↓

Go to the next page.

5. Is there any other number where you can often be reached?

   Other: (__ __ __) __ __ __ - __ __ __ __ _____
   Whose phone number is this?

6. When are the best times to call you?

		At home	At work	Other
_____ day of week	_____ time(s)	☐ 1	☐ 2	☐ 8
_____ day of week	_____ time(s)	☐ 1	☐ 2	☐ 8
_____ day of week	_____ time(s)	☐ 1	☐ 2	☐ 8

7. What is your birth date? **(Put month first, then day, and then year.)**

   ☐☐-☐☐-☐☐
   Month Day Year

Office Use 7.1.
___ 47-49
___ 50-79
___ <47, 80+

   7.1. What is your age now? ___ ___ years old

8. Do you think you will be living in this area for the next three years?

   ☐ 0 No ☐ 1 Yes

9. Are you now in any other research study?

   ☐ 0 No ☐ 1 Yes ↓

   9.1. What is the name of that study? _____
   _____
   _____

Office Use 9.2.
☐ 0 No
☐ 1 Yes

10. Did a doctor ever say that you had breast cancer?

    ☐ 0 No ☐ 1 Yes

11. Did a doctor ever say that you had colon, rectum, bowel, or intestinal cancer?

☐ 0 No ☐ 1 Yes

↓

11.1. Were you first told that you had this cancer in the last 10 years?

☐ 0 No ☐ 1 Yes

12. Did a doctor ever say that you had endometrial cancer (cancer of the lining of the uterus or womb)?

☐ 0 No ☐ 1 Yes

↓

12.1. Were you told that you had this cancer in the last 10 years?

☐ 0 No ☐ 1 Yes

13. Did a doctor ever say that you had skin cancer?

☐ 0 No ☐ 1 Yes

↓

13.1. Was the skin cancer melanoma?

☐ 0 No ☐ 1 Yes

↓

13.2. Were you told that you had melanoma in the last 10 years?

☐ 0 No ☐ 1 Yes

14. In the past 10 years, did a doctor ever say that you had any other cancers?

☐ 0 No ☐ 1 Yes

The next question asks about your background. This information will help us describe in general ways, the women who are interested in the study.

15. How would you describe your racial or ethnic group? If you are of mixed blood, which group do you identify with most?

- ☐ 1 American Indian or Alaskan Native
- ☐ 2 Asian or Pacific Islander (ancestry is Chinese, Indo-Chinese, Korean, Japanese, Pacific Islander, Vietnamese)
- ☐ 3 Black or African-American (not of Hispanic origin)
- ☐ 4 Hispanic/Latino (ancestry is Mexican, Cuban, Puerto Rican, Central American, or South American)
- ☐ 5 White (not of Hispanic origin)
- ☐ 8 Other **(Specify)**: _____

16. How did you hear about the study? **(Mark one. If you heard in more than one way, mark the one that made you decide to contact us.)**

- ☐ 1 Mailed letter
- ☐ 2 Brochure
- ☐ 3 T.V.
- ☐ 4 Radio
- ☐ 5 Newspaper or Magazine
- ☐ 6 Meeting
- ☐ 7 Friend/Relative
- ☐ 8 Other **(Specify):** _____

Office Use
16.1.
RSC
☐☐

Now we want to ask you some questions about hormones and your menstrual history.

17. Did you ever use any female hormones like estrogen (Premarin) or progesterone (Provera)? These might be pills, skin patches, implants, creams, suppositories, shots, or birth control pills. **(This does not include birth control pills you used before you were 50 years old.)**

☐ 0 No ☐ 1 Yes ↓

17.1. Are you taking female hormones now?

☐ 0 No →
☐ 1 Yes ↓

17.2. Have you taken female hormones in the last 3 months?

☐ 0 No ☐ 1 Yes

17.3. Have you ever had an osteoporosis-related fracture or broken bone? (Osteoporosis is a condition where bones become brittle and weak as a woman ages.)

☐ 0 No ☐ 1 Yes ↓

17.4. Did a doctor give you hormones to <u>treat</u> the fracture or broken bone?

☐ 0 No ☐ 1 Yes

18. Did you ever have a hysterectomy? (This is an operation to take out your uterus or womb.)

☐ 0 No ☐ 1 Yes ↓

18.1. Was your hysterectomy within the last 3 months?

☐ 0 No ☐ 1 Yes

18.2. How old were you when you had your hysterectomy?

Less than 30	30-34	35-39	40-44	45-49	50-54	55-59	60 or older
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Go to the next page.

19. When was the last time you had any menstrual bleeding or spotting? **(Your best guess.)**

☐ 1 Still having menstrual bleeding
☐ 2 Within the last 6 months
☐ 3 7 to 12 months ago
☐ 4 Over 12 months ago

These questions are about your diet and your health.

20. How many of your meals are prepared away from your home each week, that is, meals that you eat in a restaurant, or as "take-out," or at friends' or relatives' houses?

☐ 0 Less than 10 meals each week
☐ 1 10 or more meals each week

21. Are you following a special diet for malabsorption, celiac sprue (sometimes this is called a gluten-free diet), ulcerative colitis, or Crohn's disease that is prescribed by a doctor? **(We know that these may be unfamiliar words. If you have not been told to follow one of these diets, mark No.)**

☐ 0 No ☐ 1 Yes

22. Are you following a special low-fiber or low-residue diet (low in fruits, vegetables, and grains) that was prescribed for you by your doctor?

☐ 0 No ☐ 1 Yes

23. Did a doctor ever say that you had sugar diabetes or high blood sugar when you were <u>not</u> pregnant?

☐ 0 No ☐ 1 Yes ↓

23.1. How old were you when you were <u>first</u> told you had sugar diabetes? **(Don't include diabetes you had only when pregnant.)**

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

23.2. Were you ever hospitalized for a diabetic coma?

☐ 0 No ☐ 1 Yes

23.3. Did a doctor ever tell you to keep a special diet for your diabetes?

☐ 0 No ☐ 1 Yes

23.4. Did you ever take insulin shots?

☐ 0 No ☐ 1 Yes ↓

23.5. Are you using insulin now?

☐ 0 No ☐ 1 Yes

23.6. Did you ever take pills for your diabetes to lower your blood sugar?

☐ 0 No ☐ 1 Yes

23.7. Do you have sugar diabetes or high blood sugar now?

☐ 0 No ☐ 1 Yes

24. Did a doctor ever say that you had a blood clot in your legs? This is sometimes called deep vein thrombosis or DVT. This does not include varicose veins or phlebitis.

☐ 0 No ☐ 1 Yes ↓

24.1. Did you have a blood clot in your leg in the last 6 months?

☐ 0 No ☐ 1 Yes

24.2. Did this blood clot occur within one month after a serious accident, fracture, injury, or operation?

☐ 0 No ☐ 1 Yes

Go to the next page.

25. Did a doctor ever say that you had a blood clot in your lung? This is sometimes called a pulmonary embolus or PE.

☐ 0 No ☐ 1 Yes

↓

25.1. Did you have a blood clot in your lung in the last 6 months?

☐ 0 No ☐ 1 Yes

25.2 Did this blood clot occur within one month after a serious accident, fracture, injury, or operation?

☐ 0 No ☐ 1 Yes

26. Did a doctor ever say that you had a stroke?

☐ 0 No ☐ 1 Yes

↓

26.1. Did you have a stroke in the last 6 months?

☐ 0 No ☐ 1 Yes

Office Use
26.1.
____ **FE**

27. Did a doctor ever say that you had a small stroke that lasted less than 24 hours? This is sometimes called a TIA or transient ischemic attack.

☐ 0 No ☐ 1 Yes

↓

27.1. Did you have a TIA in the last 6 months?

☐ 0 No ☐ 1 Yes

Office Use
27.1.
____ **FE**

Go to the next page.

28. Did a doctor ever say that you had a heart attack? This is sometimes called a coronary, MI, or myocardial infarction.

☐ 0 No ☐ 1 Yes

28.1 How old were you when you had your <u>first</u> heart attack? **(Your best guess.)**

Less than 40	40-49	50-59	60-69	70 or older
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

28.2. Did you have a heart attack in the last 6 months?

☐ 0 No ☐ 1 Yes

Office Use
28.2.
____ **FE**

29. Did a doctor ever say that you had any of the following health problems? **(Please answer No or Yes for each problem listed.)**

	No	Yes
29.1. Sickle cell anemia?	☐ 0	☐ 1
29.2. Heart failure?	☐ 0	☐ 1
29.3. Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)?	☐ 0	☐ 1
29.4. Bleeding problem?	☐ 0	☐ 1

Office Use
29.
2. ____ CP
3. ____ CP
4. ____ CP

30. Have you lost 15 or more pounds in the last 6 months without trying?

☐ 0 No ☐ 1 Yes

31. Are you on kidney dialysis or a kidney machine for kidney or renal failure?

☐ 0 No ☐ 1 Yes

32. Do you have any other long-term or chronic illness?

☐ 0 No ☐ 1 Yes

Office Use
32.
____CP

32.1.What is it? **(Specify):** _____

33. Are there any reasons, like serious emotional problems, mental illness, or too much stress, that would make it hard for you to be in a research study?

☐ 0 No ☐ 1 Yes

34. Will you be able to come to our clinic?

☐ 0 No →

☐ 1 Yes

34.1. What kind of help would you need in order to come to our clinic?

Office Use
34.1
____TE

☐ 0 Transportation
☐ 1 Child care
☐ 0 Adult Care
☐ 1 Other **(Specify):**_____

35. Do you think you might be interested in the Dietary Change part of the study?

☐ 0 No ☐ 1 Yes
☐ 9 Don't know

35.1 If you join the dietary part of the study, you will be placed in a dietary change or usual diet group. You may be attending regular group meetings. Will you be available for regular meetings for the next year?

☐ 0 No ☐ 1 Yes

Go to the next page.

36. Do you think you might be interested in the Hormone Replacement part of the study?

☐ 0 No ☐ 1 Yes
☐ 9 Don't know/need more information

36.1. If you join the hormone part of the study, you may be placed into the hormone or no-hormone (placebo) group. Would you consider taking only the hormone pills given to you by Clinical Center staff if you join the hormone part of the study?

☐ 0 No → **Go to Question 37.**
☐ 1 Yes
☐ 9 Don't know

36.2. If you are currently on hormones, are you interested in talking to your doctor about the Hormone Replacement part of the Study?

☐ 0 No
☐ 9 Don't know
☐ 2 Not on hormones
→ **Go to Question 37.**

☐ 1 Yes

36.3. Would you like us to send information about the Hormone Replacement part of the study to your doctor?

☐ 0 No → **Go to Question 37.**
☐ 1 Yes

What is the name and address of your primary doctor or gynecologist?

Doctor's Name: _____

Clinic Name: _____

Address: _____

City/State/Zip: _____

37. What is the date you finished this form?

__-__-__
Month Day Year

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 _____

Comments:	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

1. Contact Date: ⌊__⌋-⌊__⌋-⌊__⌋ (M/D/Y)
2. Staff Person: ⌊___⌋
3. Contact Type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other
4. Visit Type:
   - ☐ 2 Semi-Annual # ⌊__⌋
   - ☐ 3 Annual # ⌊__⌋
   - ☐ 4 Non-Routine

(Complete Question 5 before interview.)

5. Dosage/Adherence

5.1. Taking Standard WHI Dosage:

___ No

___ Yes → ____ Adherence rate / ____ Unable to do

5.2. Taking Altered Dosage:

___ No

___ Yes → ____ Adherence rate / ____ Unable to do

Refer to the Hysterectomy Status in WHILMA:

- If the Hysterectomy Status is "Yes", mark **YES** in 6 and go to 6.1.
- If the Hysterectomy Status is "No", ask, **"Have you had a hysterectomy?"**
  - If the participant reports a hysterectomy, mark **YES** in 6 and go to 6.1. (Contact the CCC before dispensing any study pills.)
  - If participant says she has not had a hysterectomy, mark **NO** in 6 and go to 6.2.

6. Has the participant had a hysterectomy?

☐ 1 **YES** →

6.1. **"Even though you've had a hysterectomy, have you had any bleeding from your vagina since your last contact?"**

☐ 0 No → *Go to Question 7.*

☐ 1 Yes → *Go to Question 7 and refer to Clinic Practitioner.*

☐ 0 **NO** →

6.2. Review *Form 53 - HRT Calendar* if available. **"Have you had any vaginal bleeding since your last contact?"**

☐ 0 No *(Go to Question 7.)* ☐ 1 Yes → *Complete interview, then refer to Clinic Practitioner.*

"These next questions are about your vaginal bleeding."

6.3. **"How heavy was it**?" *(Use the heaviest time since the previous contact.)*

- ☐ 1 Spotting - Approx. 1 pad's worth/day
- ☐ 2 Light - Approx. 2-3 pads' worth/day
- ☐ 3 Moderate - Approx. 4-7 pads' worth/day
- ☐ 4 Severe - 8 or more pads' worth/day

6.4. **"When did the bleeding start?"** *(Use the earliest time since the previous contact.)*

⌊__⌋-⌊__⌋-⌊__⌋ (M/D/Y)

6.5. **"Did the bleeding start and stop again?"**

☐ 0 No ☐ 1 Yes

6.6. **"Are you bleeding now?"** (*If bleeding even a little, mark "Yes."*)

☐ 0 No →

☐ 1 Yes

6.7. **"When did the bleeding stop?"**

⌊__⌋-⌊__⌋-⌊__⌋ (M/D/Y)

K _____

7. **"Since your last contact, have you had any breast tenderness?"**

☐ 0 No

☐ 1 Yes →

7.1 **"Was your breast tenderness mild, moderate, or severe?"**

☐ 1 Mild

☐ 2 Moderate → *Refer to Clinic Practitioner*

☐ 3 Severe

8. **"Since your last contact, have you had any operations on or noticed any <u>other</u> changes in your breasts (new lumps, nipple discharge, or skin changes)?"**

☐ 0 No

☐ 1 Yes → *Refer to Clinic Practitioner.*

"You may have already answered these questions on other forms, but I'd like to recheck these items to make sure it is safe for you to stay on your study pills."

9. **"What was the date of your last mammogram?"**

Month _____ Year _____

10. **"Are you now taking, or has your doctor prescribed, any:"**

10.1 **"Corticosteroids** (such as Prednisone, Decadron, Medrol in pill form)**?"** ☐ 0 No ☐ 1 Yes

10.2 **"Blood thinning medications** (such as Coumadin or Warfarin)?**"** ☐ 0 No ☐ 1 Yes

"Other than your WHI study pills, are you now taking, or has your doctor prescribed, any hormones such as:"

10.3 "**Estrogen?"**…….. ☐ 0 No ☐ 1 Yes

10.4 "**Progesterone?"**……. ☐ 0 No ☐ 1 Yes

10.5 "**Testosterone?"**…….. ☐ 0 No ☐ 1 Yes

10.6 "**Tamoxifen, Raloxifene …… (Evista) or other medications known as SERMs?"** ☐ 0 No ☐ 1 Yes

Refer any "Yes" responses in 10.1 - 10.6 to CP. ↵

11. **"Since your last contact, has a doctor told you that you had any of the following conditions?"**

11.1 **"Endometrial hyperplasia"** ☐ 0 No ☐ 1 Yes

11.2 **"High triglycerides in your blood (triglycerides are not the same as cholesterol)"** ☐ 0 No ☐ 1 Yes ↓

11.3 If yes: **"Were your triglycerides over 1,000 (mg/dl)?"** ☐ 0 No ☐ 1 Yes

11.4 **"Blood clot to your leg or lung"** ☐ 0 No ☐ 1 Yes

11.5 **"Melanoma of skin"** ☐ 0 No ☐ 1 Yes

11.6 **"Heart attack or stroke"** ☐ 0 No ☐ 1 Yes

11.7 **"Meningioma, or tumors in the brain"** ☐ 0 No ☐ 1 Yes

11.8 **"Breast cancer"** ☐ 0 No ☐ 1 Yes

11.9 **"Gall bladder disease"** ☐ 0 No ☐ 1 Yes

11.10 **"Problems with your pancreas"** ☐ 0 No ☐ 1 Yes

11.11 **"Transient ischemic attack (TIA or "mini-stroke")"** ___ No ___ Yes

11.12 **"Sudden, serious changes in your eyes or vision"** ___ No ___ Yes

Refer any "Yes" responses in 11.1 - 11.12 to CP. ↵

12. **"Are there any worries, discomforts, or questions you would like to discuss?"**

List below and discuss with participant. Refer to Clinic Practitioner if there are any concerns.

_____

_____

_____

_____

_____

_____

_____

13. Resulting action from participant reports of symptoms or concerns in items 6-12. (This item must be completed. Mark all that apply.)

- ☐ 1 Participant reassured and advised to continue with current study medications.
- ☐ 2 Participant advised to return to clinic for evaluation. Date and time of next appointment:

  _____
- ☐ 3 Consulting gynecologist notified.
- ☐ 4 Participant referred to primary physician:

  Physician: _____

  _____
- ☐ 6 Medications changed or stopped (*complete Form 54 – Change of Medications)*
- ☐ 8 Other *(Specify)*:_____

  _____

14. **"I'd like to talk with you about your HRT study pills."**

14.1. **"Since your last contact, how often did you take the study pills? Would you say..."** *(Mark the* response *most often true.) (Read responses to participant.)*

- ☐ 0 **"Not at all"**
- ☐ 1 **"Less than once per week"**
- ☐ 2 **"1 - 2 days per week"**
- ☐ 3 **"3 - 4 days per week"**
- ☐ 4 **"5 - 6 days per week"**
- ☐ 5 **"Every day of the week"**

14.2. **"It is common for people to miss taking pills. About how many days have you missed taking your pills in the last month?"** *(Use best estimate.)*

☐☐ days in the last month

14.3. **"What helped you remember to take your pills?"**

_____

_____

_____

_____

_____

_____

_____

_____

14.4. **"People miss taking their study pills for many reasons. If there were days you did not take the pills, what were the reasons you didn't?"** *(Mark all that apply.)*

- ☐ 1 Took all pills every day
- ☐ 2 Experienced symptoms
- ☐ 3 Forgot pill(s)
- ☐ 4 Forgot bottle
- ☐ 5 Needed/Took a break
- ☐ 6 Afraid of health problems
- ☐ 7 Family/Friend recommendation
- ☐ 8 MD recommendation
- ☐ 9 Didn't have any pills
- ☐ 88 Other _____

14.5. Strategies to improve adherence (Refer to forms instructions for specific examples.)

- ____ Ask participant to describe reason(s) given.
- ____ Provide reassurance, using validation, review of facts
- ____ Recommend palliative measures, using specific examples.
- ____ Recommend steps to improve adherence, such as ways to deal with problem at home, self-motivation, mobilizing social support
- ____ Put issues into perspective- emphasize safety of study, importance of WHI in answering health problems

Use local CC guidelines to determine if referral to CP or other specialist is needed.

15.1 Should participant be put on Intensive Adherence Program (IAP)? (See instructions for entry criteria.)

- ☐ 0 No
- ☐ 1 Yes → 15.2 Date to be recontacted ☐☐-☐☐-☐☐ (M/D/Y)

16.1 Should participant be recontacted in one month by phone for clinical follow-up?

- ☐ 0 No
- ☐ 1 Yes → 16.2 Date to be recontacted ☐☐-☐☐-☐☐ (M/D/Y)

17. Comments:

Comments:

- Affix label here-

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

First Name _____M.I._____

Last Name _____

1. Contact Date: ☐☐-☐☐-☐☐ (M/D/Y)
2. Staff Person: ☐☐☐
3. Contact Type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other
4. Visit Type:
   - ☐ 2 Semi-Annual # ☐☐
   - ☐ 3 Annual # ☐☐
   - ☐ 4 Non-Routine

(Complete Question 5 before interview.)

5. Dosage/Adherence

5.1. Taking Standard WHI Dosage:

___ No

___ Yes →

____	Adherence rate
____	Unable to do

5.2. Taking Altered Dosage:

___ No

___ Yes

____	Adherence rate
____	Unable to do

5.3. Current CaD Formulation:

____ Chewable ___ Swallowable

6. **"Are you now taking, or has your doctor prescribed, any of these medications?"**

6.1 **"Calcium** containing medications, multivitamins, or supplements (such as Oscal or Tums?)" ☐ 0 No ☐ 1 Yes

a. Dosage ☐☐☐☐☐ mg/day

b. Name _____

_____

6.2 **"Vitamin D Pills or multivitamins containing Vitamin D?"** ☐ 0 No ☐ 1 Yes

a. Dosage_____IU/Day

6.3 **"Calcitriol** (such as Rocaltrol)?" ☐ 0 No ☐ 1 Yes

Refer any "Yes" responses in 6.2 - 6.3 to CP. ↵

7. **"Since your last contact, have you been told you have any of the following medical conditions?"**

7.1 **"Hypercalcemia** (too much calcium in the blood)?" ☐ 0 No ☐ 1 Yes

7.2 **"Kidney Problems** (such as stones in your kidney or bladder)?" ☐ 0 No ☐ 1 Yes

7.3 **"Are you undergoing kidney dialysis?"** ☐ 0 No ☐ 1 Yes

Refer any "Yes" responses in 7.1 - 7.3 to CP. ↵

8. **"Are there any worries, discomforts, or questions you would like to discuss?"**

List here and discuss with participant. Refer to Clinic Practitioner if there are any concerns.

_____

_____

_____

_____

9. Resulting action from Questions 6-8. *(This item must be completed. Mark all that apply.)*

- ☐ 1 Participant reassured and advised to continue with current study medications.
- ☐ 2 Participant advised to return to clinic for evaluation.

  Date and time of next appointment:

  _____
- ☐ 3 Clinic Practitioner or Consulting Gynecologist notified.
- ☐ 4 Participant referred to primary physician:

  Physician: _____
- ☐ 6 Medications changed or stopped (*complete Form 54 - Change of Medications*)
- ☐ 8 Other *(Specify)*:_____

K _____

10. **"I'd like to talk with you about your CaD study pills."**

10.1. **"Since your last contact, how often did you take the study pills? Would you say..."** *(Mark response most often true.) (Read responses to participant.)*

- ☐ 0 **"Not at all"**
- ☐ 1 **"Less than once per week"**
- ☐ 2 **"1 - 2 days per week"**
- ☐ 3 **"3 - 4 days per week"**
- ☐ 4 **"5 - 6 days per week"**
- ☐ 5 **"Every day of the week"**

10.2. **"How do you take your pills on the days you take them?"** *(Read responses to participant.)*

- ☐ 1 **"One pill twice a day"**
- ☐ 4 **"Two pills once a day"**
- ☐ 3 **"One pill once a day"**
- ☐ 8 **Other**_____

10.3. **"It is common for people to miss taking pills. How many days have you missed taking any of your pills in the last month?"**

__ days in the last month

10.4. **"What helped you remember to take your pills?"**

_____

_____

_____

_____

10.5. **"People miss taking their study pills for many reasons. If there were days you did not take the pills, what were the reasons you didn't?"** *(Mark all that apply.)*

- ☐ 1 Took all pills every day
- ☐ 2 Experienced symptoms
- ☐ 3 Forgot pill(s)
- ☐ 4 Forgot bottle
- ☐ 5 Needed/Took a break
- ☐ 6 Afraid of health problems
- ☐ 7 Family/Friend recommendation
- ☐ 8 MD recommendation
- ☐ 9 Didn't have any pills
- ☐ 88 Other _____

10.6 Determine the participant's preference for CaD formulation.

___ Chewable ___ Swallowable

10.7. Strategies to improve adherence (Refer to forms instructions for specific examples.)

- ___ Ask participant to describe the reason(s) given.
- ___ Provide reassurance, using validation, review of facts.
- ___ Recommend palliative measures using specific examples.
- ___ Recommend steps to improve adherence, such as ways to deal with problem at home, self-motivation, mobilizing social support.
- ___ Put concerns into perspective-emphasize safety of study, importance of WHI in answering health problems.

Refer to CP if adherence strategies seem complicated.

11.1 Should participant be put on Intensive Adherence Program? (See instructions for entry criteria.)

- ☐ 0 No
- ☐ 1 Yes → 11.2 Date to be recontacted: __-__-__ (M/D/Y)

12.1 Should participant be recontacted in one month by phone for clinical follow-up?

- ☐ 0 No
- ☐ 1 Yes → 12.2 Date to be recontacted: __-__-__ (M/D/Y)

13. Comments:_____

OMB# 0925-0414 Exp.

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

OFFICE USE ONLY

Please use ink.

Your Contact Information

We would like some contact information about you, your spouse or partner, and two friends so we can keep in touch with you over the course of the study. This information is very important, so if there are any changes, please let us know immediately. Please print the information in the space provided or mark the appropriate box with an "x" (☒). <u>You do not have to answer questions that you don't want to answer</u>.

1. What is your current full legal name?

_____ _____ _____
First MI Last

2a. What other names do you use?

_____ _____
First Last

2b. What is, or was, your father's name?

_____ _____
First Last

3. Under what name is your phone number listed in the phone book?

_____ _____
First Last

☐1 Not listed in phone book

4. Please provide the names of two relatives or friends, not living in your household, who are likely to know how to contact you if we cannot contact you directly.

4.1. Name: _____

Address: _____

_____
City State Zip Code

Phone number: _____ Relationship: _____

4.2. Name: _____

Address: _____

_____

City State Zip Code

Phone number: _____ Relationship: _____

The next question asks for your Social Security Number. You are not required to give us your number. If you give us your Social Security Number, we will use it to help us keep in contact with you throughout the study. This information is being requested under Section 301 of the Public Health Services Act, 42 U.S.C. 241.

5. What is your Social Security Number? ___-___-____

The next few questions about your background are important to help describe, in general terms, the women who are part of this study.

6. What is the highest grade in school you finished? **(Mark one.)**

- ☐ 1 Didn't go to school
- ☐ 2 Grade school (1-4 years)
- ☐ 3 Grade school (5-8 years)
- ☐ 4 Some high school (9-11 years)
- ☐ 5 High school diploma or G.E.D.
- ☐ 6 Vocational or training school after high school graduation
- ☐ 7 Some college or Associate Degree
- ☐ 8 College graduate or Baccalaureate Degree
- ☐ 9 Some college or professional school after college graduation
- ☐ 10 Master's Degree
- ☐ 11 Doctoral Degree (Ph.D., M.D., J.D., etc.)

7. What is your current job status? **(Mark the one that best describes you. If more than one describes you, mark both.)**

- ☐ 1 Not working
- ☐ 2 Retired
- ☐ 3 Homemaker, raising children, care of others
- ☐ 4 Employed (full-time or part-time)
- ☐ 5 Disabled, unable to work

☐ 8 Other **(Specify)**: _____

8. Which of the statements below best describe your job? If you are not working now, which statement best describes your past job, that is, the job you held the longest? **(If you are a homemaker, but work part-time, you should mark both.)**

☐ 1 **Homemaker, raising children, care of others**

☐ 2 **Managerial, professional specialty** (Executive, managerial, administrative, professional occupations. Job titles include teacher, guidance counselor, registered nurse, doctor, lawyer, accountant, architect, computer/systems analyst, personnel manager, sales manager, etc.)

☐ 3 **Technical, sales, and administrative support** (Technical and related support occupations, sales, administrative support, clerical work. Job titles include computer programmer/operator, vocational/practical nurse, dental assistant, laboratory technician, sales clerk, cashier, receptionist, secretary, word processor, etc.)

☐ 4 **Service** (Protective service (police, fire), health or food services, craft and repair occupations, farming, forestry or fishing occupations. Job titles include policewoman, nursing assistant, teaching assistant, child care attendant, maid, cook, waitress, food service clerk, seamstress, etc.)

☐ 5 **Operators, fabricators, and laborers** (Factory, transport, and construction work. Job titles include factory, assembly, truck driver, construction worker, etc.)

☐ 8 **Other (Specify)**: _____

9. What is your current marital status? **(Mark the one that <u>best</u> describes you.)**

☐ 1 Never married
☐ 2 Divorced or separated
☐ 3 Widowed

→ **Go to Question 11 on page 5.**

☐ 4 Presently married
☐ 5 Living in a marriage-like relationship

9.1. What is your husband's (partner's) legal name? (This information helps us keep in contact with you during the study.)

_____ _____ _____
First MI Last

The next question asks for your husband's (or partner's) Social Security Number. You are not required to give us the number. If you give us the Social Security Number, we will use it to help us keep in contact with you throughout the study. This information is being requested under Section 301 of the Public Health Service Act, 42 U.S.C. 241.

9.2. What is your husband's (partner's) Social Security Number?

└┴┴┴┘-└┴┴┴┘-└┴┴┴┴┘

10. If married or living in a marriage-like relationship, which category below best describes the highest level of school your husband (partner) completed? **(Mark one.)**

- ☐ 1 Didn't go to school
- ☐ 2 Grade school (1-4 years)
- ☐ 3 Grade school (5-8 years)
- ☐ 4 Some high school (9-11 years)
- ☐ 5 High school diploma or G.E.D.
- ☐ 6 Vocational or training school after high school graduation
- ☐ 7 Some college or Associate Degree
- ☐ 8 College graduate or Baccalaureate Degree
- ☐ 9 Some college or professional school after college graduation
- ☐ 10 Master's Degree
- ☐ 11 Doctoral Degree (Ph.D., M.D., J.D., etc.)

10.1. What is your husband's (partner's) current job status? **(Mark one. If more than one applies, mark both.)**

- ☐ 1 Not working
- ☐ 2 Retired
- ☐ 3 Homemaker, raising children, care of others
- ☐ 4 Employed (full-time or part-time)
- ☐ 5 Disabled, unable to work
- ☐ 8 Other **(Specify)**: _____

10.2. Which statement below best describes your husband's (partner's) job? If not working now, which one best describes your partner's last job? **(See Question 8 for descriptions of these jobs.)**

- ☐ 1 Homemaker, raising children, care of others
- ☐ 2 Managerial, professional specialty
- ☐ 3 Technical, sales, and administrative support
- ☐ 4 Service
- ☐ 5 Operators, fabricators, and laborers
- ☐ 8 Other **(Specify)**: _____

11. What was the total family income (before taxes) from all sources within your household in the last year? (**Mark the one that is the best guess.** This information is important for describing the women in the study as a group and is kept strictly confidential.)

- ☐ 1 Less than $10,000
- ☐ 2 $10,000 to $19,999
- ☐ 3 $20,000 to $34,999
- ☐ 4 $35,000 to $49,999
- ☐ 5 $50,000 to $74,999
- ☐ 6 $75,000 to $99,999
- ☐ 7 $100,000 to $149,999
- ☐ 8 $150,000 or more
- ☐ 9 Don't know

Your Health Care Providers

12. Do you have a clinic, doctor, nurse, or physician assistant who gives you your usual medical care?

☐ 0 No ☐ 1 Yes ↓

12.1. What is the name, address, and phone number of the clinic, doctor, nurse, or physician assistant? (If you don't know the address, leave that part blank).

Name: _____

Address: _____

_____

City State Zip Code

Phone Number: _____

12.2. When did you last visit this clinic or person? **(Please give your best guess.)**

|_|_| - |_|_|

month year

↓

Go to the next page.

13. Have you ever had a mammogram (X-ray of the breasts to look for cancer)?

☐ 0 No ☐ 1 Yes

13.1. When was your last mammogram? **(Please give your <u>best</u> guess.)**

__-__
month year

13.2. If your last mammogram was done in the past 12 months, what is the full name and address of the doctor, clinic, or hospital where the mammogram was done?

Name: _____

Address: _____

_____

City State Zip Code

14. Have you ever had a Pap smear (a cancer check done during a female exam)?

☐ 0 No ☐ 1 Yes

☐ 9 Don't know

14.1. When was your last Pap smear?

__-__
month year

14.2. If your last one was done in the past 12 months, what is the full name and address of the doctor, clinic, or hospital where the test was done?

Name: _____

Address: _____

_____

City State Zip Code

14.3. Have you had an abnormal Pap smear in the last 3 years?

☐ 0 No ☐ 1 Yes

14.4. Have you ever been told you had cervical dysplasia (abnormal changes of the cervix that may or may not be early signs of cancer)?

☐ 0 No ☐ 1 Yes

Go to the next page.

15. Have you ever had a test called a "uterus biopsy," "endometrial aspiration," or a "D and C"? (This is done in a doctor's office or clinic where a small part of the lining of the uterus or womb is tested. These tests are <u>different</u> from a Pap smear or a colposcopy.)

☐ 0 No ☐ 1 Yes ↓

15.1. When did you have your last uterus biopsy, endometrial aspiration, or D and C? **(Please give your <u>best</u> guess.)**

____-____
month year

15.2. If your last one was done in the past 12 months, what is the full name and address of the doctor, clinic, or hospital where the test was done?

Name: _____

Address: _____

_____
City State Zip Code

The next question is being asked to look at how women in the study usually get their medical care paid for and how this might affect their health.

16. Which category or categories below best describe how you usually pay for your medical care? **(Mark all that apply.)**

☐ 1 Pre-paid private insurance (for example: Health Maintenance Organization, Kaiser Permanente, or other Group Health-type plan)

☐ 2 Other private insurance (for example: Blue Cross, Aetna, etc.)

☐ 3 Medicare

☐ 4 Medicaid (for example: Medical Assistance or DPA)

☐ 5 Military or Veterans Administration-sponsored

☐ 6 No insurance

☐ 8 Other

17. Have you served in the U.S. armed forces on active duty for a period of 180 days or more?

☐ 0 No

☐ 1 Yes →

17.1. Have you ever made use of a VA Medical Center?

☐ 0 No ☐ 1 Yes

18. What is the date you finished this form?

____-____-____
month day year

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

OFFICE USE ONLY

Form Administration

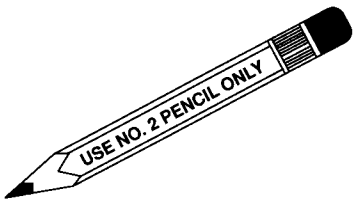
- ☐ 1 Self
- ☐ 2 Group
- ☐ 3 Interview
- ☐ 4 Assistance

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:

___ ___ ___

⓪⓪ ⓪⓪ ⓪⓪
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

○○●○●○●●●●○●●○○○●●○○○○○ 407464

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 → **Go to the next page.**

① Yes

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		

407464

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:

* U.S. GOVERNMENT PRINTING OFFICE:1997–589-303/40510

407464

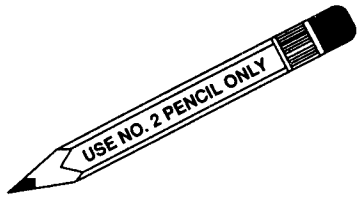
PLEASE MAKE NO MARKS IN THIS AREA

WOMEN'S HEALTH INITIATIVE

Form 31 - Reproductive 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
○●○○	✓ ⊗ ① ◪

- 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 ㊿
⑩ ⑳ ㉚ ㊵ ㊿ ㊿ ㊿ ㊿ ㊿
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

291403

PLEASE MAKE NO MARKS IN THIS AREA

The following questions ask about your monthly periods (menses) and child bearing history. We are very interested in this information so that we can understand more about women's reproductive lives and their health. Some of the questions ask you to give ages when certain things happened. If you're not sure about the exact age, please give your best guess.

1. How old were you when you had your first menstrual period (menses)?

9 or less	10	11	12	13	14	15	16	17 or older
①	②	③	④	⑤	⑥	⑦	⑧	⑨

2. During most of your life, were your periods regular; that is, did they occur about once a month? **(Do not include any time when you were pregnant or taking birth control pills.)**

⓪ No

① Yes

② Sometimes regular, sometimes irregular

2.1. How old were you when your periods first became regular? **(Your best guess.)**

9 or less	10	11	12	13	14	15	16	17 or older
①	②	③	④	⑤	⑥	⑦	⑧	⑨

3. How old were you when you last had regular menstrual bleeding (a period)? **(Your best guess.)** **(If you are still having regular bleeding or periods, enter your current age.)**

|_|_| years old

10 20 30 40 50 60 70 80
○○○○○○○○

1 2 3 4 5 6 7 8 9
○○○○○○○○○

4. Between the time you had your first period and your last period, did you ever go without any periods for at least one year? **(Do not count times when you were pregnant or breastfeeding.)**

⓪ No ① Yes

4.1. Between your first menstrual period and your last, all together, about how long did you go without having your period? **(Again, do not count times when you were pregnant or breastfeeding.) (Mark one oval.)**

① Less than 12 months

② 12 to 23 months

③ 24 months (2 years) to 48 months (4 years)

④ More than 4 years

5. How old were you when you last had any menstrual bleeding? **(If you are still having menstrual bleeding or periods, enter your current age.)**

|_|_| years old

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

6. Have you ever had menopausal symptoms, such as hot flashes or night sweats? **(Your best guess.)**

⓪ No ① Yes

6.1. How old were you when you first had symptoms such as hot flashes or night sweats? **(Your best guess.)**

|_|_| years old

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

6.2. How old were you when you last had symptoms such as hot flashes or night sweats? **(If you are still having symptoms such as hot flashes or night sweats, enter your current age.)**

|_|_| years old

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

Go to the next page.

291403

PLEASE MAKE NO MARKS IN THIS AREA

7. Have you ever been pregnant? It is very important that we know about all of your pregnancies, including live births, stillbirths, miscarriages, tubals (ectopics), and abortions.

⓪ No ① Yes

7.1. How many times have you been pregnant?

1	2	3	4	5	6	7	8 or more
①	②	③	④	⑤	⑥	⑦	⑧

7.2. Did you ever have a pregnancy that lasted at least 6 months?

⓪ No ① Yes

7.3. How many of these pregnancies did you have?

1	2	3	4	5	6	7	8 or more
①	②	③	④	⑤	⑥	⑦	⑧

7.4. How old were you at the end of the first of these pregnancies?

Less than 20	20-24	25-29	30-34	35-39	40-44	45 or older
①	②	③	④	⑤	⑥	⑦

7.5. How old were you at the end of the last of these pregnancies?

Less than 20	20-24	25-29	30-34	35-39	40-44	45 or older
①	②	③	④	⑤	⑥	⑦

Go on to Question 7.6.

For these next questions, please mark "None" if they don't apply to you.

7.6. How many live births did you have?

None	1	2	3	4	5	6	7	8 or more
⓪	①	②	③	④	⑤	⑥	⑦	⑧

7.7. How many stillbirths (from a pregnancy lasting 6 months or more) did you have?

None	1	2	3	4	5	6	7	8 or more
⓪	①	②	③	④	⑤	⑥	⑦	⑧

7.8. How many spontaneous miscarriages did you have?

None	1	2	3	4	5	6	7	8 or more
⓪	①	②	③	④	⑤	⑥	⑦	⑧

7.9. How many tubal (ectopic) pregnancies did you have?

None	1	2	3	4	5	6	7	8 or more
⓪	①	②	③	④	⑤	⑥	⑦	⑧

Go to the next page.

8. Have you ever tried to become pregnant for more than 1 year without becoming pregnant?

⓪ No ① Yes ⑨ Don't know

8.1. Did you visit a doctor or clinic because you didn't get pregnant?

⓪ No ① Yes

8.2. Was a reason found for why you did not become pregnant?

⓪ No ① Yes ⑨ Don't know

8.3. What was the reason you did not become pregnant? **(Mark all that apply.)**

① Problem with your hormones or ovulation (producing eggs)

② Problem with your tubes or uterus

③ Endometriosis

④ Other problem with you **(Specify):** _____

_____

⑤ Problem in your partner

⑨ Don't know

Go to the next page.

Go to the next page.

9. Did you breastfeed or nurse any children for at least one month?

⓪ No ① Yes

9.1. How many children did you breastfeed?

1	2	3	4	5	6	7	8 or more
①	②	③	④	⑤	⑥	⑦	⑧

9.2. How old were you when you first breastfed a child?

Less than 20	20-24	25-29	30-34	35-39	40-44	45 or older
①	②	③	④	⑤	⑥	⑦

9.3. How old were you when you last breastfed a child?

Less than 20	20-24	25-29	30-34	35-39	40-44	45 or older
①	②	③	④	⑤	⑥	⑦

9.4. Thinking about all the children you breastfed, how many months total did you breastfeed? **(Your best guess.)**

① 1-3 months
② 4-6 months
③ 7-12 months
④ 13-23 months
⑤ 2-4 years (24-48 months)
⑥ More than 4 years

10. Did you ever have an operation to have one or both of your ovaries taken out? **(Mark one oval.)**

⓪ No

① Yes, one was taken out
② Yes, both were taken out
③ Yes, unknown number taken out
④ Yes, part of an ovary was taken out
⑨ Don't know

10.1. How old were you when you had your last operation to remove an ovary?

Less than 30	30-34	35-39	40-44	45-49	50-54	55-59	60 or older
①	②	③	④	⑤	⑥	⑦	⑧

11. Did you ever have an operation to have your tubes tied to prevent pregnancy?

⓪ No ① Yes

11.1. How old were you when you had your tubes tied?

Less than 30	30-34	35-39	40-44	45 or older
①	②	③	④	⑤

Go to the next page.

291403

PLEASE MAKE NO MARKS IN THIS AREA

12. Have you ever had a needle aspiration (where a doctor puts a needle in a lump in your breast and withdraws fluid or material)?

⓪ No ① Yes

12.1. How many of these needle aspirations have you had?

1	2	3	4 or more
①	②	③	④

13. Have you ever had a breast biopsy (where a doctor removes part or all of a breast lump to check for cancer)?

⓪ No ① Yes

13.1. How many of these biopsies have you had?

1	2	3	4 or more
①	②	③	④

14. Did you ever have an operation to increase your breast size (breast augmentation) or have breast reconstruction using a breast implant?

⓪ No ① Yes

14.1. How old were you when you first had that operation?

Less than 30	30-34	35-39	40-44	45-49	50-54	55 or older
①	②	③	④	⑤	⑥	⑦

14.2. Was this operation for the right breast, left breast, or both?

① Right breast
② Left breast
③ Both breasts

14.3. What type of breast implant did you receive?

① Silicone or silicone gel-filled
② Saline-filled
⑧ Other **(Specify):** _____
⑨ Don't know

Go to the next page.

15. Have you ever had any other operations on your breasts?

⓪ No ① Yes

15.1. What type of other breast operations did you have? **(Mark all that apply.)**

① Removal of part of breast or breast reduction
② Removal of one breast
③ Removal of both breasts
⑨ Other **(Specify):** _____

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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291403

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Ver. 3
OMB #0925-0414 Exp: 6/97

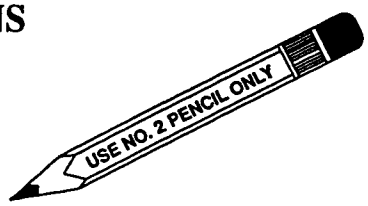
WOMEN'S HEALTH INITIATIVE

Form 32 - Family History Questionnaire

We can learn about risks of disease by asking women what diseases have run in their families. This questionnaire asks you about several diseases that may occur in more than one member of a family. For all of these questions, please think about full-blooded relatives only. Do not think about half-sisters or half-brothers, or relatives who are related to you by marriage or adoption. Full-blooded sisters and brothers are those who had the same two parents as you. If you are adopted or are not sure about some relatives' health history, please include any family history that you know about.

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 ○○○○○○○○●

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S _____

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

1. Date Received:

Month Day Year

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2. Reviewed By:

⑩⑳㉚
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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

■○■○■■■■■■■○○○■■○■○○○○○○○ 182261

PLEASE MAKE NO MARKS IN THIS AREA

1. Have you ever had any full-blooded sisters who reached adulthood (age 21)?

⓪ No ① Yes

⑨ Don't know

1.1. How many sisters?

1	2	3	4	5	6	7	8	9	10 or more
①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

2. Have you ever had any full-blooded brothers who reached adulthood (age 21)?

⓪ No ① Yes

⑨ Don't know

2.1. How many brothers?

1	2	3	4	5	6	7	8	9	10 or more
①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

3. Have you ever had any daughters who reached adulthood (age 21)?

⓪ No ① Yes

⑨ Don't know

3.1. How many daughters?

1	2	3	4	5	6	7	8	9	10 or more
①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

4. Have you ever had any sons who reached adulthood (age 21)?

⓪ No ① Yes

⑨ Don't know

4.1. How many sons?

1	2	3	4	5	6	7	8	9	10 or more
①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

Go to the next page.

The next two questions are about your natural (not adoptive) mother and father.

5. Is your natural mother still alive?

⓪ No →

5.1. How old was she when she died? **(Please guess as closely as you can.)**

Less than 40	40-49	50-59	60-69	70-79	80-89	90-99	100 or older
①	②	③	④	⑤	⑥	⑦	⑧

① Yes →

5.2. How old is she now? **(Please guess as closely as you can.)**

Less than 70	70-79	80-89	90-99	100 or older
①	②	③	④	⑤

⑨ Don't know

6. Is your natural father still alive?

⓪ No →

6.1. How old was he when he died? **(Please guess as closely as you can.)**

Less than 40	40-49	50-59	60-69	70-79	80-89	90-99	100 or older
①	②	③	④	⑤	⑥	⑦	⑧

① Yes →

6.2. How old is he now? **(Please guess as closely as you can.)**

Less than 70	70-79	80-89	90-99	100 or older
①	②	③	④	⑤

⑨ Don't know

7. Did your mother, father, full-blooded sisters, full-blooded brothers, daughters, or sons ever have sugar diabetes or high blood sugar that first appeared as an adult?

⓪ No

⑨ Don't know

① Yes ↓

7.1. How many of these relatives had diabetes?

1	2	3	4 or more
①	②	③	④

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

8. Did your mother, father, full-blooded sisters, full-blooded brothers, daughters, or sons ever have a heart attack or myocardial infarction?

⓪ No ① Yes

⑨ Don't know

Please answer the following questions for each of your relatives, starting with those who had a heart attack. If you do not have a full-blooded sister, full-blooded brother, daughter, or son, leave the spaces blank.

8.1. Did this relative have a heart attack?

	No	**Yes**				**Don't know if he or she had a heart attack**
		How old was he or she when the first heart attack occurred?				
		Less than 55	55-64	65 or older	Don't know age	
1. Mother	⓪	①	②	③	④	⑨
2. Father	⓪	①	②	③	④	⑨
3. Sister	⓪	①	②	③	④	⑨
4. Sister	⓪	①	②	③	④	⑨
5. Sister	⓪	①	②	③	④	⑨
6. Brother	⓪	①	②	③	④	⑨
7. Brother	⓪	①	②	③	④	⑨
8. Brother	⓪	①	②	③	④	⑨
9. Daughter	⓪	①	②	③	④	⑨
10. Daughter	⓪	①	②	③	④	⑨
11. Son	⓪	①	②	③	④	⑨
12. Son	⓪	①	②	③	④	⑨

Go to the next page.

9. Did your mother, father, full-blooded sisters, full-blooded brothers, daughters, or sons ever have a stroke?

⓪ No
⑨ Don't know
① Yes

9.1. How many of these relatives had a stroke?

1	2	3	4 or more
①	②	③	④

These next questions are about cancers your relatives may have had. For each question, mark "Yes" only if it describes the area where the relative's cancer started. Often cancers will start in one place and then spread. We are interested in where the cancer started.

Female Relatives

10. Did any of your female relatives ever have cancer? For female relatives, please answer about your mother, full-blooded sisters, daughters, and grandmothers. Do not include aunts, cousins, and nieces.

⓪ No
⑨ Don't know
① Yes

Go to the next page.

Go to Question 16 on page 8.

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PLEASE MAKE NO MARKS IN THIS AREA

11. Did your mother, full-blooded sisters, daughters, or grandmothers ever have breast cancer?

⓪ No ① Yes

⑨ Don't know

Please answer the following questions for each of your female relatives, starting with those who had breast cancer. If you do not have a full-blooded sister or daughter, leave the spaces blank. Please note that the age category is different than for the question about heart attacks in relatives.

11.1. Did this relative have breast cancer?

	No	**Yes**			**Don't know if she had breast cancer**
		How old was she when her first breast cancer occurred?			
		Less than 45	45 or older	Don't know age	
1. Mother	⓪	①	②	③	⑨
2. Sister	⓪	①	②	③	⑨
3. Sister	⓪	①	②	③	⑨
4. Sister	⓪	①	②	③	⑨
5. Daughter	⓪	①	②	③	⑨
6. Daughter	⓪	①	②	③	⑨
7. Daughter	⓪	①	②	③	⑨
8. Maternal grandmother (your mother's mother)	⓪	①	②	③	⑨
9. Paternal grandmother (your father's mother)	⓪	①	②	③	⑨

Go to the next page.

12. Did your mother, full-blooded sisters, or daughters ever have cancer of the colon, rectum, intestine, or bowel?

⓪ No ① Yes

⑨ Don't know

Please answer the following questions for each of your female relatives, starting with those who had colon, rectum, intestine, or bowel cancer. If you do not have a full- blooded sister or daughter, leave those spaces blank.

12.1. Did this relative have cancer of the colon, rectum, intestine, or bowel?

	No	**Yes**			**Don't know if she had this type of cancer**
		How old was she when the cancer first occurred?			
		Less than 55	55 or older	Don't know age	
1. Mother	⓪	①	②	③	⑨
2. Sister	⓪	①	②	③	⑨
3. Sister	⓪	①	②	③	⑨
4. Sister	⓪	①	②	③	⑨
5. Daughter	⓪	①	②	③	⑨
6. Daughter	⓪	①	②	③	⑨

13. Did your mother, full-blooded sisters, or daughters ever have cancer of the cervix (opening to the womb)?

⓪ No ① Yes

⑨ Don't know

13.1. How many of these relatives had cancer of the cervix?

1	2	3	4 or more
①	②	③	④

Go to the next page.

14. Did your mother, full-blooded sisters, or daughters ever have cancer of the uterus, womb, or endometrium (lining of the womb)?

⓪ No
⑨ Don't know
① Yes

14.1. How many of these relatives had cancer of the uterus, womb, or endometrium?

1	2	3	4 or more
①	②	③	④

15. Did your mother, full-blooded sisters, or daughters ever have cancer of the ovaries?

⓪ No
⑨ Don't know
① Yes

15.1. How many of these relatives had cancer of the ovaries?

1	2	3	4 or more
①	②	③	④

Male Relatives

16. Did any of your male relatives ever have cancer? **(For male relatives, please answer about your father, full-blooded brothers, and sons. Do not include uncles, cousins, and nephews.)**

⓪ No
⑨ Don't know
① Yes

Go to the next page.

Go to Question 19 on page 10.

182261

PLEASE MAKE NO MARKS IN THIS AREA

17. Did your father, full-blooded brothers, or sons ever have cancer of the colon, rectum, intestine, or bowel?

⓪ No ① Yes

⑨ Don't know

Please answer the following questions for each of your male relatives, starting with those who had colon, rectum, intestine, or bowel cancer. If you do not have a full- blooded brother or son, leave those spaces blank.

17.1. Did this relative have cancer of the colon, rectum, intestine, or bowel?

	No	**Yes**			**Don't know if he had this type of cancer**
		How old was he when the cancer first occurred?			
		Less than 55	55 or older	Don't know age	
1. Father	⓪	①	②	③	⑨
2. Brother	⓪	①	②	③	⑨
3. Brother	⓪	①	②	③	⑨
4. Brother	⓪	①	②	③	⑨
5. Son	⓪	①	②	③	⑨
6. Son	⓪	①	②	③	⑨

18. Did your father, full-blooded brothers, or sons ever have cancer of the prostate (male gland)?

⓪ No ① Yes

⑨ Don't know

18.1. How many of these relatives had cancer of the prostate?

1	2	3	4 or more
①	②	③	④

Go to the next page.

Finally, we want to ask you some questions about your parents.

19. Did your mother ever break or fracture a bone after she was 40 years old?

⓪ No ① Yes

⑨ Don't know

Please answer the following questions for each of the bones listed below. If she broke the bone more than once, mark her age when it was first broken.

19.1. Did your mother break this bone?

	No	Yes			Don't know if she broke this bone
		How old was your mother when the bone was first broken?			
		40 to 55	55 or older	Don't know age	
1. Hip	⓪	①	②	③	⑨
2. Spine or back (vertebra)	⓪	①	②	③	⑨
3. Upper arm (humerus)	⓪	①	②	③	⑨
4. Lower arm or wrist	⓪	①	②	③	⑨
5. Other (Specify): _____	⓪	①	②	③	⑨

Go to the next page.

182261

PLEASE MAKE NO MARKS IN THIS AREA

20. Did your father ever break or fracture a bone after he was 40 years old?

⓪ No ① Yes

⑨ Don't know

Please answer the following questions for each of the bones listed below. If he broke the bone more than once, mark his age when it was first broken.

20.1. Did your father break this bone?

	No	Yes — How old was your father when the bone was first broken?			Don't know if he broke this bone
		40 to 55	55 or older	Don't know age	
1. Hip	⓪	①	②	③	⑨
2. Spine or back (vertebra)	⓪	①	②	③	⑨
3. Upper arm (humerus)	⓪	①	②	③	⑨
4. Lower arm or wrist	⓪	①	②	③	⑨
5. Other (Specify): _____	⓪	①	②	③	⑨

21. 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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PLEASE MAKE NO MARKS IN THIS AREA

182261

OMB # 0925-0414 Exp:4/06

Date Received: ☐☐-☐☐-☐☐ (M/D/Y) Reviewed By: ☐☐☐	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

Contact Type:	Visit Type:	Form Administration
☐1 Phone ☐2 Mail ☐3 Visit ☐8 Other	☐2 Semi-Annual ☐3 Annual ☐4 Non-Routine # ☐☐ # ☐☐	☐1 Self ☐2 Group ☐3 Interview ☐4 Assistance

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) participant (self)
☐2 Family or friend of WHI participant
☐3 Health care provider for WHI participant
☐8 Other **(Specify):**_____
_____

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

Overnight Hospital Admissions

2. 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.)**

☐ 1 Yes ☐ 0 No → **Go to Question 3 on page 5.**

↓

Please give details of overnight hospital admissions since the date on the front of this form

2.1. **First hospital admission**

Hospital name: _____

Street address: _____

_____

City State Zip Code

2.1.1 Date you entered the hospital: ___ - ___ - ___ (month day year)

2.1.2 Date you left the hospital: ___ - ___ - ___ (month day year)

Office Use Only
Provider ID ____

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

☐ 1 Stroke or transient ischemic attack (TIA)
☐ 2 Heart problems, circulation problems, or blood clots
☐ 3 New broken, crushed, or fractured bone
☐ 4 New cancer or a malignant tumor
☐ 8 Other reasons **(Specify):**_____

2.2. **Second hospital admission (If none, go to Question 3 on page 5.)**

Hospital name: _____

Street address: _____

_____

City State Zip Code

2.2.1 Date you entered the hospital: ___ - ___ - ___ (month day year)

2.2.2 Date you left the hospital: ___ - ___ - ___ (month day year)

Office Use Only
Provider ID ____

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

☐ 1 Stroke or transient ischemic attack (TIA)
☐ 2 Heart problems, circulation problems, or blood clots
☐ 3 New broken, crushed, or fractured bone
☐ 4 New cancer or a malignant tumor
☐ 8 Other reasons **(Specify):**_____

2.3. **Third hospital admission (If none, go to Question 3 on page 5.)**

Hospital name: _____

Street address: _____

_____

City State Zip Code

2.3.1 Date you entered the hospital: ___ - ___ - ___
month day year

2.3.2 Date you left the hospital: ___ - ___ - ___
month day year

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

Office Use Only
Provider ID
____

☐ 1 Stroke or transient ischemic attack (TIA)

☐ 2 Heart problems, circulation problems, or blood clots

☐ 3 New broken, crushed, or fractured bone

☐ 4 New cancer or a malignant tumor

☐ 8 Other reasons **(Specify):**_____

2.4. **Fourth hospital admission (If none, go to Question 3 on page 5.)**

Hospital name: _____

Street address: _____

_____

City State Zip Code

2.4.1 Date you entered the hospital: ___ - ___ - ___
month day year

2.4.2 Date you left the hospital: ___ - ___ - ___
month day year

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

Office Use Only
Provider ID
____

☐ 1 Stroke or transient ischemic attack (TIA)

☐ 2 Heart problems, circulation problems, or blood clots

☐ 3 New broken, crushed, or fractured bone

☐ 4 New cancer or a malignant tumor

☐ 8 Other reasons **(Specify):**_____

2.5. **Fifth hospital admission (If none, go to Question 3 on the next page.)**

Hospital name: _____

Street address: _____

_____

City State Zip Code

2.5.1 Date you entered the hospital: ___ - ___ - ___
month day year

2.5.2 Date you left the hospital: ___ - ___ - ___
month day year

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

Office Use Only
Provider ID ____

☐ 1 Stroke or transient ischemic attack (TIA)
☐ 2 Heart problems, circulation problems, or blood clots
☐ 3 New broken, crushed, or fractured bone
☐ 4 New cancer or a malignant tumor
☐ 8 Other reasons **(Specify):**_____

2.6. **Sixth hospital admission (If none, go to Question 3 on the next page.)**

Hospital name: _____

Street address: _____

_____

City State Zip Code

2.6.1 Date you entered the hospital: ___ - ___ - ___
month day year

2.6.2 Date you left the hospital: ___ - ___ - ___
month day year

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

Office Use Only
Provider ID ____

☐ 1 Stroke or transient ischemic attack (TIA)
☐ 2 Heart problems, circulation problems, or blood clots
☐ 3 New broken, crushed, or fractured bone
☐ 4 New cancer or a malignant tumor
☐ 8 Other reasons **(Specify):**_____

Other hospital admissions: (Do not count the first six admissions you have already reported on this form.)

2.7 Since the date on the front the form, have you had any other overnight hospital admissions?

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

↓

2.7.1 How many additional hospital admissions have you had? ___

(Please write the additional hospital information on the last page of this form.)

Information on Heart Problems, Blocked or Narrowed Blood Vessels, or Circulation Problems

3. Since the date on the front of this form, have you been **treated** because of heart problems, blocked or narrowed blood vessels, or problems with your blood circulation (for example, blood clots in the legs or lungs)? **(Do not include stroke or TIA you reported in question 2.)**

☐ 1 Yes ☐ 0 No → **Go to Question 4 on page 8.**

3.1. Have you been hospitalized **overnight** for a heart problem, blocked or narrowed blood vessel, or circulation problem? **(Do not include outpatient visits, emergency room visits, or day surgery.)**

☐ 1 Yes ☐ 0 No → **Go to Question 3.3 on the next page.**

3.2. For which of the following heart and circulation problems were you **hospitalized overnight**? **(Mark all that apply.)**

Heart Problems

☐ 1 Chest pain from a heart problem (angina)

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

☐ 3 Heart failure (congestive heart failure or CHF)

☐ 4 Heart cath (cardiac catheterization)

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

☐ 6 Procedure to unblock narrowed blood vessels to your heart muscle (PTCA, coronary angioplasty, stent, or atherectomy)

☐ 7 Other heart problem **(Specify):**_____

Blood Clot Problems

☐ 12 Blood clots in the legs (deep vein thrombosis or DVT)

☐ 13 Blood clots in the lungs (pulmonary embolism or PE)

Circulation Problems

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

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

☐ 10 Amputation of a part of a leg, including toes, because of poor blood circulation or gangrene

☐ 11 Other circulation problem **(Specify):**_____

3.3. Since the date on the front of this form, have you had an **outpatient or day surgery** procedure to unblock blocked or narrowed blood vessels of the heart (called a PTCA, coronary angioplasty, stent, or atherectomy)?

☐ 1 Yes ☐ 0 No → **Go to Question 3.4 on the next page.**

↓

3.3.1 What was the date of the outpatient/day surgery procedure? ___ - ___ - ___
month day year

3.3.2 What is the name, address, and phone number of the place where you had the outpatient procedure to unblock narrowed heart vessels?

Place name: _____

Street address: _____

_____

City State Zip Code

Phone number: ( ) _____

Office Use Only
Provider ID
___

3.3.3 What is the name, address, and phone number of the doctor who treated you for narrowed or blocked heart vessels?

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 3.3.2

3.4. 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 medications such as Coumadin, Warfarin)** for blood clots in the legs called deep vein thrombosis or DVT?

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

↓

3.4.1 What was the date the shots started? ___ - ___ - ___
month day year

3.4.2 What is the name, address, and phone number of the doctor who treated you for blood clots in the legs?

Doctor's name: _____

Street address: _____

_____

City State Zip Code

Phone number: ( ) _____

Office Use Only
Provider ID
____

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

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

↓

3.5.1 What was the date the test was performed? ___ - ___ - ___
month day year

3.5.2 What is the name, address, and phone number of the place where you had the outpatient test performed for blood clots in the 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 3.4.2

Information on Broken, Fractured, or Crushed Bones (Hospitalized and Non-hospitalized)

4. Since the date on the front of this form, has a doctor told you that you had a broken, fractured, or crushed bone?

☐ 1 Yes ☐ 0 No → **Go to Question 5 on page 10.**

4.1. Which bones did you break, fracture, or crush? **(Please mark all that apply.)**

- ☐ 1 Hip
- ☐ 2 Upper leg (not hip)
- ☐ 3 Pelvis
- ☐ 4 Knee (patella)
- ☐ 5 Lower leg or ankle
- ☐ 6 Foot (not toe)
- ☐ 7 Tailbone (coccyx)
- ☐ 8 Spine or back (vertebra)
- ☐ 9 Lower arm or wrist
- ☐ 10 Hand (not finger)
- ☐ 11 Elbow
- ☐ 12 Upper arm or shoulder
- ☐ 88 Other **(Specify):** _____

4.2. How did the break, fracture, or crush happen? **(Please mark all that apply.)**

- ☐ 1 Car accident or hit by car
- ☐ 2 Fall down stairs
- ☐ 3 Fall from a height (for example, fall while standing on a ladder or chair)
- ☐ 4 Other fall or trip (for example, while walking or getting out of bed)
- ☐ 5 Sports activity (for example snow- or water-skiing, horse riding, or climbing)
- ☐ 8 Other **(Specify):** _____

4.3. Was this break, fracture, or crush diagnosed or treated during an overnight hospital stay already reported in Question 2?

☐ 0 No ☐ 1 Yes → **Go to Question 4.4 below.**

4.3.1 What is the name, address, and phone number of the medical facility where you were treated for the fracture?

Place name: _____

Street address: _____

_____

City State Zip Code

Phone number: ( ) _____

Office Use Only
Provider ID

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

4.4. Was an X-ray or imaging scan (MRI) taken to diagnose the fracture?

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

4.4.1 Was the X-ray or imaging scan (MRI) taken at the same medical facility where you were treated for your fracture?

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

4.4.2 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 4.3.1

4.4.3 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 (Hospitalized and Non-hospitalized)

5. Since the date on the front of this form, has a doctor told you that you have a new cancer, 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 6 on the next page.**

5.1. What kind of cancer or malignant tumor was it? **(Please 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 (a type of brain cancer)
- ☐88 Other cancer or malignant tumor

(Specify): _____

_____

5.2. Was this cancer or malignant tumor first diagnosed during an overnight hospital stay already reported in Question 2?

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

5.3. What was the date when this cancer or tumor was first diagnosed? ☐☐ - ☐☐ - ☐☐☐☐
month day year

5.4. 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 ☐☐☐☐☐

5.5. What is the name of the doctor who ordered the tests used to diagnose the cancer?

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 5.4

Hysterectomy

6. 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 7 below.**

↓

6.1. Did your hysterectomy occur at an overnight hospital stay already reported in Question 2?

☐ 0 No ☐ 1 Yes → **Go to Question 7 below.**

↓

6.2. What was the date of the operation? ___ - ___ - ___
month day year

6.3. 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
____

6.4. 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 6.3.

7. What is the date that you finished answering this form? ___ - ___ - ___
month day year

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

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.

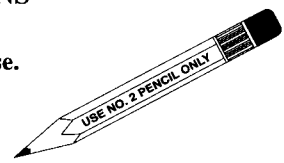
Thank you. Please take a moment to review any questions you may have missed.
Feel free to write any comments above.

WOMEN'S HEALTH INITIATIVE

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 <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.

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 1 2 3 4 5 6 7 8 9
Y 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

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

3. Contact Type:

1 Phone
2 Mail
3 Visit
8 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

■■ ■■ ■■ ■ ■■■ 1901851

PLEASE MAKE NO MARKS IN THIS AREA

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
   8 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
   8 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
   8 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

D 10 20 30 / 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.

* U.S. GOVERNMENT PRINTING OFFICE:2003-589-322/40017

PLEASE MAKE NO MARKS IN THIS AREA

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Ver. 8.1
OMB #0925-0414 Exp: 5/12

WOMEN'S HEALTH INITIATIVE

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.

OFFICE USE ONLY

1. Date Received: Month ___ Day ___ Year ___

2. Reviewed By: ___

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

3. Contact Type:
   - ○1 Phone
   - ○2 Mail
   - ○8 Other

4. Visit Type:
   - ○3 Annual
   - ○4 Non-Routine

○ FCA ○ OU1 ○ OU2

5. Language: ●1 E ○2 S

○■■○○■○■○■■○○■○■■■■■○○○○ 1025702

PLEASE MAKE NO MARKS IN THIS AREA

R:\DOC\FORMS\ENG\CURRENT\F1-199\F33V8_1.DOC 5/15/06

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):**_____

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.)**

- ○1 Heart attack (coronary, myocardial infarction or MI)
- ○2 Heart failure (congestive heart failure or CHF)
- ○3 Chest pain from a heart problem (angina)
- ○4 Heart bypass operation (coronary bypass surgery or CABG)
- ○5 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)
- ○6 Stroke
- ○7 Transient ischemic attack (TIA)
- ○8 Procedure or operation to unblock narrowed blood vessels in your neck (carotid endarterectomy, carotid angioplasty, or carotid stent)
- ○9 Blood clots in your legs (deep vein thrombosis or DVT)
- ○10 Blood clots in your lungs (pulmonary embolism or PE)
- ○11 Poor blood circulation or blocked or narrowed blood vessels to your legs or feet (claudication, peripheral arterial disease, gangrene, or Buerger's disease)
- ○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

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?

○0 No ○1 Yes

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

○1 Skin cancer (not melanoma)
○8 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?

○0 No ○1 Yes

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

○1 Hip
○2 Upper leg (not hip)
○3 Pelvis
○4 Knee (patella)
○5 Lower leg or ankle
○6 Foot (not toe)
○7 Tailbone (coccyx)
○8 Spine or back (vertebra)
○9 Lower arm or wrist
○10 Hand (not finger)
○11 Elbow
○12 Upper arm or shoulder
○13 Jaw, nose, face, and/or skull
○14 Finger or toe
○15 Ribs and/or chest or breast bone
○16 Cervical spine/neck
○88 Other **(Specify):**_____

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.")**

○1 Pills for diabetes
○2 Insulin shots for diabetes
○3 Diet and/or physical activity for diabetes
○4 Pills for high blood pressure or hypertension
○5 Treatment for depression (pills or therapy)
○6 Treatment for anxiety, panic, or phobia (pills or therapy)
○7 Pills for osteoporosis other than calcium supplements
○8 Calcium supplements for osteoporosis
○9 Pills for high cholesterol
○10 Estrogen or estrogen combination pills
○99 **None**
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)
- ○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
- ○9 Dilation and Curettage (D & C, womb scrape)
- ○10 Removal of the uterus or womb (hysterectomy)
- ○11 Endometrial biopsy
- ○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.

1025702

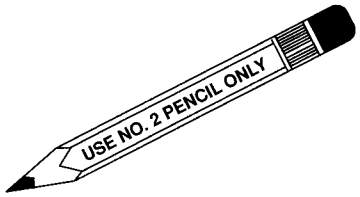
PLEASE MAKE NO MARKS IN THIS AREA

WOMEN'S HEALTH INITIATIVE

Form 34 - Personal Habits 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
○ ○ ○ ○ ○ ○ ○ ○ ●

Public reporting for this collection of information is estimated to average 10 minutes, including the time for reviewing instructions, gathering needed information and completing and reviewing the questionnaire. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: PHS Reports Clearance Officer, Rm. 721-B, Humphrey Building, 200 Independence Ave., SW, Washington, D.C. 20201, ATTN: PRA; and to Office of Management and Budget, Paperwork Reduction Project (0925-0414), Washington, D.C. 20503. Do not return the completed form to either of these addresses.

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

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Y ㉔ ㉕ ㉖ ㉗ ㉘ ㉙

2. Reviewed By:

⓪ ⑳ ㉚
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

340051

PLEASE MAKE NO MARKS IN THIS AREA

These questions ask about habits (smoking, caffeine, alcohol use, diet, and exercise) that may affect your health. Please answer each question as accurately as possible. There are no right or wrong answers.

1. During your entire life, have you smoked at least 100 cigarettes?

⓪ No ① Yes

1.1. How old were you when you first started smoking cigarettes regularly? **(Give your best guess.)**

Less than 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50 or older
①	②	③	④	⑤	⑥	⑦	⑧	⑨

1.2. Do you smoke cigarettes now?

⓪ No → 1.3. How old were you when you quit smoking regularly?

Less than 15	15-19	20-24	25-29	30-34	35-39
①	②	③	④	⑤	⑥

40-44	45-49	50-54	55-59	60 or older
⑦	⑧	⑨	⑩	⑪

1.4. Did you quit smoking because you had a health problem that was caused by or made worse by smoking?

⓪ No ① Yes

Go on to Question 1.5.

① Yes

1.5. On the average, how many cigarettes do you (did you) usually smoke each day?

Less than 1	1-4	5-14	15-24	25-34	35-44	45 or more
①	②	③	④	⑤	⑥	⑦

1.6. How many years have you been (were you) a regular smoker? Do not count the times you stayed off cigarettes.

Less than 5 years	5-9 years	10-19 years	20-29 years	30-39 years	40-49 years	50 or more years
①	②	③	④	⑤	⑥	⑦

1.7. Have you ever smoked to keep from gaining weight or to lose weight?

⓪ No ① Yes

Go to the next page.

2. Do you usually drink coffee each day?

⓪ No ① Yes

2.1. How many cups of regular coffee (not decaf) do you usually drink each day? **(If none, mark "None.")**

None	1	2	3	4	5	6 or more
⓪	①	②	③	④	⑤	⑥

Alcohol may affect a person's health. We would like to know about the alcohol you have drunk over your lifetime. (For the question below, one drink of alcohol is about equal to one can of beer, one glass of wine, or one shot of liquor.)

3. During your entire life, have you had at least 12 drinks of any kind of alcoholic beverage?

⓪ No ① Yes

3.1. Do you still drink alcohol?

⓪ No → 3.2. Why did you stop or quit drinking alcohol?

① Yes

① Health problems

② My drinking caused non-health problems

⑧ Other

Go to the next page.

340051

PLEASE MAKE NO MARKS IN THIS AREA

4. Women's weights change during their adult lives. Mark the one answer that best describes you during your adult life. Please don't include times when you were pregnant or sick. **(Mark only one.)**

① Weight has stayed about the same (within 10 pounds)

② Steady gain in weight

③ Lost weight as an adult and kept it off

④ Weight has gone up and down again by more than 10 pounds

4.1. About how many times did your weight go up and down again by more than 10 pounds? Please don't include times when you were pregnant or sick.

1-3 times	4-6 times	7-10 times	11-15 times	More than 15 times
①	②	③	④	⑤

The next set of questions are about special diets or types of foods women may choose or may be told to eat by their doctors.

5. Are you now on any of the following special diets?

	No	Yes
5.1. A low calorie diet?	⓪	①
5.2. A low-fat or low cholesterol diet?	⓪	①
5.3. A low salt (low sodium) diet?	⓪	①
5.4. A high-fiber diet?	⓪	①
5.5. A diabetic or ADA diet?	⓪	①
5.6. A lactose-free (no milk or dairy foods) diet?	⓪	①
5.7. Any other diet?	⓪	①

5.8. What kind of other diet is it? **(Specify):** _____

_____

_____

The following questions are about your usual physical activity and exercise. This includes walking and sports.

6. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? **(Mark only one.)**

- ⓪ Rarely or never
- ① 1-3 times each month
- ② 1 time each week
- ③ 2-3 times each week
- ④ 4-6 times each week
- ⑤ 7 or more times each week

6.1. When you walk outside the home for more than 10 minutes without stopping, for how many minutes do you usually walk?

Less than 20 min.	20-39 min.	40-59 min.	1 hour or more
①	②	③	④

6.2. What is your usual speed?

- ② Casual strolling or walking (less than 2 miles an hour)
- ③ Average or normal (2-3 miles an hour)
- ④ Fairly fast (3-4 miles an hour)
- ⑤ Very fast (more than 4 miles an hour)
- ⑨ Don't know

Go to the next page.

7. Not including walking outside the home, how often each week (7 days) do you usually do the exercises below?

7.1. STRENUOUS OR VERY HARD EXERCISE (You work up a sweat and your heart beats fast.) For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.

⓪ None

① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

→ 7.2. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

7.3. MODERATE EXERCISE (Not exhausting). For example, biking outdoors, using an exercise machine (like a stationary bike or treadmill), calisthenics, easy swimming, popular or folk dancing.

⓪ None

① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

→ 7.4. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

Go to the next page.

7.5. MILD EXERCISE. For example, slow dancing, bowling, golf.

⓪ None

① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

7.6. How long do you usually exercise like this at one time?

① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

8. For each of the ages below, did you usually do strenuous or very hard exercises at least 3 times a week? This would include exercise that was long enough to work up a sweat and make your heart beat fast. **(Be sure to mark "No" if you did not do very hard exercises at the ages listed below.)**

	No	Yes
8.1. 18 years old	⓪	①
8.2. 35 years old	⓪	①
8.3. 50 years old	⓪	①

9. 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
D 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:

* U.S. GOVERNMENT PRINTING OFFICE:1996--790-299/40503

340051

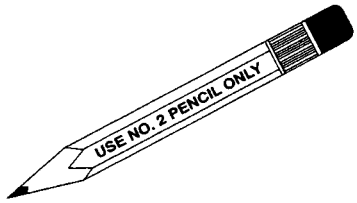
PLEASE MAKE NO MARKS IN THIS AREA

WOMEN'S HEALTH INITIATIVE

Form 35 - Personal Habits 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** ✓ ✗ ▬ •

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S_____

AFFIX LABEL BETWEEN LINES
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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 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
8 Other

4. Visit Type:
3 Annual
4 Non Routine
1 2 3 4 5 6 7 8 9 10 11

5. Form Administration:
1 Self 2 Group 3 Interview 4 Assistance

6. Language:
● E 2 S

PLEASE MAKE NO MARKS IN THIS AREA

This questionnaire asks about your physical activity, alcohol use and smoking. Please answer each question as accurately as possible. There are no right or wrong answers.

1. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? **(Mark only one.)**

   0 Rarely or never
   1 1-3 times each month
   2 1 time each week
   3 2-3 times each week
   4 4-6 times each week
   5 7 or more times each week

   1.1. When you walk outside the home for more than 10 minutes without stopping, for how many minutes do you usually walk?

   1 Less than 20 min.
   2 20-39 min.
   3 40-59 min.
   4 1 hour or more

   1.2. What is your usual speed?

   2 Casual strolling or walking (less than 2 miles an hour)
   3 Average or normal (2-3 miles an hour)
   4 Fairly fast (3-4 miles an hour)
   5 Very fast (more than 4 miles an hour)
   9 Don't know

Go to the next page.

2. Not including walking outside the home, how often each week (7 days) do you usually do the exercises below?

2.1. STRENUOUS OR VERY HARD EXERCISE (You work up a sweat and your heart beats fast.) For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

2.2. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

2.3. MODERATE EXERCISE (Not exhausting.) For example, biking outdoors, use of an exercise machine (like a stationary bike or treadmill), calisthenics, easy swimming, popular and folk dancing.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

2.4. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

2.5. MILD EXERCISE. For example, slow dancing, bowling, golf.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

2.6. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

Go to the next page.

The next questions are about alcohol. Some of you may have recently answered these same questions, but please help us by answering them again here.

3. In the last three (3) months, how often did you usually drink the following alcoholic beverages?

First: Mark how often, on the average, you drank the beverage.
Second: Mark your usual serving size as small, medium or large.

Please note:
- A small serving is about one-half (1/2) the medium serving size, or less.
- A large serving is about one-and-a-half (1 1/2) times the medium serving size, or more.
- If you did not drink alcoholic beverages, mark "Never or less than once per month," and omit the serving size altogether.

	HOW OFTEN (Mark one)									AMOUNT (Mark one)			
	Never or less than once per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day	Medium Serving Size	Your Serving Size S	M	L
3.1. Beer	0	1	2	3	4	5	6	7	8	12 ounce can or bottle	1	2	3
3.2. Wine	0	1	2	3	4	5	6	7	8	1 medium glass (6 ounces)	1	2	3
3.3. Liquor	0	1	2	3	4	5	6	7	8	1 shot (1 1/2 ounces)	1	2	3

4. Do you smoke cigarettes now?

0 No 1 Yes

4.1. How many cigarettes do you usually smoke each day? **(Mark one.)**

1 Less than 1	5 25-34
2 1-4	6 35-44
3 5-14	7 45 or more
4 15-24	

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PLEASE MAKE NO MARKS IN THIS AREA

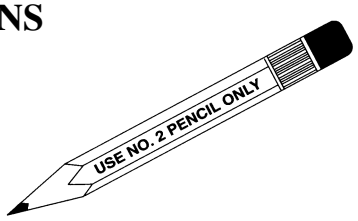
WOMEN'S HEALTH INITIATIVE

Form 37 - Thoughts and Feelings

This booklet has questions about your behavior, feelings, and experiences. Please answer each question as honestly as you can. Make sure you look at both sides of the page. No one will see your answers except for the scientists and staff at your clinic. Your answers will be kept secret and will never be put with your name in a report. Please answer using your first thoughts about each question. Do not go back later to "figure out" answers. Your answers will help us to understand the health of women like you. Thank you for your help.

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.



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AFFIX LABEL BETWEEN LINES
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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 04 05

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
8 Other

4. Visit Type:
2 Semi-Annual 5 6 7 8 9 10 11 12
3 Annual 5 6 7 8 9 10 11 12
4 Non-Routine

5. Form Administration:
1 Self 2 Group 3 Interview 4 Assistance

6. Language:
E 2 S

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PLEASE MAKE NO MARKS IN THIS AREA

People sometimes look to others for help, friendship, or other types of support. Next are some questions about the support that you have. How often is each of the following kinds of support available to you if you need it? (Mark one oval on each line.)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Someone you can count on to listen to you when you need to talk	1	2	3	4	5
2. Someone to give you good advice about a problem	1	2	3	4	5
3. Someone to take you to the doctor if you need it	1	2	3	4	5
4. Someone to have a good time with	1	2	3	4	5
5. Someone to help you understand a problem when you need it	1	2	3	4	5
6. Someone to help with daily chores if you are sick	1	2	3	4	5
7. Someone to share your most private worries and fears	1	2	3	4	5
8. Someone to do something fun with	1	2	3	4	5
9. Someone to love you and make you feel wanted	1	2	3	4	5

The next questions are about your living and social activities.

10. Who lives with you? **(Mark one oval for each item.)**

	No	Yes
10.1. I live alone	0	1
10.2. I live with my husband or partner	0	1
10.3. I live with my children	0	1
10.4. I live with my brother and/or sister	0	1
10.5. I live with other relatives	0	1
10.6. I live with friends	0	1
10.7. Other: _____ (Please describe)	0	1

11. Do you have a pet?

⓪ No ① Yes

11.1. What kind of pet do you have? **(Mark <u>all</u> that apply.)**

Dog(s) ① Cat(s) ② Bird(s) ③ Fish ④ Other ⑤

12. How often have you gone to a religious service or to a church during the <u>past month</u>? **(Mark only one oval.)**

Not at all in the past month ① | Once in the past month ② | 2 or 3 times in the past month ③ | Once a week ④ | 2 to 6 times a week ⑤ | Every day ⑥

13. How much does religion give you strength and comfort? **(Mark only one oval.)**

None ① | A little ② | A great deal ③

14. How often have you gone to meetings of clubs, lodges, or parent groups in the last month? **(Mark only one oval.)**

Not at all in the past month ① | Once in the past month ② | 2 or 3 times in the past month ③ | Once a week ④ | 2 to 6 times a week ⑤ | Every day ⑥

These next questions are about the people who are important in your life right now. For each question, mark only one oval.

15. Are you now helping at least one sick, limited, or frail family member or friend on a regular basis?

⓪ No ① Yes

15.1. In the past 4 weeks, how often have you helped this friend or family member?

Less than once a week ① | 1-2 times a week ② | 3-4 times a week ③ | 5 or more times a week ④

Go to the next page.

SERIAL #

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Of the people who are important to you, how many . . .

	None	One	Some	Most	All
16. Get on your nerves?	1	2	3	4	5
17. Ask too much of you?	1	2	3	4	5
18. Do not include you?	1	2	3	4	5
19. Try to get you to do things you don't want to?	1	2	3	4	5

Please answer the following questions about yourself. Mark one oval for each question. Try not to let an answer to one question affect your answer to other questions.

	Strongly Disagree	Disagree	Neutral (In-between)	Agree	Strongly Agree
20. In unclear times, I usually expect the best	1	2	3	4	5
21. If something can go wrong for me, it will	1	2	3	4	5
22. I'm always hopeful about my future	1	2	3	4	5
23. I hardly ever expect things to go my way	1	2	3	4	5
24. I rarely count on goods things happening to me	1	2	3	4	5
25. Overall, I expect more good things to happen to me than bad	1	2	3	4	5
26. When I am angry, people around me usually know	1	2	3	4	5
27. People can tell from my facial expressions how I am feeling	1	2	3	4	5
28. I always express disappointment when things don't go as I'd like them to	1	2	3	4	5
29. If someone makes me angry in a public place, I will "cause a scene"	1	2	3	4	5

	Strongly Disagree	Disagree	Neutral (In-between)	Agree	Strongly Agree
30. After I express anger at someone it bothers me for a long time	1	2	3	4	5
31. I try to suppress my anger, but I would like other people to know how I feel	1	2	3	4	5
32. I worry that if I express negative emotions such as fear and anger, other people will not approve of me	1	2	3	4	5

The following questions are about your opinions and beliefs. Read each statement and decide whether it is true as applied to you or false as applied to you. If the statement is true or mostly true, mark the oval under the "True" column. If it is false or usually false, mark the oval under the "False" column. Remember to give your own opinion of yourself. Do not leave any blank lines if you can avoid it; try to make some answer to every statement.

	False	True
33. I have often had to take orders from someone who did not know as much as I did	0	1
34. I think a great many people make a lot of their own bad luck in order to gain the sympathy and help of others	0	1
35. It takes a lot of argument to convince most people of the truth	0	1
36. I think most people would lie to get ahead	0	1
37. Most people are honest mainly through fear of being caught	0	1
38. Most people will use somewhat unfair means to gain profit or an advantage rather than lose it	0	1
39. No one much cares what happens to you	0	1
40. It is safer to trust nobody	0	1
41. Most people make friends because friends are likely to be useful to them	0	1
42. Most people inwardly do not like putting themselves out to help other people	0	1
43. I have often met people who were supposed to be experts who were no better than I	0	1
44. People often demand more respect for their own rights than they are willing to allow for others	0	1
45. A large number of people are guilty of bad sexual behavior	0	1

SERIAL #

PLEASE MAKE NO MARKS IN THIS AREA

46. Overall, how would you rate your quality of life? **(Mark one oval in the box below.)**

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
Worst					Halfway					Best

As bad or worse than being dead

Best quality of life

47. How satisfied are you with your current quality of life? **(Mark one oval in the box below.)**

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
Dissatisfied					Halfway					Satisfied

Not at all happy with quality of life now

Very happy with quality of life now

48. How would you rate your **current** sense of well-being? **(Mark one oval in the box below.)**

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
Worst					Halfway					Best

49. In general, would you say your health is: **(Mark one oval.)**

Excellent	Very Good	Good	Fair	Poor
①	②	③	④	⑤

50. Compared to one year ago, how would you rate your health in general now? **(Mark one oval.)**

① Much better now than 1 year ago

② Somewhat better now than 1 year ago

③ About the same

④ Somewhat worse now than 1 year ago

⑤ Much worse now than 1 year ago

The following questions are about a typical (or usual) day's activities. Does your health now limit you in these activities and, if so, how much? (Mark one oval for each question.)

	No, not limited at all	Yes, limited a little	Yes, limited a lot
51. Vigorous activities, such as running, lifting heavy objects, or strenuous sports	3	2	1
52. Moderate activities, such as moving a table, vacuuming, bowling, or golfing	3	2	1
53. Lifting or carrying groceries	3	2	1
54. Climbing several flights of stairs	3	2	1
55. Climbing one flight of stairs	3	2	1
56. Bending, kneeling, stooping	3	2	1
57. Walking more than a mile	3	2	1
58. Walking several blocks	3	2	1
59. Walking one block	3	2	1
60. Bathing or dressing yourself	3	2	1

61. During the <u>past 4 weeks</u>, to what extent has your physical health or emotional problems interfered with your normal social activities with family, neighbors, friends, or groups? **(Mark one oval.)**	Not at all 1	Slightly 2	Moderately (Medium) 3	Quite a bit 4	Extremely (A lot) 5

62. During the <u>past 4 weeks</u>, how much bodily pain have you had? **(Mark one oval.)**	None 0	Very Mild 2	Mild 3	Moderately (Medium) 4	Severe 5

63. During the <u>past 4 weeks</u>, how much did pain interfere with your normal work (both outside your home and at home? **(Mark one oval.)**	Not at all 1	A little bit 2	Moderately (Medium) 3	Quite a bit 4	Extremely (A lot) 5

SERIAL #

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The next questions are about your regular daily activities like work, child care, or community activities. As a result of your physical health, have any of the following problems occurred during the past 4 weeks?

	No	Yes
64. You cut down on the amount of time you spent on work or other activities	0	1
65. You accomplished less than you would have liked	0	1
66. You were limited in the kind of work or other activities you did	0	1
67. You had difficulty performing work or other activities (it took extra effort)	0	1

In the past 4 weeks, as a result of any emotional problem (feeling depressed or anxious), have any of the following occurred?

	No	Yes
68. You cut down on the amount of time you spent on work or other activities	0	1
69. You accomplished less than you would have liked	0	1
70. You did work or other things less carefully than usual	0	1

Of these statements, how true or false is each for you?

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
71. I seem to get sick a little easier than other people	1	2	3	4	5
72. I am as healthy as anybody I know	1	2	3	4	5
73. I expect my health to get worse	1	2	3	4	5
74. My health is excellent	1	2	3	4	5

75. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends or relatives)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
1	2	3	4	5

These questions are about how you feel and how things have been during the past 4 weeks. Give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
76. Did you feel full of pep?	1	2	3	4	5	6
77. Have you been a very nervous person?	1	2	3	4	5	6
78. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
79. Have you felt calm and peaceful?	1	2	3	4	5	6
80. Did you have a lot of energy?	1	2	3	4	5	6
81. Have you felt downhearted and blue?	1	2	3	4	5	6
82. Did you feel worn out?	1	2	3	4	5	6
83. Have you been happy?	1	2	3	4	5	6
84. Did you feel tired?	1	2	3	4	5	6

85. Can you eat:

1 Without help (able to feed yourself completely)
2 With some help (need some help cutting, etc.)
3 Or are you completely unable to feed yourself?

86. Can you dress and undress yourself:

1 Without help (able to pick out clothes, dress and undress yourself)
2 With some help
3 Or are you completely unable to dress and undress yourself?

87. Can you get in and out of bed:

1 Without any help or aids
2 With some help (either from a person or with the aid of some device)
3 Or are you totally dependent on someone else to lift you?

88. Can you take a bath or a shower:

1 Without help
2 With some help (need help getting in and out of the tub, or need special attachments on the tub)
3 Or are you completely unable to bathe yourself?

89. **Below is a list of symptoms people sometimes have. For each item, mark the one oval that best describes how bothersome the symptoms was during the <u>past 4 weeks</u> for you. Be sure to mark one oval each line.**

If you did not have the problem, please mark the oval under "symptom did not occur." If you had the symptom, use the following key to indicate how bothersome it was:

Mild = symptom did not interfere with usual activities.
Moderate = symptom interfered somewhat with usual activities.
Severe = symptom was so bothersome that usual activities could not be performed.

		Symptom did not occur	Symptom occurred and was: Mild	Moderate	Severe
89.1.	Bloating or gas	0	1	2	3
89.2.	Constipation (difficulty having bowel movements)	0	1	2	3
89.3.	Night sweats	0	1	2	3
89.4.	General aches or pains	0	1	2	3
89.5.	Breast tenderness	0	1	2	3
89.6.	Hot flashes	0	1	2	3
89.7.	Diarrhea	0	1	2	3
89.8.	Mood swings	0	1	2	3
89.9.	Nausea	0	1	2	3
89.10.	Dizziness	0	1	2	3
89.11.	Feeling tired	0	1	2	3
89.12.	Forgetfulness	0	1	2	3
89.13.	Increased appetite	0	1	2	3
89.14.	Heart racing or skipping beats	0	1	2	3
89.15.	Tremors (shakes)	0	1	2	3
89.16.	Heartburn	0	1	2	3
89.17.	Restless or fidgety	0	1	2	3
89.18.	Low back pain	0	1	2	3
89.19.	Neck pain	0	1	2	3
89.20.	Skin dryness or scaling	0	1	2	3

PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

		Symptom did not occur	Symptom occurred and was: Mild	Moderate	Severe
89.21.	Headaches or migraines	0	1	2	3
89.22.	Clumsiness	0	1	2	3
89.23.	Any trouble seeing that is uncorrected by lenses	0	1	2	3
89.24.	Vaginal or genital irritation or itching	0	1	2	3
89.25.	Difficulty concentrating	0	1	2	3
89.26.	Joint pain or stiffness	0	1	2	3
89.27.	Decreased appetite	0	1	2	3
89.28.	Hearing loss	0	1	2	3
89.29.	Swelling of hands or feet	0	1	2	3
89.30.	Vaginal or genital dryness	0	1	2	3
89.31.	Upset stomach or belly pain or discomfort	0	1	2	3
89.32.	Pain or burning while urinating	0	1	2	3
89.33.	Cough or wheezing	0	1	2	3
89.34.	Vaginal or genital discharge	0	1	2	3

90. **<u>During the last 4 weeks</u>, how often have you been bothered by any of the following problems?**

		Not at all	Several days	More than half the days
90.1.	Feeling nervous, anxious, on edge, or worrying a lot about different things	0	1	2
90.2.	Feeling restless so that it is hard to sit still	0	1	2
90.3.	Getting tired very easily	0	1	2
90.4.	Muscle tension aches or soreness	0	1	2
90.5.	Trouble falling asleep or staying asleep	0	1	2
90.6.	Trouble concentrating on things, such as reading a book or watching TV	0	1	2
90.7.	Becoming easily annoyed or irritable	0	1	2
90.8.	Having an anxiety attack – suddenly feeling fear or panic	0	1	2

Below are some hard things that sometimes happen to people. Please try to think back over the past year to remember if any of these things happened. Mark the answer that seems best.

Over the past year:	No	**Yes,** and it upset me: Not too much	Moderately (Medium)	Very much
91. Did your spouse or partner die?	0	1	2	3
92. Did your spouse or partner have a serious illness?	0	1	2	3
93. Did a close friend or family member die or have a serious illness (other than your spouse or partner)?	0	1	2	3
94. Did you have any major problems with money?	0	1	2	3
95. Did you have a divorce or break-up with a spouse or partner?	0	1	2	3
96. Did a family member or close friend have a divorce or break-up?	0	1	2	3
97. Did you have a major conflict with children or grandchildren?	0	1	2	3
98. Did you have any major accidents, disasters, mugging, unwanted sexual experiences, robberies, or similar events?	0	1	2	3
99. Did you or a family member or close friend lose their job or retire?	0	1	2	3
100. Were you physically abused by being hit, slapped, pushed, shoved, punched or threatened with a weapon by a family member or close friend?	0	1	2	3
101. Were you verbally abused by being made fun of, severely criticized, told you were a stupid or worthless person, or threatened with harm to yourself, your possessions, or your pets, by a family member or close friend?	0	1	2	3
102. Did a pet die?	0	1	2	3

SERIAL #

PLEASE DO NOT WRITE IN THIS AREA

These questions are about your feelings during the past week. For each of the statements, please indicate the choice that tells how often you felt this way.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
103. You felt depressed (blue or down)	0	1	2	3
104. Your sleep was restless	0	1	2	3
105. You enjoyed life	0	1	2	3
106. You had crying spells	0	1	2	3
107. You felt sad	0	1	2	3
108. You felt that people disliked you	0	1	2	3

109. In the past year, have you had two weeks or more during which you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed?

0 No 1 Yes

110. Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

0 No 1 Yes

110.1. Have you felt depressed or sad much of the time in the past year?

0 No 1 Yes

Go to the next page.

These next questions are about your sleep habits. Please mark <u>one</u> of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the <u>past 4 weeks</u>.

	No, not in past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
111. Did you take any kind of medication or alcohol at bedtime to help you sleep?	1	2	3	4	5
112. Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?	1	2	3	4	5
113. Did you nap during the day?	1	2	3	4	5
114. Did you have trouble falling asleep?	1	2	3	4	5
115. Did you wake up several times at night?	1	2	3	4	5
116. Did you wake up earlier than you planned to?	1	2	3	4	5
117. Did you have trouble getting back to sleep after you woke up too early?	1	2	3	4	5
118. Did you snore?	9 Don't know	1	2	3	4	5

119. Overall, was your typical night's sleep during the past 4 weeks:

Very sound or restful	Sound or restful	Average quality	Restless	Very restless
5	4	3	2	1

120. About how many hours of sleep did you get on a typical night during the past 4 weeks?

5 or less hours	6 hours	7 hours	8 hours	9 hours	10 or more hours
1	2	3	4	5	6

Many women report that they leak urine (or pee). The next questions are about problems you may have had with leaking urine.

121. Have you ever leaked even a very small amount of urine involuntarily and you couldn't control it?

0 No 1 Yes

(If you answered "No," go to question 128 on the last page.)

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122. How often does this leaking urine occur? **(Mark one oval.)**

Not once during the past year	Less than once a month	More than once a month but less than once a week	One or more times a week but less than every day	Daily
1	2	3	4	5

123. When do you usually leak urine? **(Mark all that apply.)**

No longer leak urine	When I cough, laugh, sneeze, lift, stand up, or exercise	When I feel the need to urinate and can't get to a toilet fast enough	When I am sleeping	Other _____ (Please describe)
0	1	2	3	8

(If you "No longer leak urine," go to question 128 on the last page.)

124. How much urine do you usually lose when it leaks? **(Mark one oval.)**

None	Barely noticeable on underpants	Soaked underpants	Soaked through to outer clothing
1	2	3	4

125. What protection do you wear in case you leak urine? **(Mark all that apply.)**

None	Mini-pad, tissue or paper towel	Menstrual pad or shield	Diaper, towel, Attends, Depends	Other
1	2	3	4	8

126. How often does the leakage of urine limit your daily activities? **(Mark one oval.)**

Never	Almost never	Sometimes	Fairly often	Very often
1	2	3	4	5

127. How much does the leakage of urine bother or disturb you? **(Mark one oval.)**

Not at all disturbing	A little disturbing	Somewhat disturbing	Very disturbing	Extremely disturbing
1	2	3	4	5

The last questions in this booklet ask about some personal topics. Although the following questions are sensitive and personal, they are important. Your answers will help us understand the health of women and may help us find better treatments for their health problems. Please be assured that your responses to these questions will remain confidential.

128. Are you currently married or in an intimate relationship with at least one person?

No	Yes
⓪	①

129. Did you have any sexual activity with a partner in the last year?

No	Yes	Don't want to answer
⓪	①	⑨

130. How satisfied are you with your current sexual activities, either with a partner or alone? **(Mark one oval.)**

Very unsatisfied	A little unsatisfied	Somewhat satisfied	Very satisfied	Don't want to answer
①	②	③	④	⑨

131. Are you satisfied with the frequency of your sexual activity, or would you like to have sex more or less often? **(Mark one oval.)**

Less often	Satisfied with current frequency	More often	Don't want to answer
①	②	③	⑨

132. Are you worried that sexual activities will affect your health? **(Mark one oval.)**

Not at all worried	A little worried	Somewhat worried	Very worried	Don't want to answer
①	②	③	④	⑨

133. Regardless of whether you are currently sexually active, which response best describes who you have had sex with over your adult lifetime?

① Have never had sex

② Sex with a woman or with women

③ Sex with a man or with men

④ Sex with both men and women →

⑨ Prefer not to answer

133.1. Which response best describes who you have had sex with after 45 years of age?

⓪ Never had sex
① Sex with a woman or with women
② Sex with a man or with men
③ Sex with both men and women

Thank you. Please take a few minutes to review any questions you may have missed.

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SERIAL #

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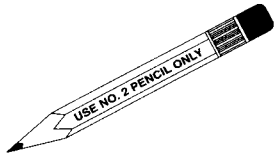
WOMEN'S HEALTH INITIATIVE

Form 38 - Daily Life

This booklet contains questions about the experiences of your daily life. Please answer each question as honestly as you can. Make sure you look at both sides of the page. No one will see your answers except for the scientists and staff at your clinic. Your answers will be kept secret and will never be put with your name in a report. Please answer using your first thoughts about each question. Do not go back later to "figure out" answers. Your answers will help us to understand the health of women like you. Thank you for your help.

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_____

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 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

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

3. Contact Type:

1 Phone
2 Mail
3 Visit
8 Other

4. Visit Type:

1 Screening 0 1 2 3 11
2 Semi-Annual 1 2 3 4 5 6 7 8 9 10
3 Annual 1 2 3 4 5 6 7 8 9 10
4 Non Routine 11

5. Form Administration:

1 Self 2 Group 3 Interview 4 Assistance

PLEASE MAKE NO MARKS IN THIS AREA

521403

1. Overall, how would you rate your quality of life? **(Mark one oval in the box below.)**

0	1	2	3	4	5	6	7	8	9	10
Worst					Halfway					Best

As bad or worse than being dead

Best quality of life

2. How satisfied are you with your current quality of life? **(Mark one oval in the box below.)**

0	1	2	3	4	5	6	7	8	9	10
Dissatisfied					Halfway					Satisfied

Not at all happy with quality of life now

Very happy with quality of life now

	Excellent	Very good	Good	Fair	Poor
3. In general, would you say your health is **(Mark one oval.):**	1	2	3	4	5

4. Compared to one year ago, how would you rate your health in general now? **(Mark one oval.)**

1 Much better now than 1 year ago

2 Somewhat better now than 1 year ago

3 About the same

4 Somewhat worse now than 1 year ago

5 Much worse than 1 year ago

The following are questions about a typical (or usual) day's activities. Does your health now limit you in these activities and, if so, how much? (Mark one oval for each question.)

	No, not limited at all	Yes, limited a little	Yes, limited a lot
5. Vigorous activities, such as running, lifting heavy objects, or strenuous sports	3	2	1
6. Moderate activities, such as moving a table, vacuuming, bowling, or golfing	3	2	1
7. Lifting or carrying groceries	3	2	1
8. Climbing several flights of stairs	3	2	1
9. Climbing one flight of stairs	3	2	1
10. Bending, kneeling, stooping	3	2	1
11. Walking more than a mile	3	2	1
12. Walking several blocks	3	2	1
13. Walking one block	3	2	1
14. Bathing or dressing yourself	3	2	1

	Not at all	Slightly	Moderately (Medium)	Quite a bit	Extremely (A lot)
15. During the <u>past 4 weeks</u>, to what extent has your physical health or emotional problems interfered with your normal social activities with family, neighbors, friends, or groups? **(Mark one oval.)**	1	2	3	4	5

	None	Very mild	Mild	Moderate (Medium)	Severe
16. During the <u>past 4 weeks</u>, how much bodily pain have you had? **(Mark one oval.)**	0	2	3	4	5

	None at all	A little bit	Moderately (Medium)	Quite a bit	Extremely (A lot)
17. During the <u>past 4 weeks</u>, how much did pain interfere with your normal work (both outside your home and at home)? **(Mark one oval.)**	1	2	3	4	5

PLEASE MAKE NO MARKS IN THIS AREA

521403

The next questions are about your regular daily activities like work, child care, or community activities. As a result of your physical health, have any of the following problems occurred during the past 4 weeks?

	No	Yes
18. You cut down on the amount of time you spent on work or other activities	0	1
19. You accomplished less than you would have liked	0	1
20. You were limited in the kind of work or other activities you did	0	1
21. You had difficulty performing work or other activities (it took extra effort)	0	1

In the past 4 weeks, as a result of any emotional problem (feeling depressed or anxious), have any of the following occurred?

	No	Yes
22. You cut down on the amount of time you spent on work or other activities	0	1
23. You accomplished less than you would have liked	0	1
24. You did work or other things less carefully than usual	0	1

Of these statements, how true or false is each for you?

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
25. I seem to get sick a little easier than other people	1	2	3	4	5
26. I am as healthy as anybody I know	1	2	3	4	5
27. I expect my health to get worse	1	2	3	4	5
28. My health is excellent	1	2	3	4	5

29. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends and relatives)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
1	2	3	4	5

These questions are about how you feel and how things have been during the past 4 weeks. Give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
30. Did you feel full of pep?	1	2	3	4	5	6
31. Have you been a very nervous person?	1	2	3	4	5	6
32. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
33. Have you felt calm and peaceful?	1	2	3	4	5	6
34. Did you have a lot of energy?	1	2	3	4	5	6
35. Have you felt downhearted and blue?	1	2	3	4	5	6
36. Did you feel worn out?	1	2	3	4	5	6
37. Have you been happy?	1	2	3	4	5	6
38. Did you feel tired?	1	2	3	4	5	6

39. Can you eat:

1 Without help (able to feed yourself completely)
2 With some help (need help with cutting, etc.)
3 Or are you completely unable to feed yourself?

40. Can you dress and undress yourself:

1 Without help (able to pick out clothes, dress and undress yourself)
2 With some help
3 Or are you completely unable to dress and undress yourself?

41. Can you get in and out of bed:

1 Without any help or aids
2 With some help (either from a person or with the aid of some device)
3 Or are you totally dependent on someone else to lift you?

42. Can you take a bath or shower:

1 Without help
2 With some help (need help getting in and out of the tub, or need special attachments on the tub)
3 Or are you completely unable to bathe yourself?

PLEASE MAKE NO MARKS IN THIS AREA

521403

Below is a list of symptoms people sometimes have. For each item, mark the one oval that best describes how bothersome the symptom was during the <u>past 4 weeks</u> for you. Be sure to mark one oval on each line.

If you did not have the problem, please mark the oval under "symptom did not occur." If you had the symptom, use the following key to indicate how bothersome it was:

Mild = symptom did not interfere with usual activities.
Moderate = symptom interfered somewhat with usual activities.
Severe = symptom was so bothersome that usual activities could not be performed.

		Symptom did not occur	Symptom occurred and was: Mild	Moderate	Severe
43.1.	Bloating or gas	0	1	2	3
43.2.	Constipation (difficulty having bowel movements)	0	1	2	3
43.3.	Night sweats	0	1	2	3
43.4.	General aches or pains	0	1	2	3
43.5.	Breast tenderness	0	1	2	3
43.6.	Hot flashes	0	1	2	3
43.7.	Diarrhea	0	1	2	3
43.8.	Mood swings	0	1	2	3
43.9.	Nausea	0	1	2	3
43.10.	Dizziness	0	1	2	3
43.11.	Feeling tired	0	1	2	3
43.12.	Forgetfulness	0	1	2	3
43.13.	Increased appetite	0	1	2	3
43.14.	Heart racing or skipping beats	0	1	2	3
43.15.	Tremors (shakes)	0	1	2	3
43.16.	Heartburn	0	1	2	3
43.17.	Restless or fidgety	0	1	2	3
43.18.	Low back pain	0	1	2	3
43.19.	Neck pain	0	1	2	3
43.20.	Skin dryness or scaling	0	1	2	3

	Symptom did not occur	Symptom occurred and was: Mild	Moderate	Severe
43.21. Headaches or migraines	0	1	2	3
43.22. Clumsiness	0	1	2	3
43.23. Any trouble seeing that is uncorrected by lenses	0	1	2	3
43.24. Vaginal or genital irritation or itching	0	1	2	3
43.25. Difficulty concentrating	0	1	2	3
43.26. Joint pain or stiffness	0	1	2	3
43.27. Decreased appetite	0	1	2	3
43.28. Hearing loss	0	1	2	3
43.29. Swelling of hands or feet	0	1	2	3
43.30. Vaginal or genital dryness	0	1	2	3
43.31. Upset stomach or belly pain or discomfort	0	1	2	3
43.32. Pain or burning while urinating	0	1	2	3
43.33. Cough or wheezing	0	1	2	3
43.34. Vaginal or genital discharge	0	1	2	3

Below are some hard things that sometimes happen to people. Please try to think back over the past year to remember if any of these things happened. Mark the answer that seems best.

Over the past year:	No	**Yes,** and it upset me: Not too much	Moderately (Medium)	Very much
44.1. Did your spouse or partner die?	0	1	2	3
44.2. Did your spouse or partner have a serious illness?	0	1	2	3
45. Did a close friend or family member die or have a serious illness (other than your spouse or partner)?	0	1	2	3
46. Did you have any major problems with money?	0	1	2	3
47. Did you have a divorce or break-up with a spouse or partner?	0	1	2	3
48. Did a family member or close friend have a divorce or break-up?	0	1	2	3
49. Did you have a major conflict with children or grandchildren?	0	1	2	3
50. Did you have any major accidents, disasters, muggings, unwanted sexual experiences, robberies, or similar events?	0	1	2	3

Over the past year:

		No	Yes, and it upset me: Not too much	Moderately (Medium)	Very much
51.	Did you or a family member or close friend lose their job or retire?	0	1	2	3
52.	Were you physically abused by being hit, slapped, pushed, shoved, punched or threatened with a weapon by a family member or close friend?	0	1	2	3
53.	Were you verbally abused by being made fun of, severely criticized, told you were a stupid or worthless person, or threatened with harm to yourself, your possessions, or your pets, by a family member or close friend?	0	1	2	3
54.	Did a pet die?	0	1	2	3

These questions are about your feeling during the past week. For each of the statements, please indicate the choice that tells how often you felt that way.

		Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
55.1.	You felt depressed (blue or down)	0	1	2	3
55.2.	Your sleep was restless	0	1	2	3
55.3.	You enjoyed life	0	1	2	3
55.4.	You had crying spells	0	1	2	3
55.5.	You felt sad	0	1	2	3
55.6.	You felt that people disliked you	0	1	2	3

56. In the past year, have you had two weeks or more during which you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed?

0 No 1 Yes

57. Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

0 No 1 Yes

57.1. Have you felt depressed or sad much of the time in the past year?

0 No 1 Yes

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA

521403

These next questions are about your sleep habits. Please mark <u>one</u> of the answers for each of the following questions. Pick the answer that best describes how often you experienced the situation in the <u>past 4 weeks</u>.

	No, not in past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
58. Did you take any kind of medication or alcohol at bedtime to help you sleep?	1	2	3	4	5
59. Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?	1	2	3	4	5
60. Did you nap during the day?	1	2	3	4	5
61. Did you have trouble falling asleep?	1	2	3	4	5
62. Did you wake up several times at night?	1	2	3	4	5
63. Did you wake up earlier than you planned to?	1	2	3	4	5
64. Did you have trouble getting back to sleep after you woke up too early?	1	2	3	4	5
65. Did you snore?	1	2	3	4	5
	9 Don't know				

66. Overall, was your typical night's sleep during the past 4 weeks:

Very sound or restful	Sound or restful	Average quality	Restless	Very restless
5	4	3	2	1

67. About how many hours of sleep did you get on a typical night during the past 4 weeks?

5 or less hours	6 hours	7 hours	8 hours	9 hours	10 or more hours
1	2	3	4	5	6

Many women report that they leak urine (or pee). The next questions are about problems you may have had with leaking urine.

68. Have you ever leaked even a very small amount of urine involuntarily and you couldn't control it?

0 No 1 Yes

(If you answered "No," go to question 75.)

69. How often does this leaking urine occur? **(Mark one oval.)**

Not once during the past year	Less than once a month	More than once a month but less than once a week	One or more times a week but less than every day	Daily
1	2	3	4	5

70. When do you usually leak urine? **(Mark all that apply.)**

No longer leak urine	When I cough, laugh, sneeze, lift, stand up, or exercise	When I feel the need to urinate and can't get to a toilet fast enough	When I am sleeping	Other _____ (Please describe)
0	1	2	3	8

(If you "no longer leak urine," go to question 75.)

71. How much urine do you usually lose when it leaks? **(Mark one oval.)**

None	Barely noticeable on underpants	Soaked underpants	Soaked through to outer clothing
1	2	3	4

72. What protection do you wear in case you leak urine? **(Mark all that apply.)**

None	Mini-pad, tissue or paper towel	Mentrual pad or sheild	Diaper, towel, Attends, Depends	Other
1	2	3	4	8

73. How often does the leakage of urine limit your daily activities? **(Mark one oval.)**

Never	Almost never	Sometimes	Fairly often	Very often
1	2	3	4	5

74. How much does the leakage of urine bother or disturb you? **(Mark one oval.)**

Not at all disturbing	A little disturbing	Somewhat disturbing	Very disturbing	Extremely disturbing
1	2	3	4	5

PLEASE MAKE NO MARKS IN THIS AREA

521403

The last questions in this booklet ask about some personal topics. Although the following questions are sensitive and personal, they are important. Your answers will help us understand the health of women and may help us find better treatments for their health problems. Please be assured that your responses to these questions will remain confidential.

75. Are you currently married or in an intimate relationship with at least one person?	No 0	Yes 1	
76. Did you have any sexual activity with a partner in the last year?	No 0	Yes 1	Don't want to answer 9

77. How satisfied are you with your current sexual activities, either with a partner or alone? **(Mark one oval.)**	Very unsatisfied 1	A little unsatisfied 2	Somewhat satisfied 3	Very satisfied 4	Don't want to answer 9
78. Are you satisfied with the frequency of your sexual activity, or would you like to have sex more or less often? **(Mark one oval.)**	Less often 1	Satisfied with current frequency 2	More often 3		Don't want to answer 9
79. Are you worried that sexual activities will affect your health? **(Mark one oval.)**	Not at all worried 1	A little worried 2	Somewhat worried 3	Very worried 4	Don't want to answer 9

Thank you. Feel free to write any comments here or notes about things to ask your clinic staff.

* U.S. GOVERNMENT PRINTING OFFICE:2003-589-322/40017

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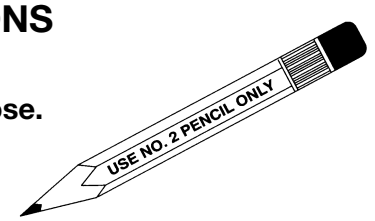
WOMEN'S HEALTH INITIATIVE

Form 39 - Cognitive Assessment

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 the date is May, 1995:

0	5	9	5
Month		Year	

M 1 2 3 4 ● 5 6 7 8 9 10 11 12

Y 95 ● 96 97 98 99

OFFICE USE ONLY

S_____

1. **Contact Date:**

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 95 96 97 98 99 00 01 02 03 04 05 06 07

2. **Completed 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
   - 8 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

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PLEASE MAKE NO MARKS IN THIS AREA

"I would like to ask you a few questions that require concentration and memory. Some are a little bit more difficult than others. Some questions will be asked more than once."

1. "When were you born?" Record responses.

month	day	year
0 0	0 0	0 0 0 0
1 1	1 1	1 1 1 1
2 2	2 2	2 2 2 2
3 3	3 3	3 3 3 3
4 4	4 4	4 4 4 4
5 5	5 5	5 5 5 5
6 6	6 6	6 6 6 6
7 7	7 7	7 7 7 7
8 8	8 8	8 8 8 8
9 9	9 9	9 9 9 9

"Where were you born?" Record responses.

place of birth:	answer given	can't do/ refused	not att/ disabled
1.1. city/town _____	1	0	9
1.2. state/country _____	1	0	9

You will ask again in Question 18.

2. "I am going to say three words for you to remember. Repeat them after I have said all three words: 'socks,' blue,' 'charity'."

Do not repeat the words for the participant until after the first trial. The participant may give the words in any order. If there are errors on the first trial, repeat the items up to six times until they are learned.

first trial only:	answer given	error/ refused	not att/ disabled
a. socks	1	0	9
b. blue	1	0	9
c. charity	1	0	9

d. number of presentations necessary for the participant to repeat the sequence (1-7): ___ 1 2 3 4 5 6 7

3. "I would like you to count from 1 to 5."

3.1. 1 able to count forward
0 unable to count forward — Say **"1-2-3-4-5"**

3.2. "Now I would like you to count backwards from 5 to 1."

Record the responses in the order given: _____

1st No. 5 4 3 2 1
2nd No. 5 4 3 2 1
3rd No. 5 4 3 2 1
4th No. 5 4 3 2 1
5th No. 5 4 3 2 1

4. "Spell 'world'."

4.1. 1 able to spell
0 unable to spell — **"It's spelled W-O-R-L-D."**

4.2. "Now spell 'world' backwards."

Record letters in the order given: _____

1st letter D L R O W
2nd letter D L R O W
3rd letter D L R O W
4th letter D L R O W
5th letter D L R O W

5. "What three words did I ask you to remember earlier?"

The words may be repeated in any order. If the participant cannot give the correct answer after a category cue, provide the three choices listed. If the participant still cannot give the correct answer from the three choices, mark 0 and provide the correct answer.

5.1. socks
3 spontaneous recall
2 correct word/incorrect form
2 after **"Something to wear."**
1 after **"Was it shirt, shoes or socks?"**
0 unable to recall/refused (provide the correct answer)
9 not attempted/disabled

5.2. blue
3 spontaneous recall
2 correct word/incorrect form
2 after **"A color."**
1 after **"Was it blue, black, brown?"**
0 unable to recall/refused (provide the correct answer)
9 not attempted/disabled

5.3. charity
3 spontaneous recall
2 correct word/incorrect form
2 after **"A good, personal quality."**
1 after **"Was it honesty, charity, modesty?"**
0 unable to recall/refused (provide the correct answer)
9 not attempted/disabled

6.1. "What is today's date?" Probe for the month, day or year if not volunteered.

month	day	year
0 0	0 0	0 0 0 0
1 1	1 1	1 1 1 1
2 2	2 2	2 2 2 2
3 3	3 3	3 3 3 3
4 4	4 4	4 4 4 4
5 5	5 5	5 5 5 5
6 6	6 6	6 6 6 6
7 7	7 7	7 7 7 7
8 8	8 8	8 8 8 8
9 9	9 9	9 9 9 9

6.2. "What is the day of the week?"

1 correct
0 error/refused
9 not attempted/disabled

Record answer in error. Enter 'x' if no response.

_____ day of week

6.3. "What season of the year is it?"

1 correct
0 error/refused
9 not attempted/disabled

Record answer in error. Enter 'x' if no response.

_____ season

7.1. "What state are we in?"

1 correct
0 error/refused
9 not attempted/disabled

Record answer in error. Enter 'x' if no response.

_____ state

7.2. "What country are we in?"

1 correct
0 error/refused
9 not attempted/disabled

Record answer in error. Enter 'x' if no response.

_____ country

7.3. "What (city/town) are we in?"

1 correct
0 error/refused
9 not attempted/disabled

Record answer in error. Enter 'x' if no response.

_____ city/town

7.4. "Are we in a clinic, store, or home?"

If the correct answer is not among the three alternatives, (e.g., hospital or nursing home), substitute it for the middle alternative (store). If the participant states that none is correct, ask them to make the best choice of the three options.

1 correct
0 error/refused
9 not attempted/disabled

8. Point to the object or a part of your own body and ask the participant to name it. Score 0 if the participant cannot name it within 2 seconds or gives an incorrect name. Do not wait for the participant to mentally search for the name.

		correct	error/ refused	not att/ disabled
8.1.	pencil: **"What is this?"**	1	0	9
8.2.	watch: **"What is this?"**	1	0	9
8.3.	forehead: **"What do you call this part of the face?"**	1	0	9
8.4.	chin: **". . . And this part?"**	1	0	9
8.5.	shoulder: **". . . And this part of the body?"**	1	0	9
8.6.	elbow: **". . . And this part?"**	1	0	9
8.7.	knuckle: **". . . And this part of the hand?"**	1	0	9

SERIAL #

PLEASE MAKE NO MARKS IN THIS AREA

9. "What animals have four legs? Tell me as many as you can."

Discontinue after 30 seconds. Count all correct responses. If the participant gives no response in 10 seconds, and there are at least 10 seconds of remaining time, gently remind (once only) **"What (other) animals have four legs?"** The first time an incorrect answer is provided, say **"I want four-legged animals."** Do not correct for subsequent errors.

score (total correct responses):

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

(Write any additional correct answers on a separate sheet of paper.)

10.1. "In what way are an arm and a leg alike?"

If the participant fails to give an answer that is worth 2 points, mark the appropriate score of 1 or 0. If the answer is not worth 2 points, coach the participant by saying **"An arm and a leg are both limbs or extremities."** Do not coach for questions 10.2 and 10.3.

(2) limbs, extremities
(1) lesser correct answer (e.g., body parts, both bend, have joints)
(0) error (e.g., states differences, gives unrelated answer)/refused
(9) not attempted/disabled

10.2. "In what way are laughing and crying alike?"

(2) expressions of feelings, emotions
(1) lesser correct answer (e.g., sounds, expressions)
(0) error (e.g., states differences, gives unrelated answer)/refused
(9) not attempted/disabled

10.3. "In what way are eating and sleeping alike?"

(2) necessary bodily functions, essential for life
(1) lesser correct answer (e.g., bodily functions, relaxing, "good for you")
(0) error (e.g., states differences, gives unrelated answer)/refused
(9) not attempted/disabled

11. "Repeat what I say: I would like to go out."

Pronounce the individual words clearly, but with normal tempo of a spoken sentence.

(2) correct
(1) 1 or 2 words missed
(0) 3 or more words missed/refused
(9) not attempted/disabled

12. "Now repeat: No ifs, ands or buts."

Pronounce the individual words clearly, but with normal tempo of a spoken sentence. Give no credit if the participant misses the "s."

	correct	error/ refused	not att/ disabled
12.1. no ifs	(1)	(0)	(9)
12.2. ands	(1)	(0)	(9)
12.3. or buts	(1)	(0)	(9)

13. Hold up Card 39-1 and say: **"Please do this."**

If the participant does not close her eyes within 5 seconds, prompt by pointing to the sentence and saying **"Read and do what this says."** If the participant has already read the sentence aloud spontaneously, simply say, **"Do what this says."**

Allow 5 seconds for the response. Mark 1 if the participant reads the sentence aloud, either spontaneously or after your request, but does not close her eyes. As soon as the participant closes her eyes, say **"Open."**

(3) closes eyes without prompting
(2) closes eyes after prompting
(1) reads aloud, but does not close eyes
(0) does not read aloud or close eyes/refused
(9) not attempted/disabled

14. "Please write the following sentence: I would like to go out."

Hand the participant a piece of blank paper and a #2 pencil with eraser. If necessary, repeat the sentence word by word as the participant writes. Allow a maximum of 1 minute after the first reading of the sentence for the scored response.

Either printing or cursive writing is allowed. Assign 1 point for each correct word, but no credit for "I." For each word, mark 0 if there are spelling errors or incorrect mixed capitalizations (all letters printed in uppercase is permissible). Do not penalize self-corrected errors.

		correct	error/ refused	not att/ disabled
14.1.	would	1	0	9
14.2.	like	1	0	9
14.3.	to	1	0	9
14.4.	go	1	0	9
14.5.	out	1	0	9

14.6. Note which hand the participant uses to write. If this is not done, ask participant if she is right- or left-handed. (For use in Question 16):

1 right
2 left
9 unknown

15. "Here is a drawing. Please copy the drawing onto this piece of paper."

Hand the participant a piece of paper and Card 39-2. For right-handed participants, present the sample on their left side. For left-handed participants, present the sample on their right side. Allow one minute for copying. In scoring, do not penalize for self-corrected errors, tremors, minor gaps, or overshoots.

15.1. pentagon 1

4 5 approximately equal sides
3 5 sides, but longest:shortest side is >2:1
2 nonpentagon enclosed figure
1 2 or more lines, not an enclosure
0 less than 2 lines/refused
9 not attempted/disabled

15.2. pentagon 2

4 5 approximately equal sides
3 5 sides, but longest:shortest side is >2:1
2 nonpentagon enclosed figure
1 2 or more lines, not an enclosure
0 less than 2 lines/refused
9 not attempted/disabled

15.3. intersection

2 4-cornered enclosure
1 other than 4-cornered enclosure
0 no enclosure/refused
9 not attempted/disabled

16. Refer back to Question 14.6 to determine the participant's dominant hand. Hold up a piece of white paper in plain view of the participant but out of her reach, and say:

"Take this paper with your left (right for left-handed person) **hand, fold it in half, and hand it back to me."**

After saying the whole command, hold the paper within reach of the participant. Do not repeat any part of the command. Do not give visual cues for her to take or return the paper. She may hand it back with either hand.

		correct	error/ refused	not att/ disabled
16.1.	takes paper in correct hand	1	0	9
16.2.	folds paper in half	1	0	9
16.3.	hands paper back	1	0	9

17. "What three words did I ask you to remember earlier?"

The words may be repeated in any order. Administer even if the score = 0 on question 5. If the participant cannot give the correct answer after a category cue, provide the three choices listed. If the participant still cannot give the correct answer from the three choices, mark "0" and provide the correct answer.

17.1. socks
- ③ spontaneous recall
- ② correct word/incorrect form
- ② after **"Something to wear."**
- ① after **"Was it shirt, shoes or socks?"**
- ⓪ unable to recall/refused (provide the correct answer)
- ⑨ not attempted/disabled

17.2. blue
- ③ spontaneous recall
- ② correct word/incorrect form
- ② after **"A color."**
- ① after **"Was it blue, black, brown?"**
- ⓪ unable to recall/refused (provide the correct answer)
- ⑨ not attempted/disabled

17.3. charity
- ③ spontaneous recall
- ② correct word/incorrect form
- ② after **"A good, personal quality."**
- ① after **"Was it honesty, charity, modesty?"**
- ⓪ unable to recall/refused (provide the correct answer)
- ⑨ not attempted/disabled

18. "Would you please tell me again where you were born?"

Ask only when a response was given in Question 1.1 and 1.2. Record the response. Score the responses by checking the match with the responses in Question 1.1 and 1.2.

place of birth:	matches	does not match/ refused	not att/ disabled
18.1. city/town _____	①	⓪	⑨
18.2. state/country _____	①	⓪	⑨

19. Special problems?

① Yes
⓪ No

19.1 Primary problem:

- ① Vision
- ② Hearing
- ③ Inability to write due to injury/illness
- ④ Illiteracy/lack of education
- ⑤ Language (difficulty speaking/ understanding English)
- ⑧ Other, specify:_____

Secondary problem (specify): _____

_____

20. "Please tell me which hand you would normally use to throw a ball to hit a target."

- ① always left
- ② usually left
- ③ no preference
- ④ usually right
- ⑤ always right
- ⑨ unknown

21. "Please tell me which hand you would normally use to hold a toothbrush while cleaning teeth."

- ① always left
- ② usually left
- ③ no preference
- ④ usually right
- ⑤ always right
- ⑨ unknown

SERIAL #

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PLEASE DO NOT WRITE ON THIS PAGE

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SERIAL #

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WOMEN'S HEALTH INITIATIVE

Addendum to 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 ✓ ✗ ⬬ ⊙

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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 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
8 Other

4. Visit Type:
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

6. Language:
● E 2 S

■ ○○○○○○○○○○○○○○○○ ■■■■■■ **SERIAL #**

PLEASE MAKE NO MARKS IN THIS AREA

The following questions ask you about a specific disorder that may have occurred in one or more members of YOUR FAMILY. When answering these questions, please think about full-blooded relatives only. Do not think about half-sisters or brothers, or relatives who are related to you by marriage or adoption. Full-blooded sisters and brothers are those who had the same two parents as you.

1. Did your mother, father, full-blooded sisters, full-blooded brothers, daughters, or sons ever have **deep vein thrombosis** or **DVT** (large blood clot in the veins of legs)? A deep vein thrombosis usually occurs in one leg only, and causes swelling and pain in that leg. A deep vein thrombosis is different from a blood clot of the veins under the skin of the legs (superficial thrombophlebitis or just "phlebitis") and is also different from varicose veins.

⓪ No

⑨ Don't know

① Yes

1.1 How many of these relatives had a deep vein thrombosis?

① 1 relative

② 2 relatives

③ 3 relatives

④ 4 or more relatives

2. Did your mother, father, full-blooded sisters, full-blooded brothers, daughters, or sons ever have a blood clot in the lung, usually called a **pulmonary embolus** or **PE**? A pulmonary embolus is a serious condition that causes sudden shortness of breath, pain in the chest, and sometimes coughing up of blood.

⓪ No

⑨ Don't know

① Yes

2.1 How many of these relatives had a blood clot in the lungs?

① 1 relative

② 2 relatives

③ 3 relatives

④ 4 or more relatives

★ U.S. GOVERNMENT PRINTING OFFICE:2002–689-258/40007

OMB #0925-0414 Exp: 4/06

1. Date Received: ☐☐-☐☐-☐☐ (M/D/Y) **2. Reviewed By:** ☐☐☐	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

3. Contact Type:	**4. Visit Type:**	**5. Form Administration**	**6. Language**
☐ 1 Phone ☐ 3 Visit ☐ 2 Mail ☐ 8 Other	☐ 2 Semi-Annual #☐☐ ☐ 3 Annual #☐☐ ☐ 4 Non-Routine	☐ 1 Self ☐ 3 Interview ☐ 2 Group ☐ 4 Assistance	☒ 1 E ☐ 2 S

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These questions ask about your racial/ethnic background. This information will help us describe the groups of women who are participating in the WHI. Please answer both questions. Mark the appropriate box with an "x" (☒) or write the information in the space provided.

1. Are you Spanish/Hispanic/Latino? Mark the "**No**" box if **not** Spanish/Hispanic/Latino.

☐ 0 **No**, not Spanish/Hispanic/Latino

☐ 1 Yes, Puerto Rican

☐ 2 Yes, Mexican, Mexican American, or Chicano

☐ 3 Yes, Cuban

☐ 4 Yes, other Spanish/Hispanic/Latina

(Please specify what group: _____)

Go to the next page

2. What is your race? **Mark one or more races** to indicate what you consider yourself to be.

☐ 1 White

☐ 2 Black, African-American, or Negro

☐ 3 American Indian or Alaska Native
(Please specify enrolled or principal tribe: _____)

☐ 4 Asian Indian

☐ 5 Chinese

☐ 6 Filipino

☐ 7 Japanese

☐ 8 Korean

☐ 9 Vietnamese

☐ 10 Other Asian (Please specify race: _____)

☐ 11 Native Hawaiian

☐ 12 Guamanian or Chamorro

☐ 13 Samoan

☐ 14 Other Pacific Islander (Please specify race: _____)

☐ 15 Some other race (Please specify race: _____)

OMB#0925-0414 Exp: 6/00

Date Received: ☐☐-☐☐-☐☐ (M/D/Y) Reviewed By: ☐☐☐	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
Contact Type: ☐1 Phone ☐2 Mail ☐3 Visit ☐8 Other	Visit Type: ☐1 Screening # ☐ ☐2 Semi-Annual # ☐☐ ☐3 Annual # ☐☐ ☐4 Non-Routine
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The first set of questions asks about your birth and when <u>you</u> were a baby.

1. When <u>you</u> were born, about how much did you weigh? **(Give your best guess.)**

Less than 6 pounds	6 pounds to 7 pounds, 15 ounces	8 pounds to 9 pounds, 15 ounces	10 or more pounds	Don't know
☐1	☐2	☐3	☐4	☐9

2. When <u>you</u> were born, were you:

Full term (pregnancy lasted about 9 months)	4 or more weeks premature	Don't know
☐1	☐2	☐9

3. When you were born, were you a twin or triplet?

☐0 No ☐1 Yes

4. When you were a baby, did your mother breast feed you?

☐0 No ☐1 Yes ☐9 Don't know

The next set of questions ask about your coffee and tea drinking habits.

5. Do you usually drink coffee each day?

☐ 0 No ☐ 1 Yes

5.1. How many cups of regular coffee (not decaf) do you usually drink each day? **(Count tall [12 oz. or more] cups and espresso drinks made with double shots of espresso as 2 cups.)**

None	1 cup	2-3 cups	4-5 cups	6 or more cups
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

5.2. How many cups of decaf coffee do you usually drink each day? **(Count tall [12 oz. or more] cups and espresso drinks made with double shots of espresso as 2 cups.)**

None	1 cup	2-3 cups	4-5 cups	6 or more cups
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

5.3. How is the coffee usually made? **(Mark one or two.)**

Drip	Espresso	Instant	Boiled	Percolated	French Press
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

6. Do you usually drink tea each day? **(Do not include decaf or herbal tea.)**

☐ 0 No ☐ 1 Yes

6.1. How many cups of tea do you usually drink each day? **(Do not include decaf or herbal tea.)**

1 cup	2-3 cups	4-5 cups	6 or more cups
☐ 1	☐ 2	☐ 3	☐ 4

Go to the next page.

The next set of questions ask about your alcohol drinking habits. For the questions below, one drink of alcohol is equal to one can of beer, one glass of wine, or one shot of liquor (whiskey, brandy or gin).

7. During your entire life, have you had 12 drinks or more of any kind of alcoholic drink?

☐ 0 No ☐ 1 Yes

7.1. When you were between 14 and 17 years old, how many drinks of alcohol did you usually have?

None or less than 1 each month	1-3 each month	1-2 each week	3-6 each week	1-2 each day	3 or more each day
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7.2. When you were between 18 and 22 years old, how many drinks of alcohol did you usually have?

None or less than 1 each month	1-3 each month	1-2 each week	3-6 each week	1-2 each day	3 or more each day
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7.3. When you were between 23 and 29 years old, how many drinks of alcohol did you usually have?

None or less than 1 each month	1-3 each month	1-2 each week	3-6 each week	1-2 each day	3 or more each day
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7.4. When you were between 30 and 49 years old, how many drinks of alcohol did you usually have?

None or less than 1 each month	1-3 each month	1-2 each week	3-6 each week	1-2 each day	3 or more each day
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7.5. When you were about 50 years old, how many drinks of alcohol did you usually have?

None or less than 1 each month	1-3 each month	1-2 each week	3-6 each week	1-2 each day	3 or more each day
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Go to the next page.

The next set of questions ask about being around people who smoke.

8. As a child (less than 18 years old), did you ever live with someone who smoked cigarettes inside your home?

☐ 0 No ☐ 1 Yes

☐ 9 Don't know

8.1. As a child, how many years did you live with someone who smoked inside your home?

Less than 1 year	1-4 years	5-9 years	10-18 years
☐ 1	☐ 2	☐ 3	☐ 4

9. Since age 18, have you ever lived with someone (including a parent, husband, or other adult person) who smoked cigarettes inside your home?

☐ 0 No ☐ 1 Yes

9.1. Since age 18, how many years have you lived with someone who smoked cigarettes inside your home?

Less than 1 year	1-4 years	5-9 years	10-19 years	20-29 years	30-39 years	40 or more years
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

9.2. Does anyone living with you now smoke cigarettes inside your home?

☐ 0 No ☐ 1 Yes

9.3. Please mark all the people who live with you now and who smoke cigarettes inside your home.

Husband or partner	Son(s) or daughter(s)	Other person/people
☐ 1	☐ 2	☐ 3

Go to the next page.

10. Have you <u>ever worked</u> in a space where people smoked cigarettes?

☐ 0 No ☐ 1 Yes

10.1. How many total years have you <u>worked</u> in a space where people smoked cigarettes?

Less than 1 year	1-4 years	5-9 years	10-19 years	20-29 years	30-39 years	40 or more years
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

10.2. Do you <u>now</u> work in a space where people smoke?

☐ 0 No ☐ 1 Yes

The next set of questions is about breast exams and breast disease.

11. Have you ever done a breast self-examination (a breast exam on yourself)?

☐ 0 No ☐ 1 Yes

11.1. How many times have you done a breast self-exam in the last 12 months?

None	1-5 times	6-10 times	11 or more times
☐ 0	☐ 1	☐ 2	☐ 3

12. Have you ever had a breast physical exam done by a doctor, nurse, or physician assistant?

☐ 0 No ☐ 1 Yes

12.1. How many of these exams have you had in the last 5 years?

None	1 exam	2 exams	3 exams	4 exams	5 or more exams
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

12.2. How long ago did you last have a breast exam by a doctor, nurse, or physician assistant?

Less than 1 year ago	1 year ago	2 years ago	3 years ago	4 years ago	5 or more years ago
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Go to the next page.

13. Has a doctor ever told you that you had benign breast disease or fibrocystic disease in your breasts?

☐ 0 No ☐ 1 Yes

14. Have you had a mammogram (x-ray of the breast to look for cancer or other breast problems) in the last 5 years?

☐ 0 No ☐ 1 Yes

14.1. How many mammograms have you had in the last 5 years?

1	2	3	4	5 or more
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

The next set of questions are about the use of powders (talc, baby powder, deodorant powder).

15. Have you ever used powder on your private parts (genital areas)?

☐ 0 No ☐ 1 Yes

15.1. For how many years?

Less than 1 year	1-4 years	5-9 years	10-19 years	20 or more years
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

16. Did you ever use a diaphragm (a birth control device that fits over the opening of your womb)?

☐ 0 No ☐ 1 Yes

16.1. Did you ever use powder on your diaphragm?

☐ 0 No ☐ 1 Yes

16.2. For how many years did you use powder on your diaphragm?

Less than 1 year	1-4 years	5-9 years	10-19 years	20 or more years
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Go to the next page.

17. Did you ever use powder on a sanitary napkin or pad?

☐ 0 No ☐ 1 Yes

17.1. For how many years?

Less than 1 year	1-4 years	5-9 years	10-19 years	20 or more years
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

The next set of questions ask about your use of electric blankets.

18. Have you ever used an electric blanket, electric mattress pad, or heated water bed on at least half the days in any one month period?

☐ 0 No ☐ 1 Yes

18.1. How many years total did you use an electric blanket, electric mattress pad, or heated water bed?

Less than 1 year	1-4 years	5-9 years	10-19 years	20 or more years
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

18.2. In those years, how many months per year did you use an electric blanket, electric mattress pad, or heated water bed on at least half the days of the month?

Less than 1 month per year	1-3 months per year	4-6 months per year	7-9 months per year	10-12 months per year
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

18.3. When you used the electric blanket, electric mattress pad, or heated water bed, did you leave it turned on most of the time while you were sleeping, or did you use it only to warm the bed before you went to sleep?

☐ 1 On most of the time ☐ 2 Warm the bed only

18.4. Have you used an electric blanket, electric mattress pad, or heated water bed during the past year?

☐ 0 No ☐ 1 Yes

Go to the next page.

Religion

19. What is your religion?

- ☐ 0 None
- ☐ 1 Catholic
- ☐ 2 Baptist
- ☐ 3 Episcopalian or Anglican
- ☐ 4 Lutheran
- ☐ 5 Methodist
- ☐ 6 Presbyterian
- ☐ 7 Adventist
- ☐ 8 Mormon/Latter Day Saints
- ☐ 9 Other Christian
- ☐ 10 Jewish
- ☐ 11 Eastern (Buddhist, Hindu)
- ☐ 12 Muslim
- ☐ 88 Other

The next set of questions ask about some of your usual activities.

20. About how many hours each week do you usually spend doing heavy (strenuous) indoor household chores such as scrubbing floors, sweeping, or vacuuming?

Less than 1 hour	1-3 hours	4-6 hours	7-9 hours	10 or more hours
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

21. About how many months during the year do you usually do things in the yard, such as mowing, raking, gardening, or shoveling snow?

Less than 1 month	1-3 months	4-6 months	7-9 months	10 or more months
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

21.1. When you do these things in the yard, how many hours <u>each week</u> do you do them?

Less than 1 hour	1-3 hours	4-6 hours	7-9 hours	10 or more hours
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

22. During a usual <u>day and night</u>, about how many hours do you spend sitting? Be sure to include the time you spend sitting at work, sitting at the table eating, driving or riding in a car or bus, and sitting up watching TV or talking.

Less than 4 hours	4-5 hours	6-7 hours	8-9 hours	10-11 hours	12-13 hours	14-15 hours	16 or more hours
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

23. During a usual <u>day and night</u>, about how many hours do you spend sleeping or lying down with your feet up? Be sure to include the time you spend sleeping or trying to sleep at night, resting or napping, and lying down watching TV.

Less than 4 hours	4-5 hours	6-7 hours	8-9 hours	10-11 hours	12-13 hours	14-15 hours	16 or more hours
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

The next set of questions asks about work and jobs you have had.

24. Did you ever live or work on a farm?

☐ 0 No ☐ 1 Yes

24.1. For how many years?

Less than 5 years	5-9 years	10-14 years	15-19 years	20 or more years
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

25. Did you ever work for one year or more as a hairdresser, beautician, or cosmetologist where you worked with hair dyes?

☐ 0 No ☐ 1 Yes

25.1. For how many years?

1-5 years	5-9 years	10-14 years	15-19 years	20 or more years
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Go to the next page.

26. Have you ever had a job for which you were paid?

☐ 0 No ☐ 1 Yes

What are the 3 full-time or part-time jobs that you have held the longest length of time since you were 18 years old? Please start with your most recent job. **(If you worked less than one year at a job, write "01" in the boxes for total years worked.)**

	Your job	What did the company make or do?	Age Started This Job	Total number of years worked at this job
26.1.	_____ (most recent)	_____	⌊__⌋ years old	⌊__⌋ years
26.2.	_____	_____	⌊__⌋ years old	⌊__⌋ years
26.3.	_____	_____	⌊__⌋ years old	⌊__⌋ years

The next set of questions asks about your height and weight at different ages since age 18. If you don't remember exactly, give your best guess.

27. How tall were you (without shoes on) at about age 18 (your tallest adult height)?

⌊__⌋ feet ⌊__⌋ inches

28. What was your weight at about age 18 (when you were not pregnant)?

⌊___⌋ pounds

29. What was your weight at about age 35 (when you were not pregnant)?

⌊___⌋ pounds

30. What was your weight at about age 50 (when you were not pregnant)?

⌊___⌋ pounds

31. What was your maximum adult weight (the most you ever weighed since you were 18 years old) when you were not pregnant?

⌊___⌋ pounds

32. How old were you when you were at your maximum adult weight? **(Mark all that apply.)**

18-29 years old	30-39 years old	40-49 years old	50-59 years old	60-69 years old	70 years old or older
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

33. What was your minimum adult weight (the least you ever weighed since you were 18 years old)?

⌊ | | ⌋ pounds

34. How old were you when you were at your minimum adult weight? **(Mark all that apply.)**

18-29 years old	30-39 years old	40-49 years old	50-59 years old	60-69 years old	70 years old or older
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

Weight Loss

35. Within the last 20 years, when you were not pregnant or sick, did you ever lose 10 pounds or more on purpose?

☐ 0 No ☐ 1 Yes ↓

35.1. How many times did you lose 50 pounds or more?

None	1-2 times	3-4 times	5-6 times	7 or more times
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

35.2. How many times did you lose at least 20 pounds, but not more than 49 pounds?

None	1-2 times	3-4 times	5-6 times	7 or more times
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

35.3. How many times did you lose at least 10 pounds, but not more than 19 pounds?

None	1-2 times	3-4 times	5-6 times	7 or more times
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

36. How long have you been within 10 pounds of your current weight (do not count times when you were pregnant or sick)?

⌊ | ⌋ years

The next set of questions asks about places you have lived.

37. How many years have you lived in the state you **now live in**?

Less than 5 years	5-9 years	10-19 years	20 years or more
☐ 1	☐ 2	☐ 3	☐ 4

	If in the U.S., which state?	**or**	**If not in the U.S.**, which country?
38. Where were you born?	_____		_____
39. Where did you live at age 15?	_____		_____
40. Where did you live at age 35?	_____		_____
41. Where did you live at age 50?	_____		_____
42. In what state or country have you lived the longest?	_____		_____

43. What is the date you finished answering this form?

__ - __ - __
month day year

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

_____

_____

_____

_____

_____

_____

_____

_____

OFFICE USE ONLY

Form Administration

☐ 1 Self

☐ 2 Group

☐ 3 Interview

☐ 4 Assistance

OMB # 0925-0414 Exp: 06/97

- Affix label here-

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

First Name _____ M.I. _____

Last Name _____

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

"Now I have some questions about the use of hormone medications."

"The first questions are about hormone replacement therapy, hormones that are taken around the time of menopause or after menopause. This does not include hormones used for birth control."

<u>Hormone Replacement Therapy (HRT)</u>

5. **"Did you ever take any type of estrogen, such as Premarin, progesterone, such as Provera, testosterone, or any other hormone medications 1) for relief of menopausal symptoms such as hot flashes or night sweats, 2) following hysterectomy with removal of the ovaries, or 3) for prevention of disease such as bone loss? These hormones could include pills, vaginal creams or suppositories, injections, or skin patches."**

   ____ No *(If no, go on to Question 10.)*

   ____ Yes →

5.1. **"Were these hormones (estrogen, progesterone or testosterone) in the form of a:"**

	No	Yes		5.2. **"When you were taking these (hormones), did you take them for <u>3</u> <u>straight</u> <u>months</u> or more?"** No	Yes	
1. **"Pill?"**	____	____	→	____	____	→ Complete 6.1. – 6.12.
2. **"Vaginal cream or suppository?"**	____	____	→	____	____	→ Complete 7.1. – 7.12.
3. **"Skin patch?"**	____	____	→	____	____	→ Complete 8.1. – 8.12.
4. **"Shot?"**	____	____	→	____	____	→ Complete 9.1. – 9.12.

(If No, go to Question 10.)

(If Yes, go to Question 5.2.)

(If No, go to Question 10.)

(If Yes, read statement below and complete the indicated questions.)

"Now I'd like to ask you some details about your use of these hormones. First, see if you can recognize the specific type(s) you used from this chart."

[SHOW PHOTOS]

K _____

6. **If Estrogen, Progesterone, or Testosterone Pills Reported:**
Complete 6.1. - 6.12. for each episode of use.

	6.1. - 6.2.	6.3.	6.4. - 6.5.	6.6.	6.7.
	"What is the name of the *(first/next)* hormone pill you took?" *Enter complete name and code. Probe for frequency and unit of measure.* **[SHOW PHOTOS]**	**"Please tell me the reason you used this *pill*."** **[SHOW CARD]**	**"At what age did you *(first/next)* start taking this *pill*?"** **"At what age did you stop taking this *pill*?"** *If still taking, record current age.*	**"How many total years and months between *(ages in 6.4. and 6.5.)* did you take this pill?"**	**"When you were taking this hormone between *(ages in 6.4. and 6.5.)*, did you usually take it every day, or in cycles?"**
1st Pill	Name: _____ Code: ___ ___ ___ ___ per # Pills ☐1 Day ☐2 Week	*(Specify reason):* _____ _____ _____ Code: ___ ___	___ ___ Age start ___ ___ Age stop	___ ___ # of Years and ___ ___ # of Months	☐4 Every day ☐5 Every other day ☐7 In cycles (Specify) _____ ☐8 Other (Specify) _____
2nd Pill	Name: _____ Code: ___ ___ ___ ___ per # Pills ☐1 Day ☐2 Week	*(Specify reason):* _____ _____ _____ Code: ___ ___	___ ___ Age start ___ ___ Age stop	___ ___ # of Years and ___ ___ # of Months	☐4 Every day ☐5 Every other day ☐7 In cycles (Specify) _____ ☐8 Other (Specify) _____
3rd Pill	Name: _____ Code: ___ ___ ___ ___ per # Pills ☐1 Day ☐2 Week	*(Specify reason):* _____ _____ _____ Code: ___ ___	___ ___ Age start ___ ___ Age stop	___ ___ # of Years and ___ ___ # of Months	☐4 Every day ☐5 Every other day ☐7 In cycles (Specify) _____ ☐8 Other (Specify) _____
4th Pill	Name: _____ Code: ___ ___ ___ ___ per # Pills ☐1 Day ☐2 Week	*(Specify reason):* _____ _____ _____ Code: ___ ___	___ ___ Age start ___ ___ Age stop	___ ___ # of Years and ___ ___ # of Months	☐4 Every day ☐5 Every other day ☐7 In cycles (Specify) _____ ☐8 Other (Specify) _____
5th Pill	Name: _____ Code: ___ ___ ___ ___ per # Pills ☐1 Day ☐2 Week	*(Specify reason):* _____ _____ _____ Code: ___ ___	___ ___ Age start ___ ___ Age stop	___ ___ # of Years and ___ ___ # of Months	☐4 Every day ☐5 Every other day ☐7 In cycles (Specify) _____ ☐8 Other (Specify) _____

If hormone was estrogen, go to Question 6.8. Otherwise, go to next hormone.

6.8. **"While you were taking estrogen pills, did you also take progesterone?"**

No → Go to next hormone. Yes → Go to Question 6.9.

6.9. - 6.10.	6.11. - 6.12.				
"What is the name of the progesterone that you took with this estrogen?" *Enter complete name and code. Probe for frequency and unit of measure.*	**"During the** *(first/next)* **time when you were taking** *(estrogen)* **and** *(progesterone)* **in the same month, on which days did you usually take the estrogen and on which days did you usually take the progesterone?"** *Circle first and last dates of each. Then connect first to last with a line. Enter the Start Day and End Day for Estrogen (E) and Progesterone (P) and record total number of days on Estrogen (E), Progesterone (P) and Estrogen plus Progesterone (E+P).*				
[SHOW PHOTOS]	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
Name: ______________ Code: ______ ____ ☐1 Day # Pills per ☐2 Week	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	6.12. **"When you were taking this progesterone between** *(ages in 6.4. and 6.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____________ ☐11 Every three months	
Name: ______________ Code: ______ ____ ☐1 Day Pills per ☐2 Week	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	6.12. **"When you were taking this progesterone between** *(ages in 6.4. and 6.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____________ ☐11 Every three months	
Name: ______________ Code: ______ ____ ☐1 Day Pills per ☐2 Week	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	6.12. **"When you were taking this progesterone between** *(ages in 6.4. and 6.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____________ ☐11 Every three months	
Name: ______________ Code: ______ ____ ☐1 Day # Pills per ☐2 Week	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	6.12. **"When you were taking this progesterone between** *(ages in 6.4. and 6.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____________ ☐11 Every three months	
Name: ______________ Code: ______ ____ ☐1 Day # Pills per ☐2 Week	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	6.12. **"When you were taking this progesterone between** *(ages in 6.4. and 6.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____________ ☐11 Every three months	

7. If Vaginal Cream or Suppository Reported:
Complete 7.1. - 7.12. for each episode of use.

	7.1. - 7.2. **"What is the name of the *(first/next)* hormone vaginal cream or suppository you used?"** *Enter complete name and code. Probe for frequency and unit of measure.* **[SHOW PHOTOS]**	7.3. **"Please tell me the reason you used this vaginal cream or suppository."** **[SHOW CARD]**	7.4. - 7.5. **"At what age did you *(first/next)* start using this vaginal cream or suppository?" "At what age did you stop?"** *If still using, record current age.*	7.6. **"How many total years and months between *(ages in 7.4. and 7.5.)* did you use this cream or suppository?"**	7.6a. **"If using cream, how many applicator-fulls did you use each time?"**	7.7. **"When you were using the cream or suppository between *(ages in 7.4. and 7.5.)*, did you use it every week or in cycles?"**
1st Crm./ Supp.	Name: _____ Code: ____ ____ Day # Times per: ☐1 Week ☐2 Month ☐3 Year ☐4	*(Specify reason):* _____ _____ _____ Code: ____	____ Age start ____ Age stop	____ Years # of and ____ Months # of	☐5 1/4 ☐1 1/2 ☐2 1 ☐3 1½ ☐4 2 or more ☐9 Unknown	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
2nd Crm./ Supp.	Name: _____ Code: ____ ____ Day # Times per: ☐1 Week ☐2 Month ☐3 Year ☐4	*(Specify reason):* _____ _____ _____ Code: ____	____ Age start ____ Age stop	____ Years # of and ____ Months # of	☐5 1/4 ☐1 1/2 ☐2 1 ☐3 1½ ☐4 2 or more ☐9 Unknown	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
3rd Crm./ Supp.	Name: _____ Code: ____ ____ Day # Times per: ☐1 Week ☐2 Month ☐3 Year ☐4	*(Specify reason):* _____ _____ _____ Code: ____	____ Age start ____ Age stop	____ Years # of and ____ Months # of	☐5 1/4 ☐1 1/2 ☐2 1 ☐3 1½ ☐4 2 or more ☐9 Unknown	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
4th Crm./ Supp.	Name: _____ Code: ____ ____ Day # Times per: ☐1 Week ☐2 Month ☐3 Year ☐4	*(Specify reason):* _____ _____ _____ Code: ____	____ Age start ____ Age stop	____ Years # of and ____ Months # of	☐5 1/4 ☐1 1/2 ☐2 1 ☐3 1½ ☐4 2 or more ☐9 Unknown	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
5th Crm./ Supp.	Name: _____ Code: ____ ____ Day # Times per: ☐1 Week ☐2 Month ☐3 Year ☐4	*(Specify reason):* _____ _____ _____ Code: ____	____ Age start ____ Age stop	____ Years # of and ____ Months # of	☐5 1/4 ☐1 1/2 ☐2 1 ☐3 1½ ☐4 2 or more ☐9 Unknown	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____

If hormone was estrogen, go to Question 7.9. Otherwise, go to next hormone.

7.8. **"While you were using estrogen (vaginal cream/suppository), did you also take progesterone?"**

No → Go to next hormone. Yes → Go to Question 7.9.

7.9. - 7.10.	7.11. - 7.12.				
"What is the name of the progesterone that you took with this estrogen cream or suppository?" *Enter complete name and code. Probe for frequency and unit of measure.*	**"During the** *(first/next)* **time when you were taking** *(estrogen)* **and** *(progesterone)* **in the same month, on which days did you usually take the estrogen and on which days did you usually take the progesterone?"** *Circle first and last dates of each. Then connect first to last with a line. Enter the Start Day and End Day for Estrogen (E) and Progesterone (P) and record total number of days on Estrogen (E), Progesterone (P) and Estrogen plus Progesterone (E+P).*				
[SHOW PHOTOS]	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
Name: ______	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ______ ______ ☐1 Day # Pills per ☐2 Week	Start Day ___ E ___ P	End Day ___ E ___ P	Total Days ___ E ___ P ___ E+P	7.12. **"When you were taking this progesterone between** *(ages in 7.4. and 7.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	
Name: ______	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ______ ______ ☐1 Day # Pills per ☐2 Week	Start Day ___ E ___ P	End Day ___ E ___ P	Total Days ___ E ___ P ___ E+P	7.12. **"When you were taking this progesterone between** *(ages in 7.4. and 7.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	
Name: ______	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ______ ______ ☐1 Day # Pills per ☐2 Week	Start Day ___ E ___ P	End Day ___ E ___ P	Total Days ___ E ___ P ___ E+P	7.12. **"When you were taking this progesterone between** *(ages in 7.4. and 7.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	
Name: ______	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ______ ______ ☐1 Day # Pills per ☐2 Week	Start Day ___ E ___ P	End Day ___ E ___ P	Total Days ___ E ___ P ___ E+P	7.12. **"When you were taking this progesterone between** *(ages in 7.4. and 7.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	
Name: ______	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ______ ______ ☐1 Day # Pills per ☐2 Week	Start Day ___ E ___ P	End Day ___ E ___ P	Total Days ___ E ___ P ___ E+P	7.12. **"When you were taking this progesterone between** *(ages in 7.4. and 7.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	

8. If Hormone Skin Patches Reported:

Complete 8.1. - 8.12. for each episode of use.

	8.1. - 8.2. "What is the name of the *(first/next)* hormone skin patch you used?" *Enter complete name and code. Probe for frequency and unit of measure.* [SHOW PHOTOS]	8.3. "Please tell me the reason you used this skin patch." [SHOW CARD]	8.4. - 8.5. "At what age did you *(first/next)* start using these skin patches?" "At what age did you stop?" *If still using, record current age.*	8.6. "How many total years and months between *(ages in 8.4. and 8.5.)* did you use these skin patches?"	8.7. "When you were using these skin patches between *(ages in 8.4. and 8.5.)*, did you use them every week or in cycles?"
1st Patch Use	Name: _____ Code: ___ ___ ☐2 Week # Times per ☐3 Month	*(Specify reason):* _____ _____ _____ Code: ___	___ Age start ___ Age stop	___ Years # of and ___ Months # of	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
2nd Patch Use	Name: _____ Code: ___ ___ ☐2 Week # Times per ☐3 Month	*(Specify reason):* _____ _____ _____ Code: ___	___ Age start ___ Age stop	___ Years # of and ___ Months # of	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
3rd Patch Use	Name: _____ Code: ___ ___ ☐2 Week # Times per ☐3 Month	*(Specify reason):* _____ _____ _____ Code: ___	___ Age start ___ Age stop	___ Years # of and ___ Months # of	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
4th Patch Use	Name: _____ Code: ___ ___ ☐2 Week # Times per ☐3 Month	*(Specify reason):* _____ _____ _____ Code: ___	___ Age start ___ Age stop	___ Years # of and ___ Months # of	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
5th Patch Use	Name: _____ Code: ___ ___ ☐2 Week # Times per ☐3 Month	*(Specify reason):* _____ _____ _____ Code: ___	___ Age start ___ Age stop	___ Years # of and ___ Months # of	☐6 Every week ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____

If hormone was estrogen, go to Question 8.8. Otherwise, go to next hormone.

8.8. **"While you were using estrogen skin patches, did you also take progesterone?"**
No → Go to next hormone. Yes → Go to Question 8.9.

8.9. - 8.10. 8.11. - 8.12.

"What is the name of the progesterone that you took with this skin patch?" *Enter complete name and code. Probe for frequency and unit of measure.*	**"During the** *(first/next)* **time when you were taking** *(estrogen)* **and** *(progesterone)* **in the same month, on which days did you usually take the estrogen and on which days did you usually take the progesterone?"** *Circle first and last dates of each. Then connect first to last with a line. Enter the Start Day and End Day for Estrogen (E) and Progesterone (P) and record total number of days on Estrogen (E), Progesterone (P) and Estrogen plus Progesterone (E+P).*				
[SHOW PHOTOS]	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
Name: ____	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ____ ____ # Pills per ☐1 Day ☐2 Week	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	8.12. **"When you were taking this progesterone between** *(ages in 8.4. and 8.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____ ☐11 Every three months	
Name: ____	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ____ ____ # Pills per ☐1 Day ☐2 Week	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	8.12. **"When you were taking this progesterone between** *(ages in 8.4. and 8.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____ ☐11 Every three months	
Name: ____	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ____ ____ # Pills per ☐1 Day ☐2 Week	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	8.12. **"When you were taking this progesterone between** *(ages in 8.4. and 8.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____ ☐11 Every three months	
Name: ____	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ____ ____ # Pills per ☐1 Day ☐2 Week	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	8.12. **"When you were taking this progesterone between** *(ages in 8.4. and 8.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____ ☐11 Every three months	
Name: ____	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E E E E E P P P P P P P	E E E P P P
Code: ____ ____ # Pills per ☐1 Day ☐2 Week	Start Day ____ E ____ P	End Day ____ E ____ P	Total Days ____ E ____ P ____ E+P	8.12. **"When you were taking this progesterone between** *(ages in 8.4. and 8.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ____ ☐11 Every three months	

9. **If Estrogen, Progesterone, or Testosterone Shots Reported:**

Complete 9.1. - 9.12. for each episode of use.

	9.1. - 9.2. **"What is the name of the *(first/next)* hormone shot you received?"** *Enter complete name and code. Probe for frequency and unit of measure.*	9.3. **"Please tell me the reason you received this hormone shot."** **[SHOW CARD]**	9.4. - 9.5. **"At what age did you *(first/next)* start receiving these hormone shots?" "At what age did you stop?"** *If still using, record current age.*	9.6. **"How many total years and months between *(ages in 9.4. and 9.5.)* did you receive these hormone shots?"**	9.7. **"When you were receiving these hormone shots between *(ages in 9.4. and 9.5.)*, did you receive them every month or in cycles?"**
1st Shot	Name: _____ Code: ☐☐☐ ☐☐ # Times per: ☐2 Week ☐3 Month ☐4 Year	*(Specify reason):* _____ _____ _____ Code: ☐☐	☐☐ Age start ☐☐ Age stop	☐☐ Years # of and ☐☐ Months # of	☐6 Every week ☐9 Every month ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
2nd Shot	Name: _____ Code: ☐☐☐ ☐☐ # Times per: ☐2 Week ☐3 Month ☐4 Year	*(Specify reason):* _____ _____ _____ Code: ☐☐	☐☐ Age start ☐☐ Age stop	☐☐ Years # of and ☐☐ Months # of	☐6 Every week ☐9 Every month ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
3rd Shot	Name: _____ Code: ☐☐☐ ☐☐ # Times per: ☐2 Week ☐3 Month ☐4 Year	*(Specify reason):* _____ _____ _____ Code: ☐☐	☐☐ Age start ☐☐ Age stop	☐☐ Years # of and ☐☐ Months # of	☐6 Every week ☐9 Every month ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
4th Shot	Name: _____ Code: ☐☐☐ ☐☐ # Times per: ☐2 Week ☐3 Month ☐4 Year	*(Specify reason):* _____ _____ _____ Code: ☐☐	☐☐ Age start ☐☐ Age stop	☐☐ Years # of and ☐☐ Months # of	☐6 Every week ☐9 Every month ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____
5th Shot	Name: _____ Code: ☐☐☐ ☐☐ # Times per: ☐2 Week ☐3 Month ☐4 Year	*(Specify reason):* _____ _____ _____ Code: ☐☐	☐☐ Age start ☐☐ Age stop	☐☐ Years # of and ☐☐ Months # of	☐6 Every week ☐9 Every month ☐7 In cycles (Specify)_____ ☐8 Other (Specify)_____

If hormone was estrogen, go to Question 9.8. Otherwise, go to next hormone.

9.8. **"While you were taking estrogen shots, did you also take progesterone?"**

No → Go to next hormone. Yes → Go to Question 9.9.

9.9. - 9.10	9.11. - 9.12.				
"What is the name of the progesterone that you took with this estrogen shot?" *Enter com-plete name and code. Probe for frequency and unit of measure.* **[SHOW PHOTOS]**	**"During the** *(first/next)* **time when you were taking** *(estrogen)* **and** *(progesterone)* **in the same month, on which days did you usually take the estrogen and on which days did you usually take the progesterone?"** *Circle first and last dates of each. Then connect first to last with a line. Enter the Start Day and End Day for Estrogen (E) and Progesterone (P) and record total number of days on Estrogen (E), Progesterone (P) and Estrogen plus Progesterone (E+P).* 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
Name: ______ Code: ⌊__⌋ ⌊__⌋ # Pills per ☐1 Day ☐2 Week	E E E E E E E P P P P P P P Start Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P End Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P Total Days ⌊__⌋ E ⌊__⌋ P ⌊__⌋ E+P	E E E E E E E P P P P P P P 9.12. **"When you were taking this progesterone between** *(ages in 9.4. and 9.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	E E E P P P
Name: ______ Code: ⌊__⌋ ⌊__⌋ # Pills per ☐1 Day ☐2 Week	E E E E E E E P P P P P P P Start Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P End Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P Total Days ⌊__⌋ E ⌊__⌋ P ⌊__⌋ E+P	E E E E E E E P P P P P P P 9.12. **"When you were taking this progesterone between** *(ages in 9.4. and 9.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	E E E P P P
Name: ______ Code: ⌊__⌋ ⌊__⌋ # Pills per ☐1 Day ☐2 Week	E E E E E E E P P P P P P P Start Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P End Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P Total Days ⌊__⌋ E ⌊__⌋ P ⌊__⌋ E+P	E E E E E E E P P P P P P P 9.12. **"When you were taking this progesterone between** *(ages in 9.4. and 9.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	E E E P P P
Name: ______ Code: ⌊__⌋ ⌊__⌋ # Pills per ☐1 Day ☐2 Week	E E E E E E E P P P P P P P Start Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P End Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P Total Days ⌊__⌋ E ⌊__⌋ P ⌊__⌋ E+P	E E E E E E E P P P P P P P 9.12. **"When you were taking this progesterone between** *(ages in 9.4. and 9.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	E E E P P P
Name: ______ Code: ⌊__⌋ ⌊__⌋ # Pills per ☐1 Day ☐2 Week	E E E E E E E P P P P P P P Start Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P End Day ⌊__⌋ E ⌊__⌋ P	E E E E E E E P P P P P P P Total Days ⌊__⌋ E ⌊__⌋ P ⌊__⌋ E+P	E E E E E E E P P P P P P P 9.12. **"When you were taking this progesterone between** *(ages in 9.4. and 9.5.)*, **how often did you take it?"** ☐9 Every month ☐12 Every 4th month ☐10 Every other month ☐8 Other (Specify) ☐11 Every three months ______	E E E P P P

"Now I have some questions about the use of other types of female hormones."

10. **"Did you ever take birth control pills (oral contraceptives) for any reason?"**

___ No *(Go on to Question 11.)*
☐ 998 Yes →

10.1. **"At what age did you start taking birth control pills?"** ⌊__⌋ Age start

10.2. **"At what age did you stop taking birth control pills?"** ⌊__⌋ Age stop

10.3. **"How many total years and months between** *(ages in 10.1. and 10.2.)* **did you take birth control pills?"**

⌊__⌋ # of Years and ⌊__⌋ # of Months

10.4. **"Did you use birth control pills before your first full-term pregnancy?"**

☐ 2 Never had a full-term pregnancy → *(Go on to Question 11.)*
☐ 0 No → *(Go on to Question 11.)*
☐ 1 Yes →

10.5. **"How many total years and months did you use birth control pills before your first full-term pregnancy?"**

⌊__⌋ # of Years and ⌊__⌋ # of Months

11. **"Did you ever take DES (diethylstilbestrol)?"**

___ No *(Go on to Question 12.)*
☐ 997 Yes →

11.1. **"At what age did you start taking DES?"** ⌊__⌋ Age start

11.2. **"At what age did you stop taking DES?"** ⌊__⌋ Age stop

11.3. **"How many total years and months between** *(ages in 11.1. and 11.2.)* **did you take DES?"**

⌊__⌋ # of Years and ⌊__⌋ # of Months

12. **"Did you ever take shots called depo-provera (DMPA) for birth control or for any other reason?"**

___ No *(Go on to Question 13.)*

☐ 996 Yes →

12.1. **"When you were taking depo-provera shots, how often did you get a shot?"**

L_L_ every # Times

☐ 3 Month
☐ 5 3 months (quarter)
☐ 4 Year

12.2. **"At what age did you start taking depo-provera shots?"** L_L_ Age start

12.3. **"At what age did you stop taking depo-provera shots?"** L_L_ Age stop

12.4. **"How many total years and months between** *(ages in 12.2. and 12.3.)* **did you take depo-provera shots?"**

L_L_ Years # of and L_L_ Months # of

13. **"Have you taken any other female hormone medications that we have not discussed?"**

___ No *(Go on to ending script.)*

___ Yes →

13.1. **"What was the name of the hormone?"**

_____

13.2. **"What was the reason you took the hormone?"**

_____

13.3. **"Was this hormone in the form of a:"**

___ Pill
___ Vaginal cream or suppository
___ Skin patch
___ Shot

→ *Go to Questions 6 - 9 if the hormone was used for reasons listed in Question 5 (on page 1).*

___ Other (*Specify*):_____

"That completes this interview on the use of female hormone medications. Thank you very much for your cooperation."

SHOW CARD

REASONS FOR TAKING HORMONE REPLACEMENT THERAPY (ESTROGEN, PROGESTERONE, OR TESTOSTERONE)

01 - Menopause-related symptoms
(hot flashes, sweating, vaginal dryness, bladder problems)

02 - Depression, anxiety, emotional distress

03 - Replacement therapy after hysterectomy or oophorectomy (ovaries removed)

04 - Osteoporosis (bone loss), to prevent osteoporosis or bone loss (or thinning)

05 - Cardiovascular disease, to prevent cardiovascular disease

06 - Irregular menstrual periods, to regulate periods

07 - Treatment of disease *(Specify* _____*)*

08 - Prevention of disease *(Specify* _____*)*

09 - Anti-estrogen effect in a woman using menopausal estrogens

98 - Other *(Specify* _____*)*

WHI **Form 44 - Current Medications (Backup)** **Ver. 4**

COMMENTS

- Affix label here-

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

First Name ______________________M.I.______

Last Name ________________________________

1. Date of Contact: __ __-__ __-__ __ (M/D/Y)
2. Staff ID: __ __ __ ________________
3. Contact Type:
   - ☐1 Phone
   - ☐2 Mail
   - ☐3 Visit
   - ☐8 Other
4. Visit Type:
   - ☐1 Screening # __
   - ☐2 Semi-Annual # __ __
   - ☐3 Annual # __ __
   - ☐4 Non-Routine

---

5. Label Product Name ____

6. Label Generic Name ____

7. Dosage Form (tablet, cream, suppository, etc.) ______________________________

8. Strength ________ ____ mg ____ % ____ Other (Specify: ____________________)

UOM

D = Day M = Month
W = Week Y = Year

9. Duration __ __ __ 10. UOM _________

11. If corticosteroid, taken orally and daily? ____ Yes ____ No

---

5. Label Product Name ____

6. Label Generic Name ____

7. Dosage Form (tablet, cream, suppository, etc.) ______________________________

8. Strength ________ ____ mg ____ % ____ Other (Specify: ____________________)

UOM

D = Day M = Month
W = Week Y = Year

9. Duration __ __ __ 10. UOM _________

11. If corticosteroid, taken orally and daily? ____ Yes ____ No

---

5. Label Product Name ____

6. Label Generic Name ____

7. Dosage Form (tablet, cream, suppository, etc.) ______________________________

8. Strength ________ ____ mg ____ % ____ Other (Specify: ____________________)

UOM

D = Day M = Month
W = Week Y = Year

9. Duration __ __ __ 10. UOM _________

11. If corticosteroid, taken orally and daily? ____ Yes ____ No

---

K ________

---

5. Label Product Name ____
6. Label Generic Name ____
7. Dosage Form (tablet, cream, suppository, etc.) ________________________
8. Strength ________ _____ mg _____ % _____ Other (Specify: ____________________)

UOM
D = Day M = Month
W = Week Y = Year

9. Duration |__|__|__| 10. UOM __________
11. If corticosteroid, taken orally and daily? ____ Yes ____ No

---

5. Label Product Name ____
6. Label Generic Name ____
7. Dosage Form (tablet, cream, suppository, etc.) ________________________
8. Strength ________ _____ mg _____ % _____ Other (Specify: ____________________)

UOM
D = Day M = Month
W = Week Y = Year

9. Duration |__|__|__| 10. UOM __________
11. If corticosteroid, taken orally and daily? ____ Yes ____ No

---

5. Label Product Name ____
6. Label Generic Name ____
7. Dosage Form (tablet, cream, suppository, etc.) ________________________
8. Strength ________ _____ mg _____ % _____ Other (Specify: ____________________)

UOM
D = Day M = Month
W = Week Y = Year

9. Duration |__|__|__| 10. UOM __________
11. If corticosteroid, taken orally and daily? ____ Yes ____ No

---

5. Label Product Name ____
6. Label Generic Name ____
7. Dosage Form (tablet, cream, suppository, etc.) ________________________
8. Strength ________ _____ mg _____ % _____ Other (Specify: ____________________)

UOM
D = Day M = Month
W = Week Y = Year

9. Duration |__|__|__| 10. UOM __________
11. If corticosteroid, taken orally and daily? ____ Yes ____ No

---

5. Label Product Name ____
6. Label Generic Name ____
7. Dosage Form (tablet, cream, suppository, etc.) ________________________
8. Strength ________ _____ mg _____ % _____ Other (Specify: ____________________)

UOM
D = Day M = Month
W = Week Y = Year

9. Duration |__|__|__| 10. UOM __________
11. If corticosteroid, taken orally and daily? ____ Yes ____ No

---

K ________

Aspirin

A. **"Do you take aspirin pills or powders, for example, Anacin, Bufferin, BC? This does not include aspirin-free drugs such as Tylenol or Advil."**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, powder, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |_|_|_| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Acetaminophen

B. **"Do you take Acetaminophen tablets, or capsules, for example, Tylenol:"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |_|_|_| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Ibuprofen

C. **"Do you take Ibuprofen tablets or capsules, for example, Advil, Motrin, or Nuprin?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |_|_|_| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Other anti-inflammatory pain pills ****Note: Most of these are prescription drugs****

D. **"Do you take Naprosyn, Naproxen, Aleve, Indocin, Clinoril, Feldene, or other anti-inflammatory pain pills?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |_|_|_| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

K _____

Cold and Allergy Medications

E. **"Do you take anything for colds or allergies, for example, Dristan, Sudafed, Actifed, Dimetapp, Benadryl, Seldane, or Tavist D?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, capsules, syrup, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |__|__| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Laxatives

F. **"Do you take bulk laxatives or fiber-containing medications such as Metamucil, Fiber-eze, Citrucel, Senokot, Ex-Lax, or stool softeners such as Colace or DOSS, or any other medications for laxative purposes?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, powder, liquid, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |__|__| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Digestive Aids

G. **"Do you use any medications to help you with digestion, such as Mylanta, Tums, DiGel, Alka-Seltzer, Pepcid AC, or Pepto-bismol?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, powder, suspension, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |__|__| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

Herbal Estrogens

H. **"Do you use any herbal estrogens, natural female hormones, or phytoestrogens, such as dong quai or black cohosh?"**

5. Label Product Name _____

6. Label Generic Name _____

7. Dosage Form (tablets, powder, suspension, etc.) _____

8. Strength _____ ____ mg ____ % ____ Other (Specify: _____)

9. Duration |__|__| 10. UOM _____ **UOM** D = Day M = Month W = Week Y = Year

K _____

COMMENTS	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

1. Date of Contact: ⌊_⌋⌊_⌋-⌊_⌋⌊_⌋-⌊_⌋⌊_⌋ (M/D/Y)
2. Staff ID: ⌊_⌋⌊_⌋⌊_⌋ _____
3. Contact Type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other
4. Visit Type:
   - ☐ 1 Screening # ⌊_⌋
   - ☐ 2 Semi-Annual # ⌊_⌋⌊_⌋
   - ☐ 3 Annual # ⌊_⌋⌊_⌋
   - ☐ 4 Non-Routine

Supplement Definitions (see Instructions for more details)

Multi-Vitamin	A multi-vitamin with **no** minerals. These supplements usually have 10 or more vitamins, often at levels of 100% U.S. RDA.
	Nutrients of Interest: Beta-carotene (or Vitamin A/Beta-Carotene mix), and Vitamin C.
Multi-Vitamin with Minerals	Multi-vitamin with minerals. These supplements usually have 20-30 vitamins and minerals, often at levels of 100% U.S. RDA or less.
	Nutrients of Interest: Beta-carotene (or Vitamin A/Beta-Carotene mix), Vitamin C, Calcium and Selenium.
Stress Multi-Supplement	Multi-vitamin with high doses (usually > 200% RDA levels) of several B-vitamins. May contain large dose of Vitamin C or some Minerals.
	Nutrients of Interest: Beta-carotene (or Vitamin A/Beta-Carotene mix), Vitamin C, Calcium and Selenium.
Other Supplement Mixture	A mixture of 10 or fewer vitamins and /or minerals that does not fit into one of the preceding three categories. Examples are B-complex and anti-oxidant mixtures such as Protegra. If a supplement contains 11 or more nutrients, it should be classified as a multi-vitamin or multi-vitamin with minerals.
Single Supplements	These supplements contain only one vitamin or mineral. Commonly used supplements are Vitamins C and E and the minerals Calcium and Iron.

K _____

Type of Supplement	Dose or Quantity	Circle Default Unit or cross out Default and write in Other: Default Unit	Circle Default Unit or cross out Default and write in Other: Other Unit	Months Taken Last Year	Pills Per Week	Years Taken
Multi-Vitamin (No minerals)	1	Pill				
↓						
Beta-Carotene		IU*				
(or Vitamin A/Beta-Carotene mix)		IU*				
Vitamin C (Ascorbic Acid)		mg				
Multi-Vitamin with minerals	1	Pill				
↓						
Beta-Carotene		IU*				
(or Vitamin A/Beta-Carotene mix)		IU*				
Vitamin C (Ascorbic Acid)		mg				
Calcium		mg				
Selenium		mcg				
Stress Multi-Supplement	1	Pill				
↓						
Beta-Carotene		IU*				
(or Vitamin A/Beta-Carotene mix)		IU*				
Vitamin C (Ascorbic Acid)		mg				
Calcium		mg				
Selenium		mcg				

* Note that Vitamin A and Beta-Carotene may be in International Units (IU), retinol equivalents (RE), or milligrams (mg).

Type of Supplement	Dose or Quantity	Circle Default Unit or cross out Default and write in Other: Default Unit	Circle Default Unit or cross out Default and write in Other: Other Unit	Months Taken Last Year	Pills Per Week	Years Taken
Other Supplement Mixture	1	Pill				

↓

Vitamins			
Vitamin A		IU*	
Beta-Carotene		IU*	
(or Vitamin A/Beta-Carotene Mix)		IU*	
Vitamin B1 (Thiamine)		mg	
Vitamin B2 (Riboflavin)		mg	
Vitamin B6 (Pyridoxine)		mg	
Vitamin B12 (Cyanocobalamin)		mcg	
Biotin		mcg	
Vitamin C (Ascorbic Acid)		mg	
Vitamin D (Calciferol)		IU	
Vitamin E (Tocopherol)		IU	
Folic Acid (Folacin)		mcg	
Niacin (Niacinamide)		mg	
Pantothenic Acid (Pantothenate)		mg	
Minerals (record elemental levels)			
Calcium		mg	
Chromium		mcg	
Copper		mg	
Iron		mg	
Magnesium		mg	
Manganese		mg	
Molybdenum		mcg	
Selenium		mcg	
Zinc		mg	

* Note that Vitamin A and Beta-Carotene may be in International Units (IU), retinol equivalents (RE), or milligrams (mg).

Type of Supplement	Dose or Quantity	Circle Default Unit or cross out Default and write in Other: Default Unit	Circle Default Unit or cross out Default and write in Other: Other Unit	Months Taken Last Year	Pills Per Week	Years Taken
Single Supplements						
Vitamins						
Vitamin A		IU*				
Beta-Carotene		IU*				
(or Vitamin A/Beta-Carotene Mix)		IU*				
Vitamin B1 (Thiamine)		mg				
Vitamin B2 (Riboflavin)		mg				
Vitamin B6 (Pyroxidine)		mg				
Vitamin B12 (Cyanocobalamin)		mcg				
Biotin		mcg				
Vitamin C (Ascorbic Acid)		mg				
Vitamin D (Calciferol)		IU				
Vitamin E (Tocopherol)		IU				
Folic Acid (Folacin)		mcg				
Niacin (Niacinamide)		mg				
Pantothenic Acid (Pantothenate)		mg				
Minerals (record elemental levels)						
Calcium, Tums or Oscal		mg				
Chromium		mcg				
Copper		mg				
Iron		mg				
Magnesium		mg				
Manganese		mg				
Molybdenum		mcg				
Selenium		mcg				
Zinc		mg				

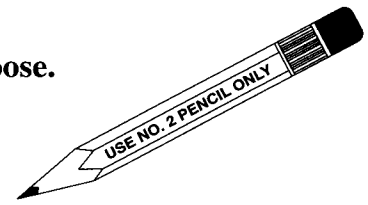
* Note that Vitamin A and Beta-Carotene may be in International Units (IU), retinol equivalents (RE), or milligrams (mg).

WOMEN'S HEALTH INITIATIVE

Form 48 - OS Follow-Up 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 weight is 159:

1	5	9

100 200 300 400 500 600 700
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AFFIX LABEL BETWEEN LINES
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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

6. Language:

● E ○ S

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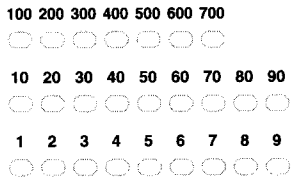
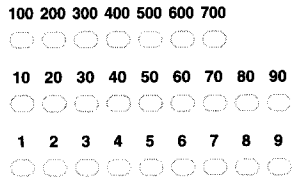
PLEASE MAKE NO MARKS IN THIS AREA

This questionnaire asks you to provide information on factors that may affect your health. These include weight changes, eating patterns, types of fat in your diet, wine drinking, smoking habits, use of female hormones, contact with insecticides, and your use of computers and hair dryers.

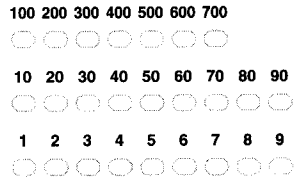
1. What is your current weight? ⌊_⌊_⌊_⌋ pounds



2. In the past year, what was your highest weight? ⌊_⌊_⌊_⌋ pounds



3. In the past year, what was your lowest weight? ⌊_⌊_⌊_⌋ pounds



4. In the past year, did you lose five or more pounds on purpose at any time?

⓪ No ① Yes
⑨ Don't know

4.1. What method(s) did you use to lose weight? **(Mark all that apply.)**

① Low calorie diet	⑦ Diet pills
② Low fat diet	⑧ Commercial weight loss program
③ Other type of diet	⑨ Stomach surgery/intestinal bypass
④ Skipped meals/fasted	⑩ Started or increased smoking
⑤ Decreased alcohol intake	⑧⑧ Other
⑥ Increased exercise	

5. In the past year, did you lose five or more pounds not on purpose at any time?

⓪ No ① Yes
⑨ Don't know

5.1. What was the cause of this weight loss? **(Mark all that apply.)**

① Illness	④ Life events (e.g., change in job or marital status)
② Depression	⑧ Other
③ Stressful time	⑨ Don't know

Go to the next page.

6. How many times per week do you usually eat the following meals or snacks? **(Answer each question. If you usually do not eat the meal or snack, answer "Never or less than once.")**

Eat	Never or less than once	1-2 times	3-4 times	5-6 times	7 or more times
	Times per week				
6.1. Before breakfast meal	⓪	①	②	③	④
6.2. Breakfast	⓪	①	②	③	④
6.3. Between breakfast and lunch	⓪	①	②	③	④
6.4. Lunch	⓪	①	②	③	④
6.5. Between lunch and dinner	⓪	①	②	③	④
6.6. Dinner	⓪	①	②	③	④
6.7. After dinner	⓪	①	②	③	④

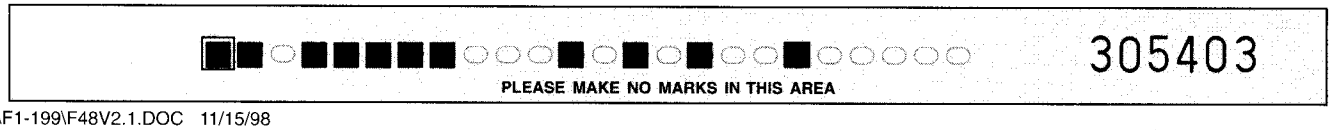
7. In the past three months, what kinds of fat or oil did you usually use to deep fry, pan fry, or sauté foods? **(Mark the one or two used most often. If you did not use fat, mark "Did not use fat.")**

① Butter
② Low calorie margarine
③ Stick margarine
④ Tub margarine
⑤ Solid vegetable fat (e.g., Crisco®)
⑥ Shortening (lard, bacon fat, drippings, salt pork or ham hock)
⑦ Olive oil
⑧ Canola oil
⑨ Peanut oil
⑩ Other vegetable oils (corn, safflower, sunflower)
⑪ Non-stick spray (e.g., Pam®)
⑬ Other fat(s)
⓪ Did not use fat

8. In the past three months, what kinds of fat or oil did you usually use when cooking vegetables, potatoes, beans, or rice? **(Mark the one or two used most often. If you did not use fat, mark "Did not use fat.")**

① Butter
② Low calorie margarine
③ Stick margarine
④ Tub margarine
⑤ Solid vegetable fat (e.g., Crisco®)
⑥ Shortening (lard, bacon fat, drippings, salt pork or ham hock)
⑦ Olive oil
⑧ Canola oil
⑨ Peanut oil
⑩ Other vegetable oils (corn, safflower, sunflower)
⑪ Non-stick spray (e.g., Pam®)
⑬ Other fat(s)
⓪ Did not use fat

Go to the next page.



9. In the past three months, what kinds of fat or oil did you usually add after cooking vegetables, potatoes, beans, or rice? **(Mark the one or two used most often. If you did not use fat, mark "Did not use fat.")**

① Butter
② Low calorie margarine
③ Stick margarine
④ Tub margarine
⑦ Olive oil
⑧ Canola oil
⑨ Peanut oil
⑩ Other vegetable oils (corn, safflower, sunflower)
⑪ Non-fat or low-fat sour cream
⑫ Regular sour cream
⑬ Other fat(s)
⓪ Did not use fat

10. In the past three months, what kinds of fat or oil did you usually use on breads, bagels, muffins, tortillas, and rolls? **(Mark the one or two used most often. If you did not use fat, mark "Did not use fat.")**

① Butter
② Low calorie margarine
③ Stick margarine
④ Tub margarine
⑤ Olive oil
⑬ Other fat(s)
⓪ Did not use fat

11. In the past three months, how many glasses of RED wine did you drink? **(Consider one glass as 6 ounces. Mark one.)**

⓪ None or less than 1 each month
① 1-3 each month
② 1 each week
③ 2-4 each week
④ 5-6 each week
⑤ 1 each day
⑥ 2-3 each day
⑦ 4 or more each day

12. In the past three months, how many glasses of WHITE or ROSÉ wine did you drink? **(Consider one glass as 6 ounces. Mark one.)**

⓪ None or less than 1 each month
① 1-3 each month
② 1 each week
③ 2-4 each week
④ 5-6 each week
⑤ 1 each day
⑥ 2-3 each day
⑦ 4 or more each day

Go to the next page.

13. Do you smoke cigarettes now?

① Yes

⓪ No → **Go to the next page.**

13.1. How many cigarettes do you usually smoke each day? **(Mark one.)**

① Less than 5

② 5-14

③ 15-24

④ 25-34

⑤ 35-44

⑥ 45 or more

13.2. Do you usually smoke filter tip or non-filter tip cigarettes? **(Mark one.)**

① Filter tip

② Non-filter tip

13.3. Do you usually smoke regular or low tar and nicotine cigarettes (lites)? **(Mark one.)**

① Regular

② Low tar and nicotine (lite)

13.4. What size cigarettes do you usually smoke? **(Mark one.)**

① Slim

② Regular size

③ King size

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

The next questions are about female hormones you get with a doctor's prescription.

14. In the past year, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and progestin (PROGESTERONE) COMBINED in the same pill or package (for example Prempro, Premphase)? (Do not include use of two separate estrogen and progestin pills used at the same time.)

⓪ No
⑨ Don't know
① Yes

14.1. In the past year, how many months did you use the COMBINED female hormone PILL which contained both ESTROGEN and PROGESTIN?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

15. In the past year, did you use the female hormone medication called ESTROGEN (for example, Premarin, Estrace, Ogen)? (This may have been in the form of a pill, skin patch, shot, vaginal cream or suppository, or skin cream or gel.) **(Do not include the combined pill of estrogen and progestin.)**

⓪ No
⑨ Don't know
① Yes

15.1. In the past year, how many months did you use any type of ESTROGEN? **(Mark one. If you had shots, count each shot as one month.)**

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

15.2. In the past year, what type of ESTROGEN did you use the longest? **(Mark one.)**

① Pills (or capsules)
② Shots
③ Skin Patches
④ Vaginal cream or suppositories
⑧ Other creams or gels

Go to Question 15.3 on the next page.

Skip the next page and go to Question 16 on page 8.

15.3. In the past year, did you take ESTROGEN pills (e.g., Premarin, Estrace, Ogen) by mouth?

⓪ No
⑨ Don't know
① Yes

15.4. What was the average number of days each month that you used ESTROGEN pills? **(Mark one.)**

⓪ Less than 1 day
① 1-7 days
② 8-14 days
③ 15-21 days
④ 22-27 days
⑤ 28 or more days

15.5. In the past year, what type of ESTROGEN pill did you use the longest? **(Mark one.)**

① Premarin or conjugated equine estrogens
② Estrace
③ Ogen
⑧ Other
⑨ Don't know

15.6. What dose did you usually take each day? **(Mark one. If you regularly take more than one dose, mark the lowest dose.)**

① 0.3 mg
② 0.625 mg
③ 0.9 mg
④ 1 mg
⑤ 1.25 mg
⑥ 2 mg
⑦ 2.5 mg
⑧ Other
⑨ Don't know

15.7. In the past year, did you use ESTROGEN skin patches (for example, Estraderm, Climera)?

⓪ No
⑨ Don't know
① Yes

15.8. What dose skin patch did you usually use? **(Mark one.)**

① 0.05 mg
② 0.1 mg
⑧ Other
⑨ Don't know

15.9. What was the average number of times each week that you changed your ESTROGEN skin patch? **(Mark one.)**

① Less than once each week
② 1-2 times each week
③ 3-4 times each week
④ 5 or more times each week

Go to the next page.

16. In the past year, did you use the female hormone medication called PROGESTERONE or PROGESTIN (for example, Provera, Cycrin, Amen, Megace or micronized progesterone)? (This may have been in the form of a pill, skin patch, shot, vaginal cream or suppository, or skin cream or gel.) **(Do not include the combined pill of estrogen and progestin.)**

① Yes
⓪ No
⑨ Don't know → **Go to the next page.**

16.1. In the past year, how many months did you use PROGESTERONE or PROGESTIN? **(Mark one. If you had shots, count each shot as one month.)**

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

16.2. In the past year, what type of PROGESTERONE or PROGESTIN did you use the longest? **(Mark one.)**

① Pills or capsules
② Shots
③ Skin patches
④ Vaginal creams or suppositories
⑧ Other creams or gels

16.3. In the past year, did you take PROGESTERONE or PROGESTIN pills by mouth?

⓪ No
⑨ Don't know
① Yes

16.4. In the past year, what was the average number of days each month that you used PROGESTERONE or PROGESTIN pills? **(Mark one.)**

① Not used or less than 1 day
② 1-9 days
③ 10-12 days
④ 13-18 days
⑤ 19-27 days
⑥ 28 or more days

16.5. In the past year, did you take Provera, Cycrin or Amen (MEDROXYPROGESTERONE-MPA) pills?

⓪ No
⑨ Don't know
① Yes

16.6. What dose did you usually take each day? **(Mark one. If you regularly take more than one dose, mark the lowest dose.)**

① 2.5 mg
② 5 mg
③ 7.5 mg
④ 10 mg
⑤ More than 10 mg
⑨ Don't know

16.7. In the past year, did you take MICRONIZED PROGESTERONE pills?

① Yes
⓪ No
⑨ Don't know


305403

PLEASE MAKE NO MARKS IN THIS AREA

17. Since age 21, have you or someone else ever poured, mixed, sprayed or applied insecticides (such as bug or flea spray, garden/lawn/crop insecticides) in your immediate surroundings at home, leisure, or work? (Do not include insect repellents, weed killers, fungus/mildew killers, or flea tick or mite treatments applied directly to pets.) **(Mark one.)**

① Yes, at work only
② Yes, at home or leisure only
③ Yes, both at work and at home or leisure

⓪ No
⑨ Don't know

→ **Go to the next page.**

17.1. What types of exposure have you had to insecticides? **(Mark all that apply.)**

① I mixed them
② I sprayed or applied them
③ Lawn service applied them at my home
④ Applied in home by commercial service
⑧ Other

17.2. How many years in total did you personally mix or apply insecticides at home or at work? **(Mark one.)**

① Never or less than 1 year
② 1-4 years
③ 5-9 years
④ 10-14 years
⑤ 15-19 years
⑥ 20 or more years

17.3. In those years, what was the average number of times each year that you personally mixed or applied insecticides at home or at work? **(Mark one.)**

⓪ Never or less than once each year
① 1-5 times each year
② 6-12 times each year
③ 13-24 times each year
④ 25-49 times each year
⑤ 50 or more times each year

17.4. How many years in total did someone other than yourself (for example, a lawn service or a commercial applicator) apply insecticides to your home, lawn, or garden? **(Mark one.)**

⓪ Never or less than 1 year
① 1-4 years
② 5-9 years
③ 10-14 years
④ 15-19 years
⑤ 20 or more years

17.5. In those years, what was the average number of times each year that someone other than yourself applied insecticides to your home, lawn, or garden? **(Mark one.)**

⓪ Never or less than once each year
① 1-5 times each year
② 6-12 times each year
③ 13-24 times each year
④ 25 or more times each year

Go to the next page.

18. Have you ever sat in front of a computer screen within three feet with the power turned "on" (for example, when writing letters)?

① Yes ⓪ No → **Go to the next page.**

18.1. How many years in total did you sit in front of a computer screen regularly (at least once each week) with the power turned "on"? **(Mark one.)**

① Less than 1 year
② 1-4 years
③ 5-9 years
④ 10-14 years
⑤ 15-19 years
⑥ 20 or more years

18.2. In the past five years, what was the average number of days each week that you sat in front of a computer screen with the power turned "on"? **(Mark one.)**

⓪ Less than 1 day each week → **Go to the next page.**
① 1 day each week
② 2 days each week
③ 3 days each week
④ 4 days each week
⑤ 5 or more days each week

18.3. On the days that you used a computer, what was the average number of hours that you sat in front of a computer screen with the power turned "on"? **(Mark one.)**

① Less than 1 hour each day
② 1-3 hours each day
③ 4-6 hours each day
④ 7 or more hours each day

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

19. Since age 21, have you ever lived with a pet in your home?

① Yes ⓪ No → **Go to the next page.**

19.1. What methods have you used to treat your pets for fleas, mites or ticks? (Do not include spraying the house for fleas or insects. **(Mark all that apply.)**

⓪ None → **Go to the next page.**

① Flea and tick collars

② Powder or spray

③ Dips

⑧ Other

19.2. How many years in total have you treated a pet in your home for fleas, mites or ticks? **(Mark one.)**

① Less than 1 year

② 1-4 years

③ 5-9 years

④ 10-19 years

⑤ 20-29 years

⑥ 30 or more years

Go to the next page.

20. Have you ever used a hand-held hair dryer regularly (at least once a week)?

⓪ No

① Yes

20.1. How many years in total have you used a hand-held hair dryer? **(Mark one.)**

① Less than 1 year

② 1-4 years

③ 5-9 years

④ 10-14 years

⑤ 15-19 years

⑥ 20 or more years

20.2. In those years, what was the average number of times per week that you used a hand-held hair dryer? **(Mark one.)**

① Once each week or less

② 2-3 times each week

③ 4-5 times each week

④ 6 or more times each week

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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Comments:

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

First Name _____M.I._____

Last Name _____

1. Date of Action: ⌊__⌋⌊__⌋-⌊__⌋⌊__⌋-⌊__⌋⌊__⌋ (M/D/Y)

2. Completed By: ⌊__⌋⌊__⌋⌊__⌋ _____

3. Contact Type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other

4. Visit Type:
   - ☐ 1 Screening #⌊__⌋
   - ☐ 2 Semi-Annual #⌊__⌋⌊__⌋
   - ☐ 3 Annual #⌊__⌋⌊__⌋
   - ☐ 4 Non-Routine

5. What study medication schedule did the participant follow?

HRT	__ __ pills/week
CEE 0.3 mg	__ __ pills/week
CEE 0.625 mg	__ __ pills/week
MPA 2.5 mg	__ __ pills/week
MPA 5 mg	__ __ pills/week
MPA 10 mg	__ __ pills/week
CaD	__ __ pills/week

6. What is the new study medication schedule? (Include all study medications the participant should take, including those that you are not changing.)

6.1. Medication:	6.2. Dosage:
1. ____ HRT:	⌊__⌋⌊__⌋ pills/week
2. ____ CEE 0.3 mg:	⌊__⌋⌊__⌋ pills/week
3. ____ CEE 0.625 mg:	⌊__⌋⌊__⌋ pills/week
4. ____ MPA 2.5 mg:	⌊__⌋⌊__⌋ pills/week
5. ____ MPA 5 mg:	⌊__⌋⌊__⌋ pills/week
6. ____ MPA 10 mg:	⌊__⌋⌊__⌋ pills/week
7. ____ CaD:	⌊__⌋⌊__⌋ pills/week

6.3 Is this a cyclic regimen?

☐ 0 No ☐ 1 Yes

7. Is the new study medication scheduled permanent?

☐ 0 No → 7.1. For how long should the participant follow this new study medication schedule? (Record shortest length of time if more than one medication.)

⌊__⌋⌊__⌋ weeks

☐ 1 Yes

8. Why did you make the change in the medication schedule?

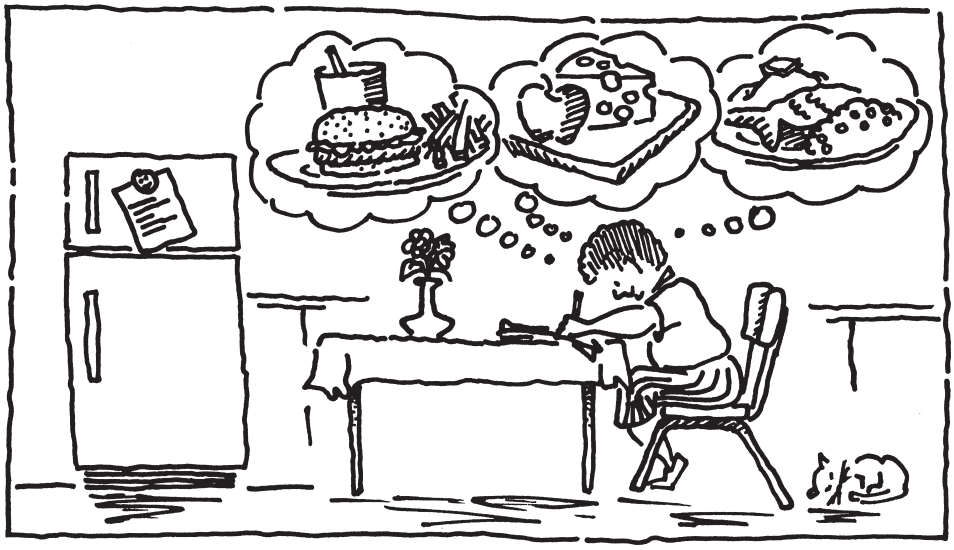
8.1. HRT *(Mark all that apply.)*
   - ☐ 1 Bleeding
   - ☐ 2 Biopsy abnormality
   - ☐ 3 Abnormal transvaginal ultrasound
   - ☐ 4 Symptom intolerance *(Specify):* _____
   - ☐ 8 Other *(Specify):* _____

8.2. CaD *(Mark all that apply.)*
   - ☐ 1 Symptom intolerance *(Specify):* _____
   - ☐ 8 Other *(Specify):* _____

K_____ V_____

WOMEN'S HEALTH INITIATIVE

FOOD QUESTIONNAIRE



Name _____

Date _____

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AFFIX LABEL BETWEEN LINES

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1. Date Completed:

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 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
8 Other

4. Visit Type:

1 Screening 0 1 2 3 11
2 Semi-Annual 1 2 3 4 5 6 7 8 9 10
3 Annual 1 2 3 4 5 6 7 8 9 10
4 Non Routine 11

5. Form Administration:

1 Self
2 Group
3 Interview
4 Assistance

6. Language:

● E 2 S

SERIAL #

PLEASE MAKE NO MARKS IN THIS AREA

Your answers to this questionnaire will help us learn about nutrition and health. It takes about 45 minutes to complete. Please follow these instructions:

- **Answer each question as best you can - estimate if you aren't sure. There are no "right" or "wrong" answers.**
- **Use an ordinary (#2) pencil. Do not use pen or felt-tipped marker.**
- **Fill in the ovals completely. Do not use check marks, Xs, or other marks.**
- **Do not make any other marks or write anything else on this form.**
- **Answer each question completely. Some questions have more than one part as shown in the example below. Make sure you complete all parts of the question.**

Example: This woman ate oil-packed tuna. It was usually prepared as tuna salad or tuna noodle casserole.

4. Did you eat canned tuna during the last three months?

○ No (Go to question 5.) ● Yes

4.1 When you ate canned tuna was it usually . . .
- ○ Water-packed
- ● Oil-packed
- ○ Either one
- ○ Don't know

4.2 When you ate canned tuna how was it usually prepared? (Mark one or two.)
- ○ Tuna, plain
- ● Tuna salad with mayonnaise
- ● Tuna noodle casserole

These questions ask about the foods you ate during the <u>LAST THREE (3) MONTHS</u>.

1. Did you eat chicken or turkey during the last three months?

○ No (Go to question 2.) ○ Yes

1.1 When you ate chicken or turkey, how often did you eat the skin?
- ○ Almost always
- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

1.2 Did you usually choose . . .
- ○ Light meat
- ○ Dark meat
- ○ Both

2. Did you eat beef, pork or lamb during the last three months?

○ No (Go to question 3.) ○ Yes

2.1 When you ate beef, pork or lamb, how often did you eat the fat?
- ○ Almost always
- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

3. Did you eat hamburger or other ground meat during the last three months? (Mark one.)

○ No (Go to question 4.) ○ Yes

3.1 When you ate hamburger or other ground meat, was it usually . . .
- ○ Regular
- ○ Lean
- ○ Extra lean
- ○ Ground turkey
- ○ Don't know

4. Did you eat canned tuna during the last three months?

○ No (Go to question 5.) ○ Yes

4.1 When you ate canned tuna was it usually . . .
- ○ Water-packed
- ○ Oil-packed
- ○ Either one
- ○ Don't know

4.2 When you ate canned tuna how was it usually prepared? (Mark one or two.)
- ○ Tuna, plain
- ○ Tuna salad with mayonnaise
- ○ Tuna noodle casserole

5. Did you drink milk or beverages made with milk, such as hot chocolate, during the last three months? (Do not include milk used on cereal or in coffee or tea.) (Mark one.)

- ○ No (Go to question 6.)
- ○ Yes

5.1 When you drank milk or milk beverages, was it usually . . .

- ○ Whole milk
- ○ 2% milk
- ○ 1% milk or buttermilk
- ○ Non-fat or skim milk
- ○ Evaporated or condensed milk
- ○ Soy milk
- ○ Don't know

6. Did you use milk, cream or creamer on cereal during the last three months?

- ○ No (Go to question 7.)
- ○ Yes

6.1 When you used milk, cream or creamer on cereal, what type did you usually use? (Mark one or two.)

- ○ Cream or half and half
- ○ Whole milk
- ○ 2% milk
- ○ 1% milk
- ○ Non-fat or skim milk
- ○ Evaporated or condensed milk
- ○ Soy milk
- ○ Non-dairy creamer
- ○ Don't know

7. Did you use milk, cream or creamer in coffee or tea during the last three months?

- ○ No (Go to question 8.)
- ○ Yes

7.1 When you used milk, cream or creamer in coffee or tea, what type did you usually use? (Mark one or two.)

- ○ Cream or half and half
- ○ Whole milk
- ○ 2% milk
- ○ 1% milk
- ○ Non-fat or skim milk
- ○ Evaporated or condensed milk
- ○ Soy milk
- ○ Non-dairy creamer
- ○ Don't know

8. Did you eat cold cereals during the last three months?

- ○ No (Go to question 9.)
- ○ Yes

8.1 When you ate cold cereals, what type did you usually eat? (Mark one or two.)

- ○ Granola cereals
- ○ High-fiber or bran cereals such as FiberOne®, Raisin Bran®
- ○ Whole grain cereals such as Cheerios®, Shredded Wheat®
- ○ Fortified cereals such as Total®, Product 19®
- ○ Other cereals such as corn flakes, Frosted Flakes®

9. Did you eat okra, squash, or yams during the last three months?

- ○ No (Go to question 10.)
- ○ Yes

9.1 When you ate okra, squash, or yams, how often were they fried? (Do not include potatoes.)

- ○ Almost always
- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

10. What kinds of fat did you usually use to deep fry, pan fry or sauté foods? (Mark one or two.)

- ○ Stick margarine
- ○ Tub margarine
- ○ Butter
- ○ Shortening (Crisco®, lard, bacon fat or drippings, salt pork, ham hock)
- ○ Olive or canola oil
- ○ Other oils (vegetable, corn, peanut, safflower)
- ○ Non-stick spray (Pam®)
- ○ Didn't add fat

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11. What kinds of fat did you usually add <u>when</u> cooking beans, rice, vegetables and potatoes? (Mark one or two.)

- ○ Low calorie or low fat margarine
- ○ Stick margarine
- ○ Tub margarine
- ○ Butter
- ○ Shortening (Crisco®, lard, bacon fat or drippings, salt pork, ham hock)
- ○ Olive or canola oil
- ○ Other oils (vegetable, corn, peanut, safflower)
- ○ Non-stick spray (Pam®)
- ○ Non-fat margarine or didn't add fat

12. What kinds of fat did you usually add <u>after</u> cooking vegetables, beans, rice and potatoes? (Mark one or two.)

- ○ Low calorie or low fat margarine
- ○ Stick margarine
- ○ Tub margarine
- ○ Butter
- ○ Sour cream
- ○ Olive or canola oil
- ○ Other oils (vegetable, corn, peanut, safflower)
- ○ Non-fat margarine or didn't add fat

13. What kinds of fat did you usually use on breads, muffins, tortillas and rolls? (Mark one or two.)

- ○ Low calorie or low fat margarine
- ○ Stick margarine
- ○ Tub margarine
- ○ Butter
- ○ Olive or canola oil
- ○ Other oils (vegetable, corn, peanut, safflower)
- ○ Non-fat margarine or didn't add fat

14. Did you make your own tortillas during the last three months?

- ○ No (Go to question 15.)
- ○ Yes

14.1 When you made tortillas, did you make them with lard, shortening, or other fat?

- ○ Yes, made with fat.
- ○ No, made without fat.

15. What type of salad dressing did you usually use? (Mark one.)

- ○ Regular, such as French or oil and vinegar
- ○ Low-fat (diet)
- ○ Fat-free (no oil)
- ○ Didn't use salad dressing

16. What type of mayonnaise did you usually use? (Mark one.)

- ○ Regular
- ○ Low-fat (diet)
- ○ Fat-free
- ○ Didn't use mayonnaise

17. Did you eat popcorn during the last three months?

- ○ No (Go to question 18.)
- ○ Yes

17.1 What type of popcorn did you usually eat? (Mark one.)

- ○ Popped in oil, pre-popped, or at movies
- ○ Regular microwave
- ○ Air-popped or special "lite" microwave

17.2 When you ate popcorn, how often did you add butter or margarine?

- ○ Almost always
- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

18. Did you eat cookies during the last three months?

- ○ No (Go to question 19.)
- ○ Yes

18.1 When you ate cookies, how often were they graham crackers, vanilla wafers, fig bars, or special *low fat* or *no fat* cookies?

- ○ Almost always
- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

19. Did you eat cakes or other pastries during the last three months?

- ○ No (Go to next page.)
- ○ Yes

19.1 When you ate cakes or other pastries, how often were they angel food cakes, sponge cakes, or special *low fat* or *no fat* cakes or pastries?

- ○ Almost always
- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

The next section is about how often you usually eat specific foods. Please think about what you usually ate during the last THREE (3) MONTHS.

First: Mark the column to show how often, on the average, you ate the food.
Second: Mark your usual serving size as small, medium or large.

Please note:

- A small serving is about one-half (1/2) the medium serving size, or less.
- A large serving is about one-and-a-half (1 1/2) times the medium serving size, or more.
- If you never ate a food, mark "Never or less than once per month," and omit the serving size altogether.
- Please *do not skip* any foods.

Example: This person ate a medium serving of rice about twice per month and never ate sausage.

TYPE OF FOOD	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1 per month	2-3 per month	1 per week	2 per week	3-4 per week	5-6 per week	1 per day	2+ per day	Medium Serving Size	Your Serving Size S	M	L
Rice	○	○	●	○	○	○	○	○	○	3/4 cup	○	●	○
Sausage	●	○	○	○	○	○	○	○	○	2 slices or 2 ounces	○	○	○

During the last three (3) months . . .

TYPE OF FOOD	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1 per month	2-3 per month	1 per week	2 per week	3-4 per week	5-6 per week	1 per day	2+ per day	Medium Serving Size	Your Serving Size S	M	L
FRUITS AND JUICES													
Apples and pears	○	○	○	○	○	○	○	○	○	1 medium or 1/2 cup	○	○	○
Bananas	○	○	○	○	○	○	○	○	○	1 medium	○	○	○
Peaches, nectarines and plums (fresh or canned)	○	○	○	○	○	○	○	○	○	1 medium or 1/2 cup	○	○	○
Cantaloupe, orange melon, muskmelon, mango and papaya	○	○	○	○	○	○	○	○	○	1/4 melon or 1 cup	○	○	○
Watermelon and red melon	○	○	○	○	○	○	○	○	○	1 medium slice or 1 cup	○	○	○
All other melon, such as honeydew	○	○	○	○	○	○	○	○	○	1 medium slice or 1 cup	○	○	○
Apricots (fresh, canned, or dried)	○	○	○	○	○	○	○	○	○	2 medium or 4 halves	○	○	○
Other dried fruit, such as raisins and prunes	○	○	○	○	○	○	○	○	○	1/4 cup	○	○	○
Oranges, grapefruit and tangerines (not juice)	○	○	○	○	○	○	○	○	○	1 orange or 1/2 grapefruit	○	○	○
Strawberries and kiwi	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Any other fruit, such as fruit cocktail, berries, grapes, applesauce, pineapple	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○

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TYPE OF FOOD	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1 per month	2-3 per month	1 per week	2 per week	3-4 per week	5-6 per week	1 per day	2+ per day	Medium Serving Size	Your Serving Size S	M	L
Orange juice and grapefruit juice	○	○	○	○	○	○	○	○	○	6 ounce glass	○	○	○
Tang®, Kool-Aid®, Hi-C®, and other fruit drinks	○	○	○	○	○	○	○	○	○	6 ounce glass	○	○	○
Other fruit juices such as apple, grape	○	○	○	○	○	○	○	○	○	6 ounce glass	○	○	○
VEGETABLES													
Green or string beans	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Green or English peas	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Refried beans	○	○	○	○	○	○	○	○	○	3/4 cup	○	○	○
All other beans such as baked beans, lima beans, black-eyed peas and chili without meat	○	○	○	○	○	○	○	○	○	3/4 cup	○	○	○
Tofu and textured vegetable products	○	○	○	○	○	○	○	○	○	3 slices or 3 ounces	○	○	○
Avocado and guacamole, including added to mixed dishes	○	○	○	○	○	○	○	○	○	1/4 medium or 1/4 cup	○	○	○
Corn and hominy	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Tomatoes, fresh or juice	○	○	○	○	○	○	○	○	○	1 medium or 6 ounce glass	○	○	○
Tomatoes cooked, tomato sauce, salsa and salsa picante	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Green peppers, green chilies, jajapeños, and green chili salsa	○	○	○	○	○	○	○	○	○	1/4 cup	○	○	○
Red peppers and red chilies	○	○	○	○	○	○	○	○	○	1/4 cup	○	○	○
Broccoli	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Cooked greens, such as spinach, mustard greens, turnip greens, collards	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Carrots, including mixed dishes with carrots	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Summer squash, zucchini, nopales, and okra	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Winter squash, such as acorn, butternut, pumpkin	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Coleslaw	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Cauliflower, cabbage, sauerkraut and Brussels sprouts	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Onions and leeks, including in cooking	○	○	○	○	○	○	○	○	○	1/4 cup	○	○	○

TYPE OF FOOD	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1 per month	2-3 per month	1 per week	2 per week	3-4 per week	5-6 per week	1 per day	2+ per day	Medium Serving Size	Your Serving Size S	M	L
Lettuce and plain lettuce salad	○	○	○	○	○	○	○	○	○	1 medium bowl	○	○	○
Mixed lettuce or spinach salad with vegetables such as carrots or tomatoes	○	○	○	○	○	○	○	○	○	1 medium bowl	○	○	○
Salad dressing, such as Italian, 1000 Island, French (include low-fat and fat-free dressings)	○	○	○	○	○	○	○	○	○	2 tablespoons	○	○	○
Plantains, fried	○	○	○	○	○	○	○	○	○	1 cup	○	○	○
French fries, fried potatoes, fried rice, fried cassava and fritters	○	○	○	○	○	○	○	○	○	3/4 cup	○	○	○
Sweet potatoes and yams	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Other potatoes, cassava, and yucca (boiled, baked, or mashed)	○	○	○	○	○	○	○	○	○	1 medium or 1/2 cup	○	○	○
Potato, macaroni, or pasta salads made with mayonnaise or oil	○	○	○	○	○	○	○	○	○	1/2 cup	○	○	○
Rice, grains and plain noodles	○	○	○	○	○	○	○	○	○	3/4 cup	○	○	○
Butter, margarine, sour cream, oils, or other fat added to vegetables, beans, rice, and potatoes, after cooking	○	○	○	○	○	○	○	○	○	2 pats or 2 teaspoons	○	○	○
MEAT, FISH, POULTRY, LUNCH ITEMS													
Ground meat including hamburgers, meatloaf, and picadillo	○	○	○	○	○	○	○	○	○	1 medium or 3 ounces	○	○	○
Beef, pork and lamb as a main dish, such as steak, roast and ham	○	○	○	○	○	○	○	○	○	4 ounces	○	○	○
Beef, pork and lamb as a sandwich (steak sandwich, BBQ sandwich)	○	○	○	○	○	○	○	○	○	3 ounces	○	○	○
Stew, pot pie and casseroles with meat or chicken	○	○	○	○	○	○	○	○	○	1 cup	○	○	○
Chili with meat and beans	○	○	○	○	○	○	○	○	○	1 cup	○	○	○
Liver, including chicken liver, and other organ meats	○	○	○	○	○	○	○	○	○	4 ounces	○	○	○
Fried chicken	○	○	○	○	○	○	○	○	○	2 small or 1 large piece	○	○	○
Chicken and turkey (roasted, stewed or broiled)	○	○	○	○	○	○	○	○	○	2 small or 1 large piece	○	○	○
Gravies made with meat drippings and white sauce	○	○	○	○	○	○	○	○	○	1/4 cup	○	○	○
Fried fish, fish sandwich, and fried shellfish (shrimp, oysters)	○	○	○	○	○	○	○	○	○	3 ounces or 1 sandwich	○	○	○

TYPE OF FOOD	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1 per month	2-3 per month	1 per week	2 per week	3-4 per week	5-6 per week	1 per day	2+ per day	Medium Serving Size	Your Serving Size S	M	L
Shellfish, not fried (shrimp, lobster, crab and oysters)										3 ounces or 1/2 cup			
Canned tuna, tuna salad, and tuna casserole										1/2 cup tuna or 1 cup casserole			
White fish (broiled or baked) such as sole, snapper, cod										3 ounces			
Dark fish (broiled or baked) such as salmon, mackerel, bluefish										3 ounces			
Macaroni and cheese, lasagna, or noodles with a cream sauce										1 cup			
Spaghetti or other noodles with meat sauce										1 cup			
Spaghetti or other noodles with tomato sauce (and no meat)										1 cup			
Low-fat pizza										2 slices of a 12" pizza			
Pizza										2 slices of a 12" pizza			
Tamales, with or without meat										1 medium			
Chilaquiles										1 cup			
Soft quesadilla										1 medium			
Crispy quesadilla and chili relleno										1 medium			
Soft taco and enchilada baked without oil										2 medium			
Flauta and crispy rolled taco										2 medium			
Regular burrito and enchilada										1 burrito or 2 enchiladas			
Taco and tostada										1 medium			
Lunch meat such as ham, turkey and other special lean meats										2 slices			
All other lunch meat such as bologna, salami, Spam®, potted and canned meat										2 slices			
Hot dogs, chorizo, and other sausage such as bratwurst										2 hot dogs or 3 ounces			

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TYPE OF FOOD	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1 per month	2-3 per month	1 per week	2 per week	3-4 per week	5-6 per week	1 per day	2+ per day	Medium Serving Size	Your Serving Size S	M	L
Cream soups such as chowders, potato, tomato, cheese, ajiaco	○	○	○	○	○	○	○	○	○	1 cup or 1 medium bowl	○	○	○
Bean soups such as pea, lentil, black bean, potajes	○	○	○	○	○	○	○	○	○	1 cup or 1 medium bowl	○	○	○
Vegetable soups	○	○	○	○	○	○	○	○	○	1 cup or 1 medium bowl	○	○	○
Menudo and tortilla soup	○	○	○	○	○	○	○	○	○	1 cup or 1 medium bowl	○	○	○
Other soups such as chicken noodle	○	○	○	○	○	○	○	○	○	1 cup or 1 medium bowl	○	○	○
BREADS, SNACKS, SPREADS													
Biscuits, muffins, scones, and croissants	○	○	○	○	○	○	○	○	○	2 biscuits or 1 medium	○	○	○
White breads, including bagels, rolls, pita bread, and English Muffins	○	○	○	○	○	○	○	○	○	2 slices or 1 medium	○	○	○
Dark breads, including dark bagels, rolls, pita bread, and English Muffins	○	○	○	○	○	○	○	○	○	2 slices or 1 medium	○	○	○
Corn bread, corn muffins, and cornmeal mush	○	○	○	○	○	○	○	○	○	1 medium or 1/2 cup	○	○	○
Tortillas, corn (not including tacos)	○	○	○	○	○	○	○	○	○	2 medium	○	○	○
Tortillas, flour or wheat (not including tacos)	○	○	○	○	○	○	○	○	○	1 - 12 inch or 2 - 7 inch	○	○	○
Indian fry bread	○	○	○	○	○	○	○	○	○	1 - 9 inch	○	○	○
Snacks such as potato chips, corn chips, tortilla chips, pork skins, Ritz® and cheese crackers	○	○	○	○	○	○	○	○	○	2 handfuls or 1 cup	○	○	○
Saltines, SnackWell's®, fat-free tortilla chips, and fat-free potato chips	○	○	○	○	○	○	○	○	○	5 crackers or 2 handfuls	○	○	○
Popcorn	○	○	○	○	○	○	○	○	○	4 handfuls or 2 cups	○	○	○
Peanut butter, peanuts, other nuts and seeds	○	○	○	○	○	○	○	○	○	2 tablespoons or 1 handful	○	○	○
Butter, margarine or oil, on bread or tortillas	○	○	○	○	○	○	○	○	○	2 pats or 2 teaspoons	○	○	○
Mayonnaise and mayonnaise type spreads, on sandwiches and in salads	○	○	○	○	○	○	○	○	○	2 tablespoons	○	○	○

TYPE OF FOOD	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1 per month	2-3 per month	1 per week	2 per week	3-4 per week	5-6 per week	1 per day	2+ per day	Medium Serving Size	Your Serving Size S	M	L
BREAKFAST FOODS													
Cold cereal										1 cup or 1 medium bowl			
Cooked cereals and grits										1 cup or 1 medium bowl			
Margarine or butter added to cooked cereal or grits										2 pats or 2 teaspoons			
Milk on cereal (cold and cooked)										1/2 cup			
Pancakes and waffles										2 pancakes or 1 medium waffle			
Eggs										2 eggs			
Bacon, breakfast sausage, and scrapple										3 strips or 2 links or 1 slice			
DAIRY PRODUCTS													
Low-fat cottage cheese										1/2 cup			
Cottage cheese and ricotta cheese										1/2 cup			
Non-fat cheeses. Include cheese added to foods and in cooking										2 slices or 1/4 cup shredded			
Part-skim or reduced fat cheeses, such as Mexican-type cheeses or mozzarella. Include cheese added to foods and in cooking										2 slices or 1/4 cup shredded			
All other cheeses, such as cheddar, Swiss, or cream cheese. Include cheese added to foods and in cooking										2 slices or 1/4 cup shredded			
Non-fat yogurt (not frozen)										1 cup			
All other yogurt (not frozen)										1 cup			
SWEETS													
Ice cream										1 scoop or 3/4 cup			
Pudding, custard, and flan										3/4 cup			
Low-fat or non-fat frozen desserts, such as frozen yogurt, sherbet, ice milk, and low-fat milkshakes										1 scoop or 3/4 cup			

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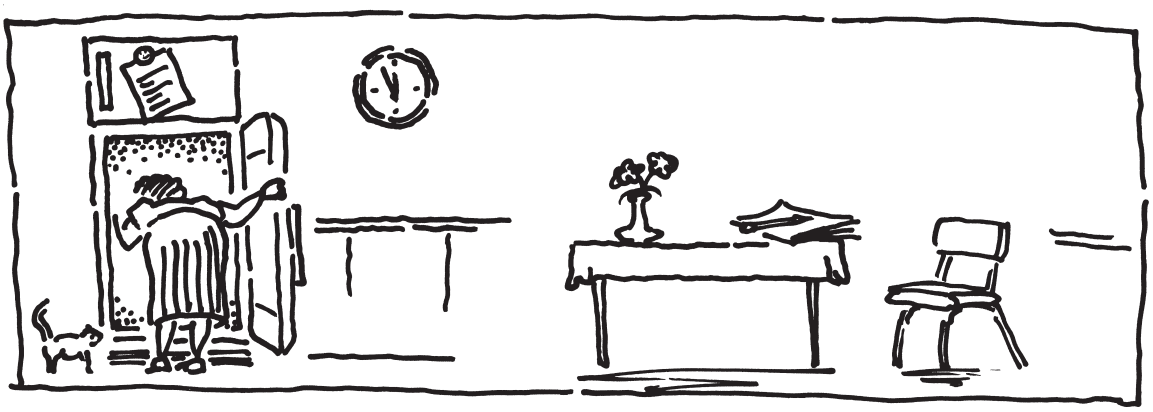
TYPE OF FOOD	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1 per month	2-3 per month	1 per week	2 per week	3-4 per week	5-6 per week	1 per day	2+ per day	Medium Serving Size	Your Serving Size S	M	L
Doughnuts, cakes, pastries, Pop-Tarts®, and pan dulce	○	○	○	○	○	○	○	○	○	1 piece	○	○	○
Cookies	○	○	○	○	○	○	○	○	○	3 small or 1 large	○	○	○
Pumpkin and sweet potato pie	○	○	○	○	○	○	○	○	○	1 medium slice	○	○	○
All other pies, fried pastries, pastelitos and fruit empanadas	○	○	○	○	○	○	○	○	○	1 medium slice or 1 piece	○	○	○
Chocolate candy and candy bars	○	○	○	○	○	○	○	○	○	1 small bar or 1 ounce	○	○	○
Hard candy, jam, jelly, honey, or syrup	○	○	○	○	○	○	○	○	○	3 pieces or 1 tablespoon	○	○	○

BEVERAGES (Please note that the frequency headings are different.) →	HOW OFTEN DID YOU EAT THE FOOD (Mark one)									AMOUNT			
	Never or less than once per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6+ per day	Medium Serving Size	Your Serving Size S	M	L
Milk, all types (including canned and soy) not on cereal	○	○	○	○	○	○	○	○	○	8 ounce glass	○	○	○
Regular soft drinks (not diet)	○	○	○	○	○	○	○	○	○	12 ounces or 1 can	○	○	○
Beer	○	○	○	○	○	○	○	○	○	12 ounce can or bottle	○	○	○
Wine	○	○	○	○	○	○	○	○	○	1 medium glass (6 ounces)	○	○	○
Liquor	○	○	○	○	○	○	○	○	○	1 shot (1 1/2 ounces)	○	○	○
Coffee or tea (all types)	○	○	○	○	○	○	○	○	○	8 ounce cup	○	○	○
Milk, cream, or creamer in coffee or tea	○	○	○	○	○	○	○	○	○	1 tablespoon	○	○	○
Sugar in coffee or tea and on cereal	○	○	○	○	○	○	○	○	○	2 teaspoons	○	○	○

During the last three (3) months . . .

SUMMARY QUESTIONS (please note that the frequency headings are different.) →	Less than one per week	1-2 per week	3-4 per week	5-6 per week	1 per day	2 per day	3 per day	4 per day	5+ per day
How often did you use fat to deep-fry, pan fry, or sauté? Count all fat such as margarine, oil, bacon drippings, or lard.	○	○	○	○	○	○	○	○	○
How often did you add fat when cooking beans, rice, vegetables, and potatoes? Count all fat such as margarine, oil, bacon drippings, or lard.	○	○	○	○	○	○	○	○	○
How often did you eat a serving of vegetables? Do not count salad, potatoes or dried beans or peas.	○	○	○	○	○	○	○	○	○
How often did you eat a serving of fruit? Do not count juices.	○	○	○	○	○	○	○	○	○

THANK YOU! ***Please take a moment to fill in any questions you may have skipped.***



★ U.S. GOVERNMENT PRINTING OFFICE:2003–589-322/40017

○ **SERIAL #**

PLEASE MAKE NO MARKS IN THIS AREA

OMB # 0925-0414 Exp: 5/03

- Affix label here-

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

First Name _____M.I._____

Last Name _____

1. Date of Exam: ⌊_⌋⌊_⌋-⌊_⌋⌊_⌋-⌊_⌋⌊_⌋ (M/D/Y)

2. Performed By: ⌊_⌋⌊_⌋⌊_⌋ _____

3. Contact Type:

   ☐ 1 Phone
   ☐ 2 Mail
   ☐ 3 Visit
   ☐ 8 Other

4. Visit Type:

   ☐ 1 Screening #⌊_⌋
   ☐ 2 Semi-Annual #⌊_⌋⌊_⌋
   ☐ 3 Annual #⌊_⌋⌊_⌋
   ☐ 4 Non-routine

5. Resting pulse in 30 sec.: ⌊_⌋⌊_⌋⌊_⌋ x 2 = _____/min

6. Blood pressure: 6.1. ⌊_⌋⌊_⌋⌊_⌋/⌊_⌋⌊_⌋⌊_⌋ Systolic/Diastolic

   6.2. ⌊_⌋⌊_⌋⌊_⌋/⌊_⌋⌊_⌋⌊_⌋ Systolic/Diastolic

   Cuff used: ___S ___Reg ___L ___Th

   Side: ___L ___R

Anthropometric Measures

7. Height: ⌊_⌋⌊_⌋⌊_⌋.⌊_⌋ cm

8. Weight: ⌊_⌋⌊_⌋⌊_⌋.⌊_⌋ kg BMI _____

9. Waist circumference: (to nearest 0.5 cm) ⌊_⌋⌊_⌋⌊_⌋.⌊_⌋ cm

10. Hip circumference: (to nearest 0.5 cm) ⌊_⌋⌊_⌋⌊_⌋.⌊_⌋ cm

K _____ V _____

Comments:

- Affix label here-
Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __
First Name _____M.I._____
Last Name _____

1. Contact date: ___-___-___ (M/D/Y)
2. Completed by: ___
3. Contact type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other

4. Visit type:
   - ☐ 1 Screening #___
   - ☐ 2 Semi-Annual #___
   - ☐ 3 Annual #___
   - ☐ 4 Non-Routine

5. Date pelvic exam performed:
   ___-___-___ (M/D/Y)

6. Pelvic exam performed by:
   - ☐ 1 CC staff
   - ☐ 2 Other →

   6.1. Report taken by: ___ _____
   6.2. MD Name:_____
   Clinic Name:_____
   Address:_____
   City/State/Zip:_____
   Phone #:_____

   6.3. Were there any abnormal findings found during the pelvic exam?
   - ☐ 0 No
   - ☐ 1 Yes

   6.4. Verbal report provided by:
   - ___ Clinician: Name/Title _____
   - ___ Participant

7. External genitalia (vulva):

		No	Yes, probably benign	Yes, possibly malignant
7.1.	Loss of adipose tissue	☐ 0	☐ 1	☐ 2
7.2.	Thinning of hair	☐ 0	☐ 1	☐ 2
7.3.	Abnormal discoloration	☐ 0	☐ 1	☐ 2
7.4.	Ulceration	☐ 0	☐ 1	☐ 2
7.5.	Growth	☐ 0	☐ 1	☐ 2

8. Vagina

		No	Yes, probably benign	Yes, possibly malignant
8.1.	Atrophy	☐ 0	☐ 1	☐ 2
8.2.	Smooth	☐ 0	☐ 1	☐ 2
8.3.	Pale	☐ 0	☐ 1	☐ 2
8.4.	Friable with contact	☐ 0	☐ 1	☐ 2
8.5.	Blood present	☐ 0	☐ 1	☐ 2
8.6.	Abnormal discoloration	☐ 0	☐ 1	☐ 2
8.7.	Ulceration	☐ 0	☐ 1	☐ 2
8.8.	Growth	☐ 0	☐ 1	☐ 2

8.9. Cystocele:
- ☐ 0 None
- ☐ 1 Grade 1 (in vagina)
- ☐ 2 Grade 2 (to introitus)
- ☐ 3 Grade 3 (outside vagina)

8.10. Rectocele:
- ☐ 0 None
- ☐ 1 Grade 1 (in vagina)
- ☐ 2 Grade 2 (to introitus)
- ☐ 3 Grade 3 (outside vagina)

Chart notes:

K _____ V _____

9. Cervix:

☐ 0 Absent

☐ 1 Present

	No	Yes, probably benign	Yes, possibly malignant
9.1. Flush with vaginal vault	☐ 0	☐ 1	☐ 2
9.2. Friable with contact	☐ 0	☐ 1	☐ 2
9.3. Surface lesion/ growth (other than ectopy, Nabothian cyst)	☐ 0	☐ 1	☐ 2
9.4. Polyp	☐ 0	☐ 1	☐ 2

10. Uterus:

☐ 0 Absent *(Go to Question 11.)*

☐ 1 Present

☐ 9 Unable to palpate *(Go to Question 11.)*

10.1. Prolapse:	10.2. Uterine size:	10.3. Enlarged since last exam:
☐ 0 None	⌊_⌋ weeks	☐ 0 No
☐ 1 Grade 1 (in vagina)		☐ 1 Yes
☐ 2 Grade 2 (to introitus)		
☐ 3 Grade 3 (outside vagina)		

11. Adnexae:

☐ 0 Normal

☐ 1 Mass present → 11.1. ☐ 1 Right ☐ 2 Left ☐ 3 Both

☐ 9 Unable to palpate/absent

External genitalia:

PAP SMEAR

12. Was Pap smear obtained?

☐ 0 No, not done

☐ 1 No, send for outside report

☐ 2 Yes, vaginal smear → Initiate *Form 92 - Pap Smear*

☐ 3 Yes, Pap smear

Follow-up

13. Was a referral made for follow-up care?

☐ 0 No

☐ 1 Yes

13.1. Referred by: ⌊_⌋ _____

13.2. Date of referral: ⌊_⌋⌊_⌋-⌊_⌋⌊_⌋-⌊_⌋⌊_⌋(M/D/Y)

13.3. Referred to:

MD/Clinic: _____

Address: _____

_____

Phone: _____

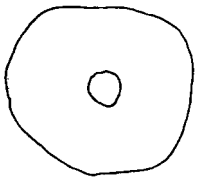
13.4. Pelvic follow-up results:

☐ 0 Normal

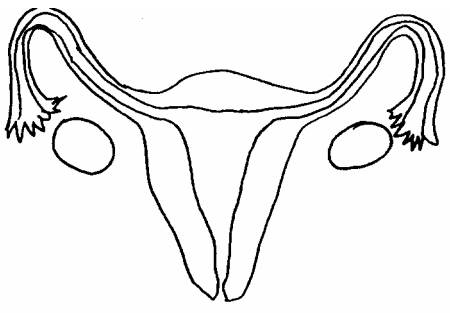
☐ 1 Benign changes

☐ 2 Possibly malignant

Cervix/vagina:



Ovaries/uterus:



Form 82 - Endometrial Aspiration

Comments:

- Affix label here-

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

First Name _____ M.I. _____

Last Name _____

1. Contact Date: __-__-__ (M/D/Y)
2. Staff Person: ____ _____
3. Contact Type:
   - ☐ 1 Phone
   - ☐ 3 Visit
   - ☐ 2 Mail
   - ☐ 8 Other
4. Visit Type:
   - ☐ 1 Screening # __
   - ☐ 2 Semi-Annual # __
   - ☐ 3 Annual # __
   - ☐ 4 Non-Routine

Endometrial Aspiration

5. Date of endometrial aspiration:
   __-__-__ (M/D/Y)
6. Was entry possible?
   - ☐ 1 Yes
   - ☐ 2 No, entry into the uterus was not possible
     → Schedule an ultrasound
   - ☐ 3 No, participant refused
   - ☐ 5 No, D&C results obtained
   - ☐ 4 No, other _____
7. Depth of uterus: __.__ cm
8. Was significant endometrial cavity fluid found?
   - ☐ 0 No
   - ☐ 1 Yes
9. Endometrial Aspiration Report results from *(Mark one)*:
   - ☐ 1 Local lab (for aspiration performed at CC)
   - ☐ 3 Participant's personal M.D. →

M.D. Name: _____
Clinic Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

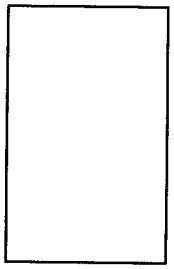
10. Date endometrial aspiration report reviewed:
    __-__-__ (M/D/Y)
11. Report reviewed by: ____ _____
12. Summary of endometrial aspiration report: *(Mark the greatest degree of severity found; if 5-10, refer to Clinic Practitioner.)*
    - ☐ 0 No endometrial tissue identified
    - ☐ 1 Insufficient specimen
    - ☐ 2 Normal atrophic endometrium
    - ☐ 3 Normal secretory endometrium
    - ☐ 4 Normal proliferative endometrium
    - ☐ 5 Cystic (simple) hyperplasia present
    - ☐ 6 Cystic (simple) hyperplasia with atypia
    - ☐ 7 Adenomatous (complex) hyperplasia present
    - ☐ 8 Adenomatous (complex) hyperplasia with atypia
    - ☐ 9 Atypia present
    - ☐ 10 Cancer present
    - ☐ 11 Other (_____)
13. Was a referral made for follow-up care?
    - ☐ 0 No
    - ☐ 1 Yes →

13.1. Referred by: ____ _____
13.2. Date of referral: __-__-__ (M/D/Y)
13.3. Referred to:
MD/Clinic: _____
Address: _____
_____
Phone: _____
13.4. Follow-up results:
- ☐ 0 Normal
- ☐ 1 Hyperplasia
- ☐ 2 Cancer

Central Lab Review

14. Endometrial Aspiration Slide Number

Slide Number



15. Date Central Lab endometrial aspiration report reviewed:

__-__-__ (M/D/Y)

16. Central Lab report reviewed by:

____ _____

17. Summary of Central Lab endometrial aspiration report: *(Mark the greatest degree of severity found; if 5-10, refer to Clinic Practitioner.)*

- ☐ 0 No endometrial tissue identified
- ☐ 1 Insufficient specimen
- ☐ 2 Normal atrophic endometrium
- ☐ 3 Normal secretory endometrium
- ☐ 4 Normal proliferative endometrium
- ☐ 5 Cystic (simple) hyperplasia present
- ☐ 6 Cystic (simple) hyperplasia with atypia
- ☐ 7 Adenomatous (complex) hyperplasia present
- ☐ 8 Adenomatous (complex) hyperplasia with atypia
- ☐ 9 Atypia present
- ☐ 10 Cancer present
- ☐ 11 Other (_____)

COMMENTS

- Affix label here-

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

First Name _____M.I._____

Last Name _____

1. Contact Date: ☐☐-☐☐-☐☐ (M/D/Y)
2. Requested By: ☐☐☐
3. Contact Type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other
4. Visit Type:
   - ☐ 1 Screening # ☐
   - ☐ 2 Semi-Annual # ☐☐
   - ☐ 3 Annual # ☐☐
   - ☐ 4 Non-Routine
5. Date of transvaginal uterine ultrasound:
   ☐☐-☐☐-☐☐ (M/D/Y)
6. Transvaginal uterine ultrasound performed by:
   Name _____
   Address _____
   City/State/Zip _____
   Phone: _____
7. Date report reviewed:
   ☐☐-☐☐-☐☐ (M/D/Y)
8. Report reviewed by:
   ☐☐☐ _____
9. Summary of report:
   - ☐ 1 Endometrial thickness ≤ 5 mm
   - ☐ 2 Endometrial thickness > 5 mm
   - ☐ 3 Unable to evaluate thickness due to leiomyomata
   - ☐ 4 No uterus seen
   - ☐ 9 Unable to perform successfully or participant refused
10. Pelvic pathology present?
    ☐ 0 No ☐ 1 Yes →

	No	Yes
10.1. Polyps	☐ 0	☐ 1
10.2. Uterine mass	☐ 0	☐ 1
10.3. Pelvic fluid	☐ 0	☐ 1
10.4. Ovarian mass	☐ 0	☐ 1
10.5. Other	☐ 0	☐ 1

10.5.1. Side: ☐ 1 Right ☐ 2 Left ☐ 3 Both

11. Other pathology present outside the reproductive structures?
    - ☐ 0 No
    - ☐ 1 Yes *(Specify)*: _____
12. Was significant endometrial cavity fluid seen?
    - ☐ 0 No
    - ☐ 1 Yes

13. Was a referral made for follow-up care?
    - ☐ 0 No
    - ☐ 1 Yes →

    13.1. Referred by: ☐☐☐ _____

    13.2. Date of referral: ☐☐-☐☐-☐☐ (M/D/Y)

    13.3. Referred to: _____

    13.4. Endometrial follow-up results
    - ☐ 0 Normal
    - ☐ 1 Hyperplasia
    - ☐ 2 Cancer

    13.5. Pelvic pathology follow-up results
    - ☐ 0 Normal/benign
    - ☐ 1 Cancer

K _____ V _____

COMMENTS:	- Affix label here- Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

1. Contact Date: |__|__|-|__|__|-|__|__| (M/D/Y)

2. Completed By: |__|__|__| _____

3. Contact Type:

   ☐ 1 Phone ☐ 3 Visit
   ☐ 2 Mail ☐ 8 Other

4. Visit Type:

   ☐ 1 Screening #|__|
   ☐ 2 Semi-Annual #|__|__|
   ☐ 3 Annual #|__|__|
   ☐ 4 Non-Routine

5. Date breast exam performed: |__|__|-|__|__|-|__|__| (M/D/Y)

6. CBE exam performed by:

   ☐ 1 CC Staff
   ☐ 8 Other →

6.1 Report taken by: |__|__|__| _____

6.2 MD Name _____
Clinic Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____

6.3 Were there any abnormal findings during the breast exam?

☐ 0 No
☐ 1 Yes

6.4 Verbal report provided by (LPN, RN, PA, NP or MD): _____

_____

K _____ V _____

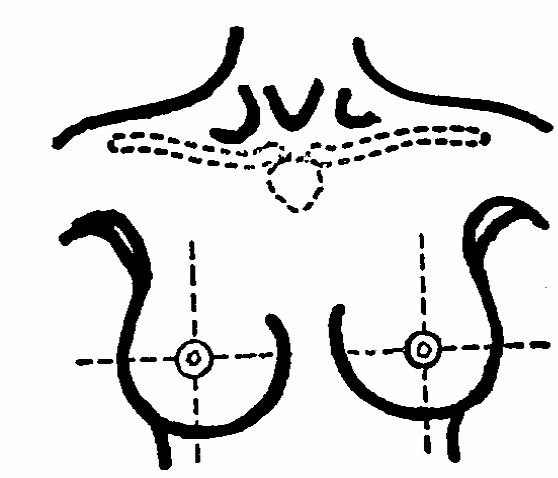
7. Summary of clinical breast exam (CBE). Also record clinical exam notes.

	Right			Left		
	No	Yes, probably benign	Yes, possibly malignant	No	Yes, probably benign	Yes, possibly malignant
7.1. Nipple discharge	☐ 0	☐ 1	☐ 2	☐ 0	☐ 1	☐ 2
7.2. Skin involvement	☐ 0	☐ 1	☐ 2	☐ 0	☐ 1	☐ 2
7.3. Axillary mass	☐ 0	☐ 1	☐ 2	☐ 0	☐ 1	☐ 2
7.4. Breast mass	☐ 0	☐ 1 ↓	☐ 2 ↓	☐ 0	☐ 1 ↓	☐ 2 ↓
For primary mass:						
	No	Yes		No	Yes	
7.5. Mobile	☐ 0	☐ 1		☐ 0	☐ 1	
7.6. Size	☐ 2 < 1 cm ☐ 3 1-3 cm ☐ 4 > 3 cm			☐ 2 < 1 cm ☐ 3 1-3 cm ☐ 4 > 3 cm		
7.7. More than one mass present	☐ 0	☐ 1		☐ 0	☐ 1	

8. Breast self-exam (BSE) teaching completed/reinforced?
   ☐ 0 No ☐ 1 Yes

9. Was a referral made for follow-up care?
   ☐ 0 No ☐ 1 Yes →

   9.1. Referred by: ____ _____
   9.2. Date of referral: __-__-__ (M/D/Y)
   9.3. Referred to:
   MD/Clinic: _____
   Address: _____
   _____
   Phone: _____



10. Final Follow-Up Results

	10.1 Right	10.2 Left
Normal	☐ 0	☐ 0
Benign changes	☐ 1	☐ 1
Possibly malignant	☐ 2	☐ 2
Cancer	☐ 3	☐ 3

COMMENTS:	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

1. Contact date: ☐☐-☐☐-☐☐ (M/D/Y)

2. Staff person: ☐☐☐ _____

3. Contact type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other

4. Visit type:
   - ☐ 1 Screening #☐
   - ☐ 2 Semi-Annual #☐☐
   - ☐ 3 Annual #☐☐
   - ☐ 4 Non-Routine

5. Date of mammogram:
   ☐☐-☐☐-☐☐ (M/D/Y)

6. Performed by:
   - MD Name: _____
   - Clinic Name: _____
   - Address: _____
   - City/State/Zip: _____
   - Phone: _____

7. Date mammogram report reviewed:
   ☐☐-☐☐-☐☐ (M/D/Y)

8. Report reviewed by:
   ☐☐☐ _____

9. Summary of mammogram report *(Mark one.)*:

	9.1. **Right**	9.2. **Left**
Negative	☐ 0	☐ 0
Benign finding - negative	☐ 1	☐ 1
Probably benign finding - short interval follow-up suggested	☐ 2	☐ 2
Suspicious abnormality - biopsy should be considered	☐ 3	☐ 3
Highly suggestive of malignancy	☐ 4	☐ 4
Not done	☐ 9	☐ 9

10. Was a referral made for follow-up care?
    - ☐ 0 No
    - ☐ 1 Yes

    10.1. Referred by:
    ☐☐☐ _____

    10.2. Date of referral:
    ☐☐-☐☐-☐☐ (M/D/Y)

    10.3. Referred to:
    - MD/Clinic: _____
    - Address: _____
    - _____
    - Phone: _____

11. Repeat mammogram recommended:
    - ☐ 1 Immediately/ASAP
    - ☐ 2 Less than one year
    - ☐ 3 One year
    - ☐ 4 Two years
    - ☐ 8 Other *(Specify)*: _____
    _____

12. Final Follow-Up Results:

	Right	**Left**
Normal	☐ 0	☐ 0
Benign changes	☐ 1	☐ 1
Possibly malignant	☐ 2	☐ 2
Cancer	☐ 3	☐ 3

K _____ V _____

COMMENTS:	**- Affix label here-** Participant ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

1. Contact date: ☐☐-☐☐-☐☐☐☐ (M/D/Y)

2. Staff person: ☐☐-☐☐☐☐☐☐ _____

3. Date of mammogram: ☐☐-☐☐-☐☐☐☐ (M/D/Y)

4. Performed by:

   MD Name: _____

   Clinic Name: _____

   Address: _____

   City/State/Zip: _____

   Phone: _____

5. Date mammogram report reviewed: ☐☐-☐☐-☐☐☐☐ (M/D/Y)

6. Report reviewed by: ☐☐-☐☐☐☐☐☐ _____

7. Summary of mammogram report *(Mark one in each column)*:

	7.1. **Right**	7.2. **Left**
Negative	☐ 0	☐ 0
Benign finding - negative	☐ 1	☐ 1
Probably benign finding - short interval follow-up suggested	☐ 2	☐ 2
Suspicious abnormality - biopsy should be considered	☐ 3	☐ 3
Highly suggestive of malignancy	☐ 4	☐ 4
Not done	☐ 9	☐ 9

RV _____ K _____

OMB # 0925-0414 Exp: 4/06

- Affix label here-

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

First Name _____M.I._____

Last Name _____

1. Date of exam: ⌊__⌋⌊__⌋-⌊__⌋⌊__⌋-⌊__⌋⌊__⌋ (M/D/Y)

2. Performed by: ⌊__⌋⌊__⌋

3. Contact type:

- ☐ 3 Visit
- ☐ 8 Other

4. Visit type:

- ☐ 1 Screening #⌊__⌋
- ☐ 2 Semi-Annual #⌊__⌋⌊__⌋
- ☐ 3 Annual #⌊__⌋⌊__⌋
- ☐ 4 Non-Routine

Performance Measures

5. Grip strength:

5.1. Side tested:

- ☐ 1 Right
- ☐ 2 Left
- ☐ 3 Attempted, unable to complete on either side
- ☐ 8 Refused
- ☐ 9 Not attempted for safety or health reasons

5.2. Dominance of hand used:

- ☐ 1 Dominant
- ☐ 2 Non-dominant

5.3. Measurement #1: ⌊__⌋⌊__⌋ kg

5.4. Measurement #2: ⌊__⌋⌊__⌋ kg

6. Single chair stand:

- ☐ 1 Test completed, arises without using her arms
- ☐ 2 Test completed, arises using her arms
- ☐ 3 Attempted, unable to rise from chair
- ☐ 8 Refused
- ☐ 9 Not attempted for safety or health reasons

Repeated chair stands in 15 seconds:

6.1. ⌊__⌋⌊__⌋ stands

6.2. ⌊__⌋⌊__⌋ stands

7. Timed walk:

- ☐ 1 Test completed or partially completed
- ☐ 2 Attempted, unable to complete one trial
- ☐ 8 Refused
- ☐ 9 Not attempted for safety or health reasons

7.1. Time: ⌊__⌋⌊__⌋.⌊__⌋ seconds

7.2. Time: ⌊__⌋⌊__⌋.⌊__⌋ seconds

7.3. Assistive device used?

- ☐ 0 No
- ☐ 1 Yes

K _____ V _____

Comments:	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

1. Contact date: ☐☐-☐☐-☐☐ (M/D/Y)

2. Completed by: ☐☐☐ _____

3. Contact type:
   - ☐ 1 Phone
   - ☐ 2 Mail
   - ☐ 3 Visit
   - ☐ 8 Other

4. Visit type:
   - ☐ 2 Semi-Annual #☐☐
   - ☐ 3 Annual #☐☐
   - ☐ 4 Non-Routine

5. Pap smear collected by:
   - ☐ 1 CC staff
   - ☐ 2 Other ↓

   MD Name _____
   Clinic Name: _____
   Address _____
   City/State/Zip _____

6. Date collected: ☐☐-☐☐-☐☐ (M/D/Y)

7. Date Pap smear report reviewed: ☐☐-☐☐-☐☐ (M/D/Y)

8. Report reviewed by: ☐☐☐ _____

9. Cells present:

	No	Yes
9.1. Endometrial cells?	☐ 0	☐ 1
9.2. Atypical endocervical cells?	☐ 0	☐ 1
9.3. Atypical squamous cells?	☐ 0	☐ 1
9.4. If cervix present, endocervical cells? (No cervix ____)	☐ 0	☐ 1

10. Results: *(Mark one.)*
    - ☐ 1 Normal (no atypical cells)

    If dysplasia category available:
    - ☐ 2 Abnormal, mild dysplasia, atypia
    - ☐ 3 Abnormal, moderate dysplasia
    - ☐ 4 Abnormal, severe dysplasia

    If Bethesda criteria available:
    - ☐ 5 Abnormal, low grade SIL, atypia
    - ☐ 6 Abnormal, high grade SIL

    Other:
    - ☐ 10 ASCUS
    - ☐ 11 AGUS/AGCUS
    - ☐ 7 Cancer
    - ☐ 8 Insufficient specimen, no results
    - ☐ 9 Slides damaged, cannot be read

11. Was a referral made for follow-up care?
    - ☐ 0 No
    - ☐ 1 Yes ↓

    11.1. Referred by: ☐☐☐ _____
    11.2. Date of referral: ☐☐-☐☐-☐☐ (M/D/Y)
    11.3. Referred to:
    MD/Clinic: _____
    Address: _____
    City, State, Zip _____
    Phone: _____

12. Final Follow-up Results (Mark one):
    - ☐ 1 Normal
    - ☐ 2 Mild dysplasia, low grade SIL, atypical cells
    - ☐ 3 Moderate to severe dysplasia, high grade SIL, CIS, cancer

K _____ V _____

OMB # 0925-0414 Exp: 4/06

- Affix label here-

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

First Name _____M.I._____

Last Name _____

BLOOD REQUEST *(Mark one.)* ___HRT ___DM ___HRT + DM ___OS

Blood Collection Tube		Three 7 ml Royal Blue		Two 4.5 ml Light Blue		One 10 ml Lavender			One 2 ml Lavender
Cryovials		Four 1.8 ml Serum	Trig. 0.5 ml Serum	Coag Panel Three 1.8 ml Plasma	One 1.8 Buffy coat	Lipid Panel Three 1.8 ml Plasma	1 RBC	1 Buffy Coat	CBC
Study	Visit								
CT/OS	SV1	X	HRT if Lipemic	X	X	X	X	X	X
CT	1st Annual	X	HRT if Lipemic	X	X	X	X	X	
CT	Subsample at 3rd, 6th, and 9th Annual	X	HRT if Lipemic	X		X			
OS	3 Year	X		X	X	X	X	X	X

BLOOD COLLECTION

1. Date blood drawn: ___-___-___ (M/D/Y)
2. Drawn by: ___
3. Contact type: ☐ 1 Phone ☐ 3 Visit ☐ 2 Mail ☐ 8 Other
4. Visit type: ☐ 1 Screening #___ ☐ 2 Semi-Annual #___ ☐ 3 Annual #___ ☐ 4 Non-Routine
5. Time drawn: ___ : ___ (Hr:Min) ☐ 1 AM ☐ 2 PM

BLOOD COLLECTION CHECKLIST

6. **"How long since you had anything to eat or drink besides water?"** ___ hours
   (If you are drawing for a lipid panel and this is less than 12 hours, do not draw blood. Arrange a time when the woman can come in for a fasting blood draw.)

7.1. **"Have you engaged in any vigorous physical activity in the last eight hours?"** ☐ 0 No ☐ 1 Yes

7.2. **"Have you taken any aspirin or anti-inflammatory agents in the last 48 hours?"** ☐ 0 No ☐ 1 Yes

8. WHI blood sample number: - Affix blood sample "Form" label here and on back of form -

K_____

BLOOD PROCESSING

9. Processed by: ⌊___⌋

10. Time began centrifugation: ⌊__:__⌋ (Hr:Min) ☐1 AM ☐2 PM

11. **For HRT and HRT + DM Screening Visits and Annual Visits Only:** Is serum in royal blue tube lipemic?
☐0 No
☐1 Yes → Process aliquot for triglyceride level

12. Time sample placed in cryovials: ⌊__:__⌋ (Hr:Min) ☐1 AM ☐2 PM

13. Time cryovials placed in freezer: ⌊__:__⌋ (Hr:Min) ☐1 AM ☐2 PM

14. WHI blood sample number: - Affix blood sample "Form" label here -

Orig Tube Color	Cryovial Color/Test	15. Cryovial Number	16. Mark if Sample Processed
Royal Blue	Orange	02	☐1
Royal Blue	Orange	03	☐1
Royal Blue	Orange	04	☐1
Royal Blue	Orange	05	☐1
Light Blue	Blue	06	☐1
Light Blue	Blue	07	☐1
Light Blue	Blue	08	☐1
Royal Blue 7ml	Trig (0.5 ml)	09	☐1
Lavender 10ml	Yellow	10	☐1
Lavender 10ml	Yellow	11	☐1
Lavender 10ml	Yellow	12	☐1
Lavender 10ml	White (Buffy Coat)	13	☐1
Lavender 10ml	Red (RBC)	14	☐1
Lavender 2 ml	CBC	16	☐1
Light Blue 10 ml	White (Buffy Coat)	20	☐1

OMB #0925-0414 Exp: 5/03

COMMENTS

-Affix label here-

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

First Name _____M.I._____

Last Name _____

1. Contact date: ☐☐-☐☐-☐☐ (M/D/Y)
2. Completed by: ☐☐☐
3. Contact type:
   - ☐ 1 Phone
   - ☐ 3 Visit
   - ☐ 2 Mail
   - ☐ 8 Other
4. Visit type:
   - ☐ 2 Semi-Annual #☐☐
   - ☐ 3 Annual #☐☐
   - ☐ 4 Non-Routine
5. What is the date of death? ☐☐ - ☐☐ - ☐☐ (M/D/Y)
6. Source of notification: ***(Mark one.)***
   - ☐ 1 Family member
   - ☐ 2 Friend/associate of deceased
   - ☐ 3 Personal physician
   - ☐ 8 Other

6.1. Name, address and phone number of the source.

Provider ID ☐☐☐☐☐

Name: _____

Address: _____

_____

Phone Number: (____) _____

7. Did the death occur in a medical institution (i.e., hospital, long term care facility, hospice)?
   - ☐ 0 No
   - ☐ 1 Yes ↓
   - ☐ 9 Unknown

7.1. Name, address and phone number of the medical institution (i.e., hospital, long term care facility, hospice).

Provider ID ☐☐☐☐☐

Hospital Name: _____

City/State: _____

Phone Number: (____) _____

8. Location and address of death, if death did not occur in a hospital/medical institution.

Location: _____

Address: _____

_____

RV_____KE_____

9. Was an autopsy done?

☐ 0 No ☐ 1 Yes ☐ 9 Unknown

↓

9.1. Name, address and phone number where autopsy was performed. Provider ID

Name: _____

Address: _____

_____

Phone Number: (____) _____

10. Where was the death certificate obtained?

☐ 1 Coroner/Medical Examiner
☐ 2 Personal physician
☐ 3 Vital Statistics Office
☐ 8 Other ***(Specify):*** _____
☐ 9 Unknown

10.1. Name, address and phone number of individual providing the death certificate. Provider ID

Name: _____

Address: _____

_____

Phone Number: (____) _____

11. (Ask of source): **To the best of your knowledge, what was the underlying cause of death?**

_____

_____

12. On the basis of currently available data, what was the underlying cause of death? ***(Mark one.)***

Cancer

☐ 1 Breast
☐ 2 Ovarian
☐ 3 Endometrial
☐ 4 Colon
☐ 5 Rectosigmoid junction
☐ 6 Rectum
☐ 7 Uterus
☐ 8 Other cancer _____
☐ 9 Unknown cancer site

Cardiovascular Disease

☐ 11 Coronary Heart Disease (CHD)
☐ 12 Cerebrovascular disease
☐ 13 Pulmonary Embolism
☐ 18 Other cardiovascular disease _____
☐ 19 Unknown cardiovascular disease

Accident/Injury

☐ 21 Homicide
☐ 22 Accident
☐ 23 Suicide
☐ 28 Other Injury _____

"Other" Cause of Death

☐ 88 Other cause of death, known _____
☐ 99 Unknown cause of death

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-Affix label here-

Member ID: __ __ __ __ - ___ ___ ___ - __

First Name _____M.I._____

Last Name _____

Contact date: ☐☐-☐☐-☐☐ (M/D/Y)

Completed by: ☐☐-☐☐☐☐

Contact type: ☐1 Phone ☐2 Mail ☐8 Other

1. **What is the date of death?** ☐☐ - ☐☐ - ☐☐ (M/D/Y)

2. Source of notification: ***(Mark one.)***

☐1 Family member ☐4 NDI (CCC use only)

☐2 Friend/associate of deceased ☐8 Other _____

☐3 Personal physician

2.1. Name, address and phone number of the source.

Name: _____

Address: _____

_____

Phone Number: (____) _____

Provider ID ☐☐☐☐☐

3. **Did the death occur in a hospital/medical institution (i.e., hospital, long term care facility, hospice)?**

☐0 No ☐1 Yes ☐9 Unknown → **Go to Page 2.**

3.1. Name, address and phone number of the hospital/medical institution (i.e., hospital, long term care facility, hospice).

Hospital Name: _____

City/State: _____

Phone Number: (____) _____

Provider ID ☐☐☐☐☐

Go to Page 2.

3.2. Location and address of death, if death did not occur in a hospital/medical institution.

Location: _____

Address: _____

_____

RV_____K_____V_____

4. **Was an autopsy done?**

☐ 0 No ☐ 1 Yes

☐ 9 Unknown

4.1. Name, address and phone number where autopsy was performed.

Name: _____

Address: _____

_____

Phone Number: (____) _____

Provider ID

5. **Where will the death certificate be obtained?**

☐ 1 Coroner/Medical Examiner

☐ 2 Personal physician

☐ 3 Vital Statistics Office

☐ 8 Other ***(Specify):*** _____

☐ 9 Unknown

5.1. Name, address and phone number of individual providing the death certificate.

Name: _____

Address: _____

_____

Phone Number: (____) _____

Provider ID

6. (Ask of source): **To the best of your knowledge, what was the underlying cause of death?**

_____

_____

7. On the basis of currently available data, what was the underlying cause of death? ***(Mark one.)***

Cancer

☐ 1 Breast
☐ 2 Ovarian
☐ 3 Endometrial
☐ 4 Colon
☐ 5 Rectosigmoid junction
☐ 6 Rectum
☐ 7 Uterus
☐ 10 Lung
☐ 8 Other cancer
_____
☐ 9 Unknown cancer site

Cardiovascular Disease

☐ 11 Coronary Heart Disease (CHD)
☐ 12 Cerebrovascular disease
☐ 13 Pulmonary Embolism
☐ 18 Other cardiovascular disease
_____
☐ 19 Unknown cardiovascular disease

Accident/Injury

☐ 21 Homicide
☐ 22 Accident
☐ 23 Suicide
☐ 28 Other Injury _____

"Other" Cause of Death

☐ 31 Alzheimer's Disease
☐ 32 COPD
☐ 33 Pneumonia
☐ 34 Pulmonary Fibrosis
☐ 35 Renal Failure
☐ 36 Sepsis
☐ 88 Another cause of death, known
_____
☐ 99 Unknown cause of death

OMB# 0925-0414 Exp: 4/06

COMMENTS	**-Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
To be completed by Physician Adjudicator Date Completed: ⌊__⌋⌊__⌋-⌊__⌋⌊__⌋-⌊__⌋⌊__⌋ (M/D/Y) Adjudicator Code: ⌊__⌋⌊__⌋⌊__⌋	*To be completed by Outcomes Specialist:* Staff person: ⌊__⌋⌊__⌋⌊__⌋ Adjudication Case No.: ⌊__⌋⌊__⌋⌊__⌋

(For items 1-11, each question specifies "mark one" or "mark all" that apply.)

Complete ECG and cardiac enzyme information for the following WHI outcomes:
Myocardial infarction (MI), coronary death [hospitalized], angina, CHF, and coronary revascularization

1. ECG pattern: ***(Mark the <u>one</u> category that applies best.)***

☐ 1 Evolving Q-wave and evolving ST-T abnormalities
☐ 2 Equivocal Q-wave evolution; or evolving ST-T abnormalities; or <u>new</u> left bundle branch block
☐ 3 Q-waves or ST-T abnormalities suggestive of an MI and not classified as code 1 or 2 above
☐ 8 Other ECG pattern, ECG uncodable, or normal ECG pattern
☐ 9 ECG not available

2. Cardiac enzyme information available?

☐ 0 No ***(Skip to Question 3 on page 3.)***
☐ 1 Yes

2.1. Serum creatine kinase (CK): ***(Mark all that apply.) (Always record % or index if available.)***

If CK-MB available:

CK-MB expressed as a % or index: (*Record peak results only.*)

☐ 1 CK-MB at least 2x upper limit of normal for % or index
☐ 2 CK-MB greater than upper limit of normal but less than 2x upper limit of normal for % or index
☐ 3 CK-MB within normal limits for % or index

CK-MB expressed in units (usually ng/ml): *(Record peak results only.)*

☐ 4 CK-MB at least 2x upper limit of normal for units
☐ 5 CK-MB greater than upper limit of normal but less than 2x upper limit of normal for units
☐ 6 CK-MB within normal limits for units

No units or % index given for CK-MB:

☐ 7 CK-MB reported as "present" without quantification
☐ 8 CK-MB reported as "weakly present" without quantification

RV_____KE_____

If CK-MB not available:

☐ 9 Total CK at least 2x upper limit of normal

☐ 10 Total CK greater than upper limit of normal but less than 2x upper limit of normal

☐ 11 Total CK within normal limits

☐ 99 CK result not available

2.2. Serum lactate dehydrogenase (LDH): ***(Mark the <u>one</u> category that applies best.) (Complete only if no other cardiac enzymes are available.)***

If LDH1 and LDH2 available:

☐ 1 LDH1 ≥ LDH2

☐ 2 LDH1 < LDH2

If LDH1 available and LDH2 missing or absent:

☐ 3 LDH1 at least 2x upper limit of normal

☐ 4 LDH1 greater than upper limit of normal but less than 2x upper limit of normal

☐ 5 LDH1 within normal limits

If LDH1 not available:

☐ 6 Total LDH at least 2x upper limit of normal

☐ 7 Total LDH greater than upper limit of normal but less than 2x upper limit of normal

☐ 8 Total LDH within normal limits

☐ 9 LDH result not available

2.3. Troponin lab test. **(*Mark the <u>one</u> category that applies best*.) (If more than one test was conducted, record the type with the most elevated lab result.)**

☐ 1 Troponin C

☐ 2 Troponin I

☐ 3 Troponin T

☐ 4 Troponin, not specified

☐ 9 Troponin not available ***(Skip to Question 2.4 below.)***

2.3.1 Results ***(Mark the <u>one</u> category that applies best.)*** Troponin values should be coded using the upper limit of normal (ULN) and not upper limit of indeterminate/indecisive as the reference value. Thus, if 2 cutpoints are given, choose the lower cutpoint for the upper limit of normal.

☐ 1 Troponin at least 2x upper limit of normal

☐ 2 Troponin greater than upper limit of normal but less than 2x upper limit of normal

☐ 3 Troponin within normal limits

☐ 9 Other

2.4. "Other" cardiac-specific lab: (write in) _____

2.4.1 Results ***(Mark the <u>one</u> category that applies best.)***

☐ 1 At least 2x upper limit of normal

☐ 2 Greater than upper limit of normal but less than 2x upper limit of normal

☐ 3 Within normal limits

☐ 9 Other

Yes ☐ 1 **No** ☐ 0 **3. Definite, probable, or aborted myocardial infarction (See MOOP *Vol. 8, Table 5.1 – Definition of Criteria for Diagnosis of Myocardial Infarction.*)**

3.1. Date of admission: ___ - ___ - ___ (M/D/Y)

3.2. Diagnosis: ***(Mark one.)***

☐ 1 Myocardial infarction not occurring as a result of or during a procedure*

☐ 2 Myocardial infarction during or resulting from a procedure*

*An MI is defined as procedure-related if it occurs within 30 days after any procedure. This includes any vascular procedure (regardless of type of anesthesia) plus all other procedures requiring more than local anesthesia.

3.3. Cardiac pain defined as: an acute episode of pain, discomfort or tightness in the chest, arm, throat or jaw: ***(Mark the one category that applies best.)***

☐ 1 Present

☐ 2 Absent

☐ 9 Unknown/Not recorded

3.4. Was a thrombolytic agent administered or emergent* revascularization procedure (e.g., angioplasty or stent) performed?

*An emergent revascularization is conducted within 12 hours of symptom onset; code both here and in Q7. Non-emergent revascularization procedures are coded only under Q7. Examples of thrombolytic agents are streptokinase, tPA, reteplase (Retavase), tenecteplase (TNKase), alteplase tPA (Activase).

☐ 0 No ***(Skip to Question 3.5 below.)***

☐ 1 Yes

☐ 9 Unknown

3.4.1 Was the myocardial infarction aborted? (*Diagnosis of an aborted MI requires*: symptoms and ECG evidence for acute MI at presentation; intervention [thrombolytic therapy or a procedure] followed by resolution of ECG changes; and all cardiac enzymes within normal limits.)

☐ 0 No

☐ 1 Yes

☐ 9 Unknown

3.5. Was the myocardial infarction fatal?

☐ 0 No

☐ 1 Yes ***(Complete Question 4 below [for hospitalized deaths only] and Form 124 - Final Report of Death.)***

For hospitalized deaths only:

Yes ☐ 1 **No** ☐ 0 **4. Coronary death *(Complete Form 124 - Final Report of Death.)***

4.1. Date of Death: ___ - ___ - ___ (M/D/Y)

4.2. Diagnosis: _____

Yes ☐1 No ☐0 **5.** **Angina pectoris (including unstable angina) requiring and/or occurring during hospitalization.** Chest pain, tightness, or shortness of breath produced by myocardial ischemia that does not result in infarction (usually caused by coronary insufficiency).

5.1. Date of Admission ☐☐ - ☐☐ - ☐☐ (M/D/Y)

5.2. **Angina pectoris (including unstable angina) based on:** ***(Mark all that apply.)***

☐1 Physician diagnosis of angina and receiving medical treatment at discharge, for angina on this admission (e.g., nitrate, beta-blocker, or calcium-channel blocker)

☐2 Physician diagnosis of angina and receiving medical treatment for angina on this admission **plus** current medical record documenting a history of coronary heart disease by previous catheterization or revascularization procedure

☐3 CABG surgery or other revascularization procedure on this admission. ***(Complete Question 7 also.)***

☐4 70% or greater obstruction of any coronary artery on angiography on this admission

☐5 Horizontal or down-sloping ST-segment depression or abnormal ST elevation ≥ 1 mm on exercise or pharmacological stress testing with pain on this admission

☐6 Scintigraphic or echocardiographic stress test positive for ischemia on this admission

☐7 Resting ECG shows horizontal or down-sloping ST depression or abnormal ST elevation ≥ 1 mm with pain that is not present on ECG without pain on this admission

Yes ☐1 No ☐0 **6.** **Congestive heart failure requiring and/or occurring during hospitalization.** (Physician diagnosis of new-onset or worsened congestive heart failure on this admission.)

6.1. Date of Admission ☐☐ - ☐☐ - ☐☐ (M/D/Y)

6.2. Congestive heart failure based on one or more of the following: ***(Mark all that apply.)***

☐1 Congestive failure diagnosed by physician and receiving medical treatment for CHF on this admission (e.g., diuretic, digitalis, vasodilator and/or angiotensin-converting enzyme inhibitor)

☐2 Congestive failure diagnosed by physician and receiving medical treatment on this admission **plus** current medical record documents a history of an imaging procedure showing impaired systolic or diastolic LV function

☐3 Pulmonary edema\congestion by chest X-ray on this admission

☐4 On this admission, dilated ventricle or poor left (or right-side) ventricular function (e.g., wall motion abnormalities) by echocardiography; radionuclide ventriculogram (RVG)/multigated acquisition (MUGA), or other contrast ventriculography, or evidence of left ventricular diastolic dysfunction

6.3. Was the congestive heart failure fatal? (Mark one.)

☐0 No, non-fatal

☐1 Yes, fatal ***(Complete Question 4 on page 3 of this form and Form 124 - Final Report of Death.)***

Yes ☐1 No ☐0 7. **Coronary revascularization on this admission**

7.1. Date of Admission: ___ - ___ - ___ (M/D/Y)

7.2. **Type of procedure:** Any one of the following procedures aimed at improving cardiac status ***(Mark all that apply.)***

☐1 Coronary artery bypass graft (CABG)

☐2 Percutaneous transluminal coronary angioplasty (PTCA), coronary stent, or coronary atherectomy

7.3. Second myocardial infarction (MI) (i.e., second MI not already reported in Question 3) occurring as a result of or during the revascularization procedure. ***(Mark one.)***

☐0 No

☐1 Yes

☐2 Unknown

Yes ☐1 No ☐0 **8.** **Stroke requiring and/or occurring during hospitalization:** Rapid onset of a persistent neurologic deficit attributable to an obstruction or rupture of the arterial system (including stroke occurring during **or resulting from a procedure***). Deficit is not known to be secondary to brain trauma, tumor, infection, or other cause. Deficit must last more than 24 hours, unless death supervenes or there is a demonstrable lesion compatible with acute stroke on CT or MRI scan.

*A stroke is defined as procedure-related if it occurs within 24 hours after any procedure or within 30 days after a cardioversion or invasive cardiovascular procedure.

8.1. Date of Admission: ___ - ___ - ___ (M/D/Y)

8.2. Diagnosis: ***(Mark the one category that applies best.)***

Hemorrhagic Stroke

☐1 Subarachnoid hemorrhage not resulting from a procedure

☐2 Intraparenchymal hemorrhage not resulting from a procedure

☐3 Other or unspecified intracranial hemorrhage (not resulting from a procedure) (nontraumatic epidural hemorrhage or subdural hemorrhage)

Ischemic Stroke

☐4 Occlusion of cerebral or pre-cerebral arteries with infarction not resulting from a procedure (cerebral thrombosis, cerebral embolism, lacunar infarction)

Other

☐5 Acute, but ill-defined, cerebrovascular disease not resulting from a procedure

☐6 Central nervous system complications during or resulting from a procedure

8.3. **Stroke diagnosis based on:** ***(Mark the one category that applies best.)***

- ☐ 1 Rapid onset of neurological deficit and CT or MRI scan shows acute focal brain lesion consistent with neurological deficit and without evidence of blood (except mottled cerebral pattern)
- ☐ 2 Rapid onset of localizing neurological deficit with duration ≥ 24 hours but imaging studies are not available
- ☐ 3 Rapid onset of neurological deficit with duration ≥ 24 hours and the only available CT or MRI scan was done early and shows no acute lesion consistent with the neurologic deficit
- ☐ 4 Surgical evidence of ischemic infarction of brain
- ☐ 5 CT or MRI findings of blood in subarachnoid space or intra-parenchymal hemorrhage, consistent with neurological signs or symptoms
- ☐ 6 Positive lumbar puncture (for subarachnoid hemorrhage)
- ☐ 7 Surgical evidence of subarachnoid or intra-parenchymal hemorrhage as the cause of a clinical syndrome consistent with stroke
- ☐ 8 None of the above (e.g., fatal strokes where no imaging studies or clinical evidence are available; or CT/MRI does not show lesion consistent with the neurologic deficit)

8.4. **If stroke fatal:** ***(Mark all that apply.) (Complete Form 124 - Final Report of Death.)***

- ☐ 1 Hospitalized stroke within 28 days of death
- ☐ 2 Previous stroke and no known potentially lethal non-cerebrovascular disease process
- ☐ 3 Stroke diagnosed as cause of death at post-mortem examination
- ☐ 4 Stroke listed as underlying cause of death on death certificate

8.5. **Participant's functional status at the time of hospital discharge (Glasgow Outcome Scale):** ***(Mark the one category that applies best.)***

- ☐ 1 Good recovery – Patient can lead a full and independent life with or without minimal neurological deficit
- ☐ 2 Moderately disabled – Patient has neurological or intellectual impairment but is independent
- ☐ 3 Severely disabled – Patient conscious but dependent on others to get through daily activities
- ☐ 4 Vegetative survival – Has no obvious cortical functioning
- ☐ 5 Dead
- ☐ 6 Unable to categorize stroke based on available case packet documentation

Yes ☐ 1 **No** ☐ 0 **9.** **Transient ischemic attack requiring and/or occurring during hospitalization:** One or more episodes of a focal neurologic deficit lasting more than 30 seconds and no longer than 24 hours. Rapid evolution of the symptoms to the maximal deficit in less than 5 minutes, with subsequent complete resolution. No head trauma occurring immediately before the onset of the neurological event.

9.1. Date of Admission ☐☐ - ☐☐ - ☐☐ (M/D/Y)

Yes ☐ 1 **No** ☐ 0 **10.** **Carotid artery disease requiring and/or occurring during hospitalization.** Disease must be **symptomatic and/or requiring intervention** (i.e., vascular or surgical procedure).

10.1. Date of Admission: ☐☐ - ☐☐ - ☐☐ (M/D/Y)

10.2. Diagnosis: ***(Mark one.)***

☐ 1 Carotid artery occlusion and stenosis without documentation of cerebral infarction

☐ 2 Carotid artery occlusion and stenosis with written documentation of cerebral infarction

10.3. **Carotid artery disease based on** (Hospitalization plus one or more of the following): ***(Mark all that apply.)***

☐ 1 Symptomatic disease with carotid artery disease listed on the hospital discharge summary

☐ 2 Symptomatic disease with abnormal findings (≥ 50% stenosis) on carotid angiogram or doppler flow study

☐ 3 Vascular or surgical procedure to improve flow to the ipsilateral brain

Yes ☐ 1 **No** ☐ 0 **11. Peripheral arterial disease (aorta, iliac arteries, or below) requiring and/or occurring during hospitalization.** Symptomatic disease including intermittent claudication, ischemic ulcers, or gangrene. Disease must be **symptomatic and/or requiring intervention** (e.g., vascular or surgical procedure for arterial insufficiency in the lower extremities or abdominal aortic aneurysm).

11.1. Date of Admission: ___ - ___ - ___ (M/D/Y)

11.2. Diagnosis: ***(Mark the one category that applies best.)***

☐ 1 Lower extremity claudication

☐ 2 Atherosclerosis of arteries of the lower extremities

☐ 3 Arterial embolism and/or thrombosis of the lower extremities

☐ 4 Abdominal aortic aneurysm (AAA)

11.3. **Peripheral arterial disease based on:** Defined by hospitalization plus one or more of the following: ***(Mark all that apply.)***

☐ 1 Ultrasonographically- or angiographically-demonstrated obstruction, or ulcerated plaque (≥ 50% of the diameter or ≥ 75% of the cross-sectional area) demonstrated on ultrasound or angiogram of the iliac arteries or below

☐ 2 Absence of pulse by doppler in any major vessel of lower extremities

☐ 3 Exercise test that is positive for lower extremity claudication

☐ 4 Surgery, angioplasty, or thrombolysis for peripheral arterial disease

☐ 5 Amputation of one or more toes or part of the lower extremity because of ischemia or gangrene

☐ 6 Exertional leg pain relieved by rest and at least one of the following: (1) claudication diagnosed by physician, or (2) ankle-arm systolic blood pressure ratio ≤ 0.8

☐ 7 Ultrasonographically- or angiographically-demonstrated abdominal aortic aneurysm

☐ 8 Surgical or vascular procedure for abdominal aortic aneurysm

_____

Responsible Adjudicator Signature

NOTE: If this is a hospitalized event, Form 125 - Summary of Hospitalization Diagnoses must be completed and any other WHI outcomes adjudicated

Form 121 - Report of Cardiovascular Outcome Ver. 8.1

OMB# 0925-0414 Exp: 05/12

COMMENTS	-Affix label here- Member ID: __ __ __ __ - ___ ___ ___ - __
To be completed by Physician Adjudicator Date Completed: ☐☐-☐☐-☐☐ (M/D/Y) Adjudicator Code: ☐☐-☐☐☐	Central Case No.: ☐☐☐☐☐☐ Case Copy No.: ☐☐

(For items 1-8, each question specifies "mark one" or "mark all" that apply.)

Complete Q1 - ECG, Q2 - cardiac enzyme, and Q3 - cardiac pain information for the following WHI Extension Study outcomes: Myocardial infarction (MI), coronary death [hospitalized], and coronary revascularization

1. ECG pattern: ***(Mark the one category that applies best.)***

- ☐ 1 Evolving Q-wave and evolving ST-T abnormalities
- ☐ 2 Equivocal Q-wave evolution; or evolving ST-T abnormalities; or new left bundle branch block
- ☐ 3 Q-waves or ST-T abnormalities suggestive of an MI and not classified as code 1 or 2 above
- ☐ 8 Other ECG pattern, ECG uncodable, or normal ECG pattern
- ☐ 9 ECG not available

2. Cardiac enzyme information available?

- ☐ 0 No ⟶ ***Skip to Question 3 on page 2.***
- ☐ 1 Yes

2.1. Serum creatine kinase (CK): ***(Mark all that apply.) (Always record % or index if available.)***

If CK-MB available:

CK-MB expressed as a % or index: (*Record peak results only.*)

- ☐ 1 CK-MB at least 2x upper limit of normal for % or index
- ☐ 2 CK-MB greater than upper limit of normal but less than 2x upper limit of normal for % or index
- ☐ 3 CK-MB within normal limits for % or index

CK-MB expressed in units (usually ng/ml): *(Record peak results only.)*

- ☐ 4 CK-MB at least 2x upper limit of normal for units
- ☐ 5 CK-MB greater than upper limit of normal but less than 2x upper limit of normal for units
- ☐ 6 CK-MB within normal limits for units

If CK-MB not available:

- ☐ 9 Total CK at least 2x upper limit of normal
- ☐ 10 Total CK greater than upper limit of normal but less than 2x upper limit of normal
- ☐ 11 Total CK within normal limits
- ☐ 99 CK result not available

2.2. Troponin lab test. ***(Mark the one category that applies best.)*** **(If more than one test was conducted, record the type with the most elevated lab result.)**

☐ 1 Troponin C
☐ 2 Troponin I
☐ 3 Troponin T
☐ 4 Troponin, not specified
☐ 9 Troponin not available → ***Skip to Question 3 below.***

2.2.1 Results ***(Mark the one category that applies best.)*** Troponin values should be coded using the upper limit of normal (ULN) and not upper limit of indeterminate/indecisive as the reference value. Thus, if 2 cutpoints are given, choose the lower cutpoint for the upper limit of normal.

☐ 1 Troponin at least 2x upper limit of normal
☐ 2 Troponin greater than upper limit of normal but less than 2x upper limit of normal
☐ 3 Troponin within normal limits
☐ 9 Other

3. Cardiac pain defined as: an acute episode of pain, discomfort or tightness in the chest, arm, throat or jaw: ***(Mark the one category that applies best.)***

☐ 1 Present
☐ 2 Absent
☐ 9 Unknown/Not recorded

Yes ☐ 1 **No** ☐ 0 **4. Definite, probable, or aborted myocardial infarction (See excerpts from *Table 8.5.1 – Definition of Criteria for Diagnosis of Myocardial Infarction* and *Table 8.5.2 – Algorithm for Enzyme Diagnostic Criteria* on the last page of this form.)**

4.1. Date of admission: ___ - ___ - ___ (M/D/Y)

4.2. Diagnosis: ***(Mark one.)***

☐ 1 Myocardial infarction not occurring as a result of or during a procedure → ***Skip to Question 4.3 on the next page.***

☐ 2 Myocardial infarction during or resulting from a procedure, i.e., within 30 days of any procedure.

4.2.1. Type of Procedure ***(Mark one.)***

☐ 1 A myocardial infarction that followed a cardiac procedure within 24 hours (for example, diagnostic coronary catheterization, percutaneous coronary intervention, CABG, pacemaker insertion, or cardioversion).

☐ 2 A myocardial infarction that followed a cardiac procedure within 2-30 days (for example, diagnostic coronary catheterization, percutaneous coronary intervention, CABG, pacemaker insertion, or cardioversion).

☐ 3 A myocardial infarction that followed a non-cardiac procedure within 30 days (for example, any elective or emergency non-cardiac vascular procedure regardless of type of anesthesia, or any elective or emergency surgical procedure requiring more than local anesthesia).

4.3 Was a thrombolytic agent administered or emergent* revascularization procedure (e.g., angioplasty or stent) performed? ***(Mark one.)***

*An emergent revascularization is conducted within 12 hours of symptom onset; code both here and in Q6. Non-emergent revascularization procedures are coded only under Q6. Examples of thrombolytic agents are streptokinase, reteplase (Retavase), tenecteplase (TNKase), alteplase tPA (Activase).

☐ 0 No
☐ 1 Yes
☐ 9 Unknown

4.4. Was the myocardial infarction fatal? ***(Mark one.)***

☐ 0 No
☐ 1 Yes ***(Complete Question 5 below [for hospitalized deaths only] and Form 124 - Final Report of Death.)***

For <u>hospitalized</u> deaths only:

Yes **No**
☐ 1 ☐ 0 **5. Coronary death *(Complete Form 124 - Final Report of Death.*)**

5.1. Date of Death: ___ - ___ - ___ (M/D/Y)

5.2. Diagnosis: _____

Yes **No**
☐ 1 ☐ 0 **6. Coronary revascularization**

6.1. Date of Admission/Procedure: ___ - ___ - ___ (M/D/Y)

6.2. **Type of procedure:** Any one of the following procedures aimed at improving cardiac status ***(Mark all that apply.)***

☐ 1 Coronary artery bypass graft (CABG)
☐ 2 Percutaneous transluminal coronary angioplasty (PTCA), coronary stent, or coronary atherectomy

6.3. Second myocardial infarction (MI) (i.e., second MI <u>not</u> already reported in Question 4) occurring as a result of or during the revascularization procedure. ***(Mark one.*)**

☐ 0 No
☐ 1 Yes
☐ 2 Unknown

Yes ☐1 **No** ☐0 **7. Carotid artery disease requiring and/or occurring during hospitalization.** Disease must be **symptomatic and/or requiring intervention** (i.e., vascular **or** surgical **procedure**).

7.1. Date of Admission: ☐☐ - ☐☐ - ☐☐ (M/D/Y)

7.2. Diagnosis: ***(Mark one.)***

- ☐1 Carotid artery occlusion and stenosis without documentation of cerebral infarction
- ☐2 Carotid artery occlusion and stenosis with documentation of cerebral infarction

7.3. **Carotid artery disease based on** (Hospitalization plus one or more of the following): ***(Mark all that apply.)***

- ☐1 Symptomatic disease with carotid artery disease listed on the hospital discharge summary
- ☐2 Symptomatic disease with abnormal findings (≥ 50% stenosis) on carotid angiogram, MRA, or Doppler flow study
- ☐3 Vascular or surgical procedure to improve flow to the ipsilateral brain

Yes ☐1 **No** ☐0 **8. Peripheral arterial disease (aorta, iliac arteries, or below) requiring and/or occurring during hospitalization.** Symptomatic disease including intermittent claudication, ischemic ulcers, or gangrene. Disease must be **symptomatic and/or requiring intervention** (e.g., vascular or surgical procedure for arterial insufficiency in the lower extremities or abdominal aortic aneurysm).

8.1. Date of Admission: ☐☐ - ☐☐ - ☐☐ (M/D/Y)

8.2. Diagnosis: ***(Mark the one category that applies best.)***

- ☐1 Lower extremity claudication
- ☐2 Atherosclerosis of arteries of the lower extremities
- ☐3 Arterial embolism and/or thrombosis of the lower extremities
- ☐4 Abdominal aortic aneurysm (AAA)

8.3. **Peripheral arterial disease based on:** Defined by hospitalization plus one or more of the following: ***(Mark all that apply.)***

- ☐1 Ultrasonographically- or angiographically-demonstrated obstruction, or ulcerated plaque (≥ 50% of the diameter or ≥ 75% of the cross-sectional area) demonstrated on ultrasound or angiogram of the iliac arteries or below
- ☐2 Absence of pulse by doppler in any major vessel of lower extremities
- ☐3 Exercise test that is positive for lower extremity claudication
- ☐4 Surgery, angioplasty, or thrombolysis for peripheral arterial disease
- ☐5 Amputation of one or more toes or part of the lower extremity because of ischemia or gangrene
- ☐6 Exertional leg pain relieved by rest and at least one of the following: (1) claudication diagnosed by physician, or (2) ankle-arm systolic blood pressure ratio ≤ 0.8
- ☐7 Ultrasonographically- or angiographically-demonstrated abdominal aortic aneurysm
- ☐8 Surgical or vascular procedure for abdominal aortic aneurysm

_____

Responsible Adjudicator Signature

Table 1
Definition of Criteria for Diagnosis of Myocardial Infarction

	Cardiac Enzyme Interpretation (see *Table 8.8* below)			
	Abnormal	**Equivocal**	**Incomplete**	**Normal**
ECG Pattern/Symptoms				
Cardiac pain present:				
Evolving Q wave and evolving ST-T abnormalities	Definite MI	Definite MI	Definite MI	Definite MI
Equivocal Q wave evolution; or evolving ST-T abnormalities, or new left bundle branch block	Definite MI	Definite MI	Probable MI	No MI
Q waves or ST-T abnormalities suggestive of an MI and not classified above	Definite MI	Probable MI	No MI	No MI
Other ECG, ECG absent or uncodable	Definite MI	No MI	No MI	No MI
Cardiac Pain absent:				
Evolving Q wave and evolving ST-T abnormalities	Definite MI	Definite MI	Definite MI	Probable MI
Equivocal Q wave evolution; or evolving ST-T abnormalities; or new left bundle branch block	Definite MI	Probable MI	No MI	No MI
Q waves or ST-T abnormalities suggestive of an MI and not classified above	Probable MI	No MI	No MI	No MI
Other ECG, ECG absent or uncodable	No MI	No MI	No MI	No MI

Table 2
Algorithm for Enzyme Diagnostic Criteria

		Interpretation	
Cardiac Enzyme	**Abnormal***	**Equivocal**	**Normal**
Creatine kinase MB fraction (CK-MB)	≥ 2x ULN (as %, index, or units); or "present" without quantification	1-2x ULN (as %, index, or units); or "weakly present"	WNL
Toponin (C, I, or T)**	Troponin ≥ 2x ULN	Troponin 1-2x ULN	Troponin is WNL
Total creatine kinase (CK) (no MB available)	N/A	Total CK ≥ 2x ULN	Total CK is 1-2x ULN or WNL

ULN = upper limit of normal
WNL = within normal limits

* If both CK-MB and Troponin are available, Troponin must be elevated to be considered abnormal, if only CK-MB is available, abnormal levels are enough to code enzymes as abnormal, i.e., WHI considers Troponin as the most accurate indicator of myocardial injury.

** Code Troponin levels using the ULN and not Upper limit of undeterminate/indecisive as the reference value. Thus, if 2 cut points are given, choose the lower cut point for the ULN.

Complete this form for all newly-diagnosed cancers excluding non-melanoma skin cancers.

OMB #0925-0414 Exp: 4/06

COMMENTS	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
To be completed by Physician Adjudicator: Date Completed: ___-___-___ (M/D/Y) Adjudicator Code: ___	*To be completed by Outcomes Specialist:* Staff person: ___ Adjudication Case No.: ___

Use a separate form for each diagnosis.

1. Primary cancer site: ***(Mark the one that applies best.)*** (The number to the right of the checkbox is the ICD-O-2 Code. Any number that includes an * has been assigned the 2-digit code for WHI only.)

Main WHI Cancer Outcomes

- ☐ 50 Breast
- ☐ 56 Ovary
- ☐ 54 Corpus uteri, endometrium
- ☐ 55 Uterus, not otherwise specified
- ☐ 18 Colon (excludes appendix, see below)
- ☐ 20 Rectum
- ☐ 19 Rectosigmoid junction

Other Cancer Outcomes

- ☐ 31 Accessory sinuses
- ☐ 74 Adrenal gland
- ☐ 21 Anus
- ☐ 86* Appendix
- ☐ 24 Biliary tract, parts of [other/unspecified]
- ☐ 67 Bladder
- ☐ 40 Bones, joints & articular cartilage of limbs
- ☐ 41 Bones, joints & articular cartilage [other/unspecified]
- ☐ 71 Brain
- ☐ 72 Central Nervous System (excludes brain)
- ☐ 53 Cervix
- ☐ 49 Connective, subcutaneous & other soft tissues
- ☐ 75 Endocrine glands & related structures [other/unspecified]
- ☐ 15 Esophagus
- ☐ 69 Eye and adnexa
- ☐ 57 Genital organs, female [other/unspecified]
- ☐ 64 Kidney

Other Cancer Outcomes (con't)

- ☐ 32 Larynx
- ☐ 42 Leukemia [hematopoietic & reticuloendothelial systems (includes blood; excludes multiple myeloma)]
- ☐ 22 Liver
- ☐ 34 Lung (bronchus)
- ☐ 77 Lymph nodes
- ☐ 83* Lymphoma, Hodgkin's disease
- ☐ 82* Lymphoma, non-Hodgkin's disease
- ☐ 44 Melanoma of the skin
- ☐ 85* Multiple myeloma
- ☐ 06 Oral (mouth) [other/unspecified]
- ☐ 05 Palate
- ☐ 25 Pancreas
- ☐ 07 Parotid gland (Stensen's duct)
- ☐ 47 Peripheral nerves & autonomic nervous system
- ☐ 12 Pyriform sinus
- ☐ 39 Respiratory system and intrathoracic organs [other/unspecified]
- ☐ 08 Salivary glands, major [other/unspecified]
- ☐ 16 Stomach
- ☐ 73 Thyroid
- ☐ 02 Tongue, part of [other/unspecified]
- ☐ 68 Urinary organs [other/unspecified]
- ☐ 00 Other ***(Specify:)*** _____

___ ICD-0-2 Code

RV_____KE_____

2. Date of diagnosis: ___-___-___ (M/D/Y)

3. Tumor Behavior:

- ☐ 1 Invasive; malignant; infiltrating; micro-invasive
- ☐ 2 In situ; intraepithelial; non-infiltrating; non-invasive; intraductal
- ☐ 3 Borderline malignancy; low malignant potential; uncertain whether benign or malignant; indeterminate malignancy
- ☐ 9 Unknown

4. Diagnostic Confirmation Status: ***(Mark one. If more than one category applies, mark the first applicable category.)***

Microscopically Confirmed:

- ☐ 1 Positive histology (pathology)
- ☐ 2 Positive exfoliative cytology, no positive histology
- ☐ 3 Positive histology (pathology), distant metastatic site only
- ☐ 4 Positive microscopic confirmation, method not specified

Not Microscopically Confirmed:

- ☐ 5 Positive laboratory test/marker study
- ☐ 6 Direct visualization without microscopic confirmation
- ☐ 7 Radiography and other imaging techniques without microscopic confirmation
- ☐ 8 Clinical diagnosis only (other than 5, 6 or 7 above)

Confirmation Unknown:

- ☐ 9 Unknown if microscopically confirmed

5. Reporting Source: ***(Mark one. If more than one category applies, mark the first applicable category.)***

- ☐ 1 Hospital inpatient
- ☐ 2 Hospital outpatient/radiation or chemotherapy facility, surgical center, or clinic
- ☐ 3 Laboratory only (hospital or private) including pathology office
- ☐ 4 Physician's office/private medical practitioner
- ☐ 5 Nursing/convalescent home/hospice
- ☐ 6 Autopsy only
- ☐ 7 Death certificate only

Complete the following questions for Breast Cancer only. (Additional documents necessary for central adjudication.)

6. Were hormone (estrogen, progesterone) receptor studies performed?

☐ 0 No ☐ 1 Yes. If test completed, please include results. ☐ 9 Unknown

7. Was an axillary lymph node and/or sentinal lymph node dissection performed?

☐ 0 No ☐ 1 Yes. If yes, please include operative and pathology reports in adjudication case packet. ☐ 9 Unknown

Responsible Adjudicator Signature

NOTE: If this is a hospitalized event, Form 125 – Summary of Hospitalization Diagnosis must be completed and any other WHI outcomes adjudicated.

OMB #0925-0414 Exp: 4/06

COMMENTS	**-Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
To be completed by Physician Adjudicator: Date Completed: ☐☐-☐☐-☐☐ (M/D/Y) Adjudicator Code: ☐☐☐	*To be completed by Outcomes Specialist:* Staff person: ☐☐☐ Adjudication Case No.: ☐☐☐

Use a separate form for each fracture.

Yes ☐1 No ☐0

1. **Confirmed hip fracture:** Fracture of the proximal femur, including fractures of the femoral neck, intertrochanteric region, and greater trochanter

1.1. Date of Diagnosis: ☐☐ - ☐☐ - ☐☐ (M/D/Y)

1.2. Fracture site: **(*Mark the one that applies best.*)**

☐1 Neck of femur (transcervical, cervical)
☐2 Intertrochanteric fracture
☐3 Greater trochanter
☐4 Unspecified part of proximal femur

1.3. Side of hip fracture: **(*Mark the one that applies best.*)**

☐1 Right
☐2 Left
☐3 Both sides
☐9 Unknown

1.4. Hip fracture based on: **(*Mark the one category that applies best.*)**

☐1 Written radiology report that is read by a radiologist and identifies the presence of a new, acute, or healing fracture of the proximal femur (femoral neck, intertrochanteric region, or the greater trochanter region) and documented on a discharge summary

☐2 Radiologist's report confirms a proximal femur fracture, but the hospital discharge summary does not (or is equivocal or missing)

☐3 All of the following:
1) hospital discharge summary listing fracture of the proximal femur, femoral neck fracture, intertrochanteric fracture, trochanteric fracture, or hip fracture;
2) equivocal written radiology report of the hip (e.g., "possible" or "probably" or "suspected" hip fracture); and,
3) a written radiologist's report of either a bone scan or MRI scan unequivocally stating that a new hip fracture or healing hip fracture is present

☐4 Hip fracture diagnosed in discharge summary, or other written report, but no radiology report available or radiograph not read by radiologist

☐5 Uncertain radiology report of hip fracture without additional documentation

1.5. Pathologic hip fracture: fracture resulting from bone tumors or cysts, Paget's disease, bone or joint prostheses, or surgical manipulation. Osteoporotic fracture is not considered a pathologic fracture. **(*Mark the one category that applies best.*)**

☐0 No
☐1 Yes
☐2 Possible

RV_____KE_____

1.6. For UCSF Bone Density Center use only:

Completed for uncertain hip fracture (i.e., box 3, 4 or 5 coded in Question 1.4).

Hip fracture confirmed after UCSF Bone Density Center review of: 1) equivocal written report from a hip radiograph, or 2) radiology reports and other documentation not evaluated by a radiologist

☐ 0 No ☐ 1 Yes

Yes ☐ 1 No ☐ 0

2. **Documented fracture other than hip:** (All other radiographically-confirmed new or acute fractures of any bone.)

2.1. Date of Diagnosis: ___ - ___ - ___ (M/D/Y)

2.2. Fracture site: (***Mark the one category that applies best.***)

Elbow:

☐ 1 Lower end of humerus

☐ 18 Upper radius and/or ulna

☐ 20 Elbow, NOS

Foot (not toe):

☐ 2 One or more tarsal and/or metatarsal bones, heel and/or calcaneus

Hand (not finger):

☐ 3 One or more metacarpal bone(s)

Knee (patella):

☐ 4 Patella

☐ 19 Tibial plateau

Lower arm or wrist:

☐ 5 Radius and/or ulna

☐ 6 One or more carpal bone (wrist)

Lower leg or ankle:

☐ 7 Tibia and/or fibula

☐ 8 Ankle (very distal tibia/fibula and/or talus)

Pelvis:

☐ 9 Pelvis

Spine or back (vertebra):

☐ 10 Thoracic (dorsal) spine

☐ 11 Lumbar spine

Tailbone:

☐ 12 Sacrum and/or coccyx

Upper arm (humerus), shoulder, or clavicle:

☐ 13 Humerus, upper end

☐ 14 Humerus, shaft or unspecified part

☐ 15 Clavicle

☐ 16 Scapula

Upper leg (not hip):

☐ 17 Shaft of femur, including subtrochanteric region and other femur

2.3. Side of fracture: **(*Mark one.*)**

- ☐ 1 Right
- ☐ 2 Left
- ☐ 3 Both sides
- ☐ 4 Not applicable (e.g., tailbone)
- ☐ 9 Unknown

2.4. Fracture confirmed as follows: **(*Mark the one category that applies best.*)**

Non-Vertebral Fractures

- ☐ 1 Written radiology report stating that a new or acute fracture of a bone is present
- ☐ 2 Written radiology report available states that evidence of a healing fracture is present and no other documentation available
- ☐ 3 Other written reports not by a radiologist, such as clinic notes, progress notes, ER notes, or operative reports, stating that a new, acute or healing fracture of a bone is present are acceptable if it is based on a review of a radiograph (podiatrist reading acceptable for foot fractures only)
- ☐ 4 The initial radiology report is uncertain or equivocal and subsequent report based on follow-up radiograph or bone scan is clearly diagnostic of a fracture or healing fracture

Vertebral Fractures

- ☐ 5 Vertebral fracture documented in radiology report based on AP or lateral thoracolumbar views
- ☐ 6 Vertebral fracture documented in radiology report not based on AP or lateral thoracolumbar views

2.5. Pathologic fracture other than hip: (Fracture resulting from bone tumors or cysts, Paget's disease, bone and joint prostheses, or surgical manipulation. Osteoporotic fracture is not considered a pathologic fracture.): **(*Mark one.*)**

- ☐ 0 No
- ☐ 1 Yes
- ☐ 2 Possible

_____

Responsible Adjudicator Signature

NOTE: If this is a hospitalized event, Form 125 - Summary of Hospitalization Diagnosis must be completed and any other WHI outcomes adjudicated.

OMB #0925-0414 Exp: 5/12

COMMENTS	**-Affix label here-** Member ID: __ __ __ __ - ___ ___ ___ - __
To be completed by Physician Adjudicator: Date Completed: ___-___-___ (M/D/Y) Adjudicator Code: ___-___	Central Case No.: _____ Case Copy No.: ___

Use a separate form for each fracture.

Yes ☐1 No ☐0

1. **Confirmed hip fracture:** Fracture of the proximal femur, including fractures of the femoral neck, intertrochanteric region, and greater trochanter

1.1. Date of Diagnosis: ___ - ___ - ___ (M/D/Y)

1.2. Fracture site: **(*Mark the one that applies best.*)**

☐1 Neck of femur (transcervical, cervical)
☐2 Intertrochanteric fracture
☐3 Greater trochanter
☐4 Unspecified part of proximal femur

1.3. Side of hip fracture: **(*Mark the one that applies best.*)**

☐1 Right
☐2 Left
☐3 Both sides
☐9 Unknown

1.4. Hip fracture based on: **(*Mark the one category that applies best.*)**

☐1 Written radiology report that is read by a radiologist and identifies the presence of a new, acute, or healing fracture of the proximal femur (femoral neck, intertrochanteric region, or the greater trochanter region) and documented on a discharge summary

☐2 Radiologist's report confirms a proximal femur fracture, but the hospital discharge summary does not (or is equivocal or missing)

☐3 All of the following:
1) hospital discharge summary listing fracture of the proximal femur, femoral neck fracture, intertrochanteric fracture, trochanteric fracture, or hip fracture;
2) equivocal written radiology report of the hip (e.g., "possible" or "probably" or "suspected" hip fracture); and,
3) a written radiologist's report of either a bone scan or MRI scan unequivocally stating that a new hip fracture or healing hip fracture is present

☐4 Hip fracture diagnosed in discharge summary, or other written report, but no radiology report available or radiograph not read by radiologist

1.5. Pathologic hip fracture: fracture resulting from bone tumors or cysts, Paget's disease, bone or joint prostheses, or surgical manipulation. Osteoporotic fracture is not considered a pathologic fracture. **(*Mark the one category that applies best.*)**

☐0 No ☐1 Yes ☐2 Possible

_____

Responsible Adjudicator Signature

RV_____K_____V_____

WHI Form 124A - Report of Death (Preliminary) Ver. 4

OMB #0925-0414 Exp: 4/06

	- Affix label here- Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
To be completed by Physician Adjudicator: Date Completed: ___-___-___ (M/D/Y) Adjudicator Code: ___	*To be completed by Outcomes Specialist:* Staff person: ___ Adjudication Case No.: ___

Preliminary Report of Death: Upon receipt of any documentation associated with the death, complete questions 1 – 3. Form must be completed within 60 days of notification of participant death. If all records associated with the death are available, complete Part B – Final Report of Death only.

Preliminary Report of Death

1. Date of death: ___-___-___ (M/D/Y)

2. Subclassification of underlying cause of death:
(***Select only one underlying cause from the following 4 categories. One category must be completed. Required for preliminary report of death.***)

Cancer

- ☐ 1 Breast
- ☐ 2 Ovarian
- ☐ 3 Endometrial
- ☐ 4 Colon
- ☐ 5 Rectosigmoid junction
- ☐ 6 Rectum
- ☐ 7 Uterus
- ☐ 8 Other Cancer
- ☐ 9 Unknown cancer site

Accident/Injury **E-Codes**

- ☐ 21 Homicide → E___.___
- ☐ 22 Accident → E___.___
- ☐ 23 Suicide → E___.___
- ☐ 28 Other injury _____

"Other" Cause of Death

- ☐ 88 Other cause of death, known
- ☐ 99 Unknown cause of death

Cardiovascular disease

- ☐ 11 Definite Coronary Heart Disease (CHD)
(No known non-CHD cause and at least one of the following: (1)-chest pain within 72 hours of death or (2)-history of chronic ischemic heart disease in the absence of valvular heart disease or non- CHD, and death certificate consistent with CHD as the underlying cause.)
- ☐ 12 Cerebrovascular
- ☐ 13 Pulmonary Embolism
- ☐ 14 Possible Coronary Heart Disease (CHD)
(No known non- CHD cause, and death certificate consistent with CHD as the underlying cause.)
- ☐ 18 Other cardiovascular
- ☐ 19 Unknown cardiovascular

3. Documentation used for death adjudication (***Mark all that apply***):

- ☐ 1 Medical records documentation
- ☐ 2 Report of autopsy findings
- ☐ 3 Death certificate
- ☐ 4 ER record
- ☐ 5 EMS report
- ☐ 6 Informant interview
- ☐ 7 *Form 120 – Initial Notification of Death*
- ☐ 9 NDI Search
- ☐ 10 Coroner's report
- ☐ 8 Other _____

WHI Form 124B - Report of Death (Final) Ver. 4

	- Affix label here- Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
To be completed by Physician Adjudicator: Date Completed: ___-___-___ (M/D/Y) Adjudicator Code: ___	*To be completed by Outcomes Specialist:* Staff person: ___ Adjudication Case No.: ___

Note: Data entry continues in the same screen as *Form 124A*.

Final Report of Death: Complete questions 4 – 9 when all records are available to adjudicate the death.

Final Report of Death

4. Date of death: ___-___-___ (M/D/Y)

5. Cause of death:

ICD-9-CM

5.1. **Underlying cause**: |_____| 5.2. ___.___

(Disease or injury that initiated events resulting in death)

5.3. Contributory cause(s) of death.
(Contributory causes do not have to be listed in the hierarchical order.)

5.3.1. |_____| 5.3.2. ___.___

5.3.3. |_____| 5.3.4. ___.___

5.3.5. |_____| 5.3.6. ___.___

5.4. **Immediate cause**: |_____| 5.5. ___.___

(Final disease or condition resulting in death)

6. Subclassification of underlying cause of death:
(*Select only one underlying cause from the following 4 categories. One category must be completed.*)

Cancer

- ☐ 1 Breast
- ☐ 2 Ovarian
- ☐ 3 Endometrial
- ☐ 4 Colon
- ☐ 5 Rectosigmoid junction
- ☐ 6 Rectum
- ☐ 7 Uterus
- ☐ 8 Other Cancer
- ☐ 9 Unknown cancer site

Accident/Injury **E-Codes**

- ☐ 21 Homicide → E___.___
- ☐ 22 Accident → E___.___
- ☐ 23 Suicide → E___.___
- ☐ 28 Other injury _____

"Other" Cause of Death

- ☐ 88 Other cause of death, known
- ☐ 99 Unknown cause of death

Cardiovascular disease

- ☐ 11 Definite Coronary Heart Disease (CHD)
  (No known non-CHD cause and at least one of the following: (1)-chest pain within 72 hours of death and/or (2)-history of chronic ischemic heart disease in the absence of valvular heart disease or non- CHD, and death certificate consistent with CHD as the underlying cause.)
- ☐ 12 Cerebrovascular
- ☐ 13 Pulmonary Embolism
- ☐ 14 Possible Coronary Heart Disease (CHD)
  (No known non- CHD cause, and death certificate consistent with CHD as the underlying cause.)
- ☐ 18 Other cardiovascular
- ☐ 19 Unknown cardiovascular

7. Was an autopsy performed? **(*Mark one.*)**

☐0 No

☐1 Yes

☐9 Unknown

8. Documentation used for death adjudication **(Mark all that apply)**:

☐1 Medical records documentation

☐2 Report of autopsy findings

☐3 Death certificate

☐4 ER record

☐5 EMS report

☐6 Informant interview

☐7 *Form 120 – Initial Notification of Death*

☐9 NDI Search

☐10 Coroner's report

☐8 Other _____

9. Coronary Death ***(In and out of hospital deaths)***

9.1. **Coronary death based on:** ***(Mark all that apply.)***

☐1 Hospitalized myocardial infarction within 28 days of death

☐2 Previous angina or myocardial infarction and no known potentially-lethal non-coronary disease process

☐3 Coronary heart disease (CHD) diagnosed as cause of death at post-mortem examination

☐4 Death resulting from a CHD-related procedure, such as coronary bypass grafting (CABG) or percutaneous transluminal coronary angioplasty (PTCA) **[For any death resulting from a revascularization procedure or an in hospital death, complete *Form 121 – Report of Cardiovascular Outcome*]**

☐8 Other (none of the above)

9.2. **Coronary death subclassification: (*Mark the <u>one</u> category that applies best.)***

☐1 Definite fatal MI: no known non-atherosclerotic cause (and death within 28 days of definite MI) or autopsy evidence of <u>acute</u> MI

☐2 Definite fatal CHD: no known non-atherosclerotic cause and at least one of the following:
(1) chest pain within 72 hours of death, or (2) history of chronic ischemic heart disease in the absence of valvular heart disease or non-ischemic cardiomyopathy

☐3 Possible fatal CHD: no known non-atherosclerotic cause, and death certificate consistent with CHD as the underlying cause

9.3. **Timing of coronary death: (Mark one.)**

☐1 Sudden death: death occurring within one hour of symptom onset or after the participant was last seen without symptoms, <u>and</u> death occurs in the absence of potentially lethal non-coronary disease process

☐2 Rapid death: death occurs within 1-24 hours of symptom onset

☐3 Other coronary death (Does not fulfill criteria for sudden or rapid coronary death.)

_____

Responsible Adjudicator Signature

NOTE: If this is a hospitalized death, or an autopsy report is available, adjudicate any WHI outcomes using the appropriate outcomes form.

OMB #0925-0414 Exp: 5/12

COMMENTS	**- Affix label here-** Member ID: __ __ __ __ - ___ ___ ___ - __
To be completed by Physician Adjudicator Date Completed: ___-___-___ (M/D/Y) Adjudicator Code: ___-___	Central Case No.: _____ Case Copy No.: ___

1. Date of death: ___-___-___ (M/D/Y)

2. Cause of death:

		ICD-9-CM/ICD-10-CM Codes	**CCC use only**
2.1.	**Underlying cause:** (Disease or injury that initiated events resulting in death.)		
	_____	2.2. ___.___	2.3. ___
	_____		
	Contributory cause(s) of death. (Contributory causes do not have to be listed in the hierarchical order.)		
2.4.	_____	2.5. ___.___	2.6. ___
	_____		
2.7.	_____	2.8. ___.___	2.9. ___
	_____		
2.10.	_____	2.11. ___.___	2.12. ___
	_____		
2.13.	**Immediate cause:** (Final disease or condition resulting in death.)		
	_____	2.14. ___.___	2.15. ___
	_____		

RV K V

3. Subclassification of underlying cause of death:
(*Select only one underlying cause from the following 4 categories (Cancer, CVD, Accident, Other). One category must be completed*.)

Cancer

- ☐ 1 Breast
- ☐ 2 Ovarian
- ☐ 3 Endometrial
- ☐ 4 Colon
- ☐ 5 Rectosigmoid junction
- ☐ 6 Rectum
- ☐ 7 Uterus
- ☐ 10 Lung
- ☐ 8 Other Cancer _____
- ☐ 9 Unknown cancer site

Cardiovascular disease

- ☐ 11 Definite Coronary Heart Disease (CHD)
  (No known non-CHD cause and at least one of the following: (1)-chest pain within 72 hours of death and/or (2)-history of chronic ischemic heart disease in the absence of valvular heart disease or non-CHD, and death certificate consistent with CHD as the underlying cause.)
- ☐ 14 Possible Coronary Heart Disease (CHD)
  (No known non-CHD cause, and death certificate consistent with CHD as the underlying cause.)

→ **If box 11 or 14 marked, complete Question 6 on the next page.**

- ☐ 12 Cerebrovascular disease
- ☐ 13 Pulmonary Embolism
- ☐ 18 Other cardiovascular disease
- ☐ 19 Unknown cardiovascular disease

Accident/Injury

- ☐ 21 Homicide
- ☐ 22 Accident
- ☐ 23 Suicide
- ☐ 28 Other injury

"Other" Cause of Death

- ☐ 31 Alzheimer's Disease
- ☐ 32 COPD
- ☐ 33 Pneumonia
- ☐ 34 Pulmonary Fibrosis
- ☐ 35 Renal Failure
- ☐ 36 Sepsis
- ☐ 88 Another cause of death, known
- ☐ 99 Unknown cause of death

4. Was an autopsy performed? **(*Mark one.*)**

☐ 0 No
☐ 1 Yes
☐ 9 Unknown

5. Documentation used for death adjudication **(Mark all that apply)**:

☐ 1 Medical records documentation (current case only)
☐ 2 Report of autopsy findings
☐ 3 Death certificate
☐ 4 ER record
☐ 5 EMS report
☐ 6 Informant interview
☐ 7 *Form 120 – Initial Notification of Death*
☐ 9 **NDI Search (CCC use only)**
☐ 10 Coroner's report
☐ 8 Other _____ (e.g., a previously adjudicated case)

6. Coronary Death ***(In and out of hospital deaths)***

6.1. **Coronary death based on:** ***(Mark all that apply.)***

☐ 1 Hospitalized myocardial infarction within 28 days of death
☐ 2 Previous angina, myocardial infarction, or revascularization procedure and no known potentially-lethal non-coronary disease process
☐ 3 Coronary heart disease (CHD) diagnosed as cause of death at post-mortem examination
☐ 4 Death resulting from a CHD-related procedure, such as coronary bypass grafting (CABG) or percutaneous transluminal coronary angioplasty (PTCA) **[For any death resulting from a revascularization procedure or an in hospital death, complete *Form 121 – Report of Cardiovascular Outcome*]**
☐ 8 Other (none of the above)

6.2. **Coronary death subclassification: (*Mark the one category that applies best.)***

☐ 1 Definite fatal MI: no known non-atherosclerotic cause (and death within 28 days of definite MI) or autopsy evidence of acute MI
☐ 2 Definite fatal CHD: no known non-atherosclerotic cause and at least one of the following: (1) chest pain within 72 hours of death, or (2) history of chronic ischemic heart disease in the absence of valvular heart disease or non-ischemic cardiomyopathy
☐ 3 Possible fatal CHD: no known non-atherosclerotic cause, and death certificate consistent with CHD as the underlying cause

6.3. **Timing of coronary death: (Mark one.)**

☐ 1 Sudden death: death occurring within one hour of symptom onset or after the participant was last seen without symptoms, and death occurs in the absence of potentially lethal non-coronary disease process
☐ 2 Rapid death: death occurs within 1-24 hours of symptom onset
☐ 3 Other coronary death (Does not fulfill criteria for sudden or rapid coronary death.)

_____
Responsible Adjudicator Signature

NOTE: If this is a hospitalized death, or an autopsy report is available, adjudicate any WHI outcomes using the appropriate outcomes form.

OMB #0925-0414 Exp: 4/06

COMMENTS	**-Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
To be completed by Physician Adjudicator: Date Completed: ☐☐-☐☐-☐☐ (M/D/Y) Adjudicator Code: ☐☐☐	*To be completed by Outcomes Specialist:* Staff person: ☐☐☐ Adjudication Case No.: ☐☐☐

Complete this form only if the participant is in the Hormone Replacement Therapy (HRT) component.

Yes No

☐1 ☐0 1. **Deep vein thrombosis (DVT)**

1.1 Date of Diagnosis:

☐☐-☐☐-☐☐ (M/D/Y)

1.2 Diagnosis: ***(Mark the one category that applies best.)***

☐1 Deep vein thrombosis of lower extremities **not resulting from a procedure** within 60 days

☐2 Deep vein thrombosis of lower extremities **during or following a procedure** within 60 days

1.3 Diagnosis of deep vein thrombosis is based on: ***(Mark <u>all</u> that apply.)***

☐1 Hospital discharge summary with a diagnosis of deep vein thrombosis

☐2 Positive findings on a venogram

☐3 Positive findings using impedance plethysmography

☐4 Positive findings on doppler duplex, ultrasound, sonogram, or other non-invasive test examination

☐5 Positive findings on isotope scan

1.4 Diagnosis of deep vein thrombosis reporting source: (***Mark one. If more than one category applies, mark the <u>first</u> applicable category.)***

☐1 Hospital inpatient

☐2 Hospital outpatient facility or clinic

☐3 Radiology or imaging facility

☐4 Physician's office/private medical practitioner

☐5 Nursing/convalescent home/hospice

☐6 Autopsy only

☐7 Death Certificate only

☐8 Other

1.5 Was a work up for pulmonary embolism performed?

☐1 Yes ☐0 No ☐8 Unknown

RV_____KE_____

Yes No

☐1 ☐0 2. **Pulmonary embolism (PE) requiring hospitalization**:

2.1 Date of Diagnosis: ⌊__⌋-⌊__⌋-⌊____⌋ (M/D/Y)

2.2 Diagnosis: ***(Mark the one category that applies best.)***

☐1 Pulmonary embolism **not resulting from a procedure** within 60 days

☐2 Pulmonary embolism **during or following a procedure** within 60 days

2.3. Diagnosis of pulmonary embolism is based on:
(Mark <u>all</u> that apply.)

☐1 Hospital discharge summary with a diagnosis of pulmonary embolism

☐2 High probability on ventilation-perfusion lung scan (exclude moderate, intermediate, or low probability on ventilation-perfusion lung scan)

☐3 Positive findings on pulmonary angiogram or spiral CT

☐4 Diagnosis of deep vein thrombosis (DVT) based on ≥1 DVT criteria in 1.3. plus signs and symptoms suggestive of PE (e.g., acute chest pain, dyspnea, tachypnea, hypoxemia, tachycardia, or chest x-ray findings suggestive of PE)

☐8 Other, including autopsy

_____

Responsible Adjudicator Signature

NOTE: If this is a hospitalized event, Form 125 - Summary of Hospitalization Diagnosis must be completed and any other WHI outcomes adjudicated.

OMB #0925-0414 Exp: 5/12

COMMENTS	**-Affix label here-** Member ID: __ __ __ __ - ___ ___ ___ - __
To be completed by Physician Adjudicator: Date Completed: ☐☐-☐☐-☐☐ (M/D/Y) Adjudicator Code: ☐☐-☐☐☐	Central Case No.: ☐☐☐☐☐☐☐ Case Copy No.: ☐☐

Complete this form only if the participant is in the Hormone Trial (HT) component.

Yes No

☐1 ☐0 1. **Deep vein thrombosis (DVT)**

1.1 Date of Diagnosis/Admission:

☐☐-☐☐-☐☐ (M/D/Y)

1.2 Diagnosis: ***(Mark the one category that applies best.)***

☐1 Deep vein thrombosis of lower extremities **not resulting from a procedure** within 60 days

☐2 Deep vein thrombosis of lower extremities **during or following a procedure** within 60 days

1.3 Diagnosis of deep vein thrombosis is based on: ***(Mark <u>all</u> that apply.)***

☐1 Hospital discharge summary with a diagnosis of deep vein thrombosis

☐2 Positive findings on a venogram

☐3 Positive findings using impedance plethysmography

☐4 Positive findings on doppler duplex, ultrasound, sonogram, or other non-invasive test examination

☐5 Positive findings on isotope scan

1.4 Diagnosis of deep vein thrombosis reporting source: (***Mark one. If more than one category applies, mark the <u>first</u> applicable category.)***

☐1 Hospital inpatient

☐2 Hospital outpatient facility or clinic

☐3 Radiology or imaging facility

☐4 Physician's office/private medical practitioner

☐5 Nursing/convalescent home/hospice

☐6 Autopsy only

☐7 Death Certificate only

☐8 Other

1.5 Was a work up for pulmonary embolism performed?

☐1 Yes ☐0 No ☐8 Unknown

RV_____K_____V_____

Yes No

☐ 1 ☐ 0 **Pulmonary embolism (PE) requiring hospitalization**:

2.1 Date of Diagnosis/Admission: ⌊__⌋⌊__⌋-⌊__⌋⌊__⌋-⌊__⌋⌊__⌋ (M/D/Y)

2.2 Diagnosis: ***(Mark the one category that applies best.)***

☐ 1 Pulmonary embolism **not resulting from a procedure** within 60 days

☐ 2 Pulmonary embolism **during or following a procedure** within 60 days

2.3 Diagnosis of pulmonary embolism is based on:
(Mark <u>all</u> that apply.)

☐ 1 Hospital discharge summary with a diagnosis of pulmonary embolism

☐ 2 High probability on ventilation-perfusion lung scan (exclude moderate, intermediate, or low probability on ventilation-perfusion lung scan)

☐ 3 Positive findings on pulmonary angiogram or spiral CT

☐ 4 Diagnosis of deep vein thrombosis (DVT) based on ≥1 DVT criteria in 1.3. plus signs and symptoms suggestive of PE (e.g., acute chest pain, dyspnea, tachypnea, hypoxemia, tachycardia, or chest X-ray findings suggestive of PE)

☐ 8 Other, including autopsy

_____

Responsible Adjudicator Signature

COMMENTS _____ *Coder Signature*	**-Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
Date Completed: ☐☐-☐☐-☐☐ (M/D/Y) CSS Staff Code: ☐☐☐	Adjudication Case No. ☐☐☐ Copy No. ☐☐

1. Date of Diagnosis: ☐☐-☐☐-☐☐ (M/D/Y)

2. Main WHI Cancer Outcomes: ***(Mark one.)***

- ☐ 50 Breast
- ☐ 56 Ovary
- ☐ 54 Corpus uteri, endometrium
- ☐ 55 Uterus, not otherwise specified
- ☐ 18 Colon
- ☐ 20 Rectum
- ☐ 19 Rectosigmoid junction
- ☐ 00 Other ***(Specify):*** _____

2.1. ICD-0-2: C ☐☐ . ☐

3. Diagnostic Confirmation Status: ***(Mark one. If more than one category applies, mark the <u>first</u> applicable category.)***

Microscopically Confirmed:

- ☐ 1 Positive histology (pathology)
- ☐ 2 Positive exfoliative cytology, no positive histology
- ☐ 3 Positive histology (pathology), distant metastatic site only
- ☐ 4 Positive microscopic confirmation, method not specified

Not Microscopically Confirmed:

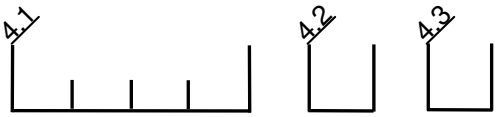
- ☐ 5 Positive laboratory test/marker study
- ☐ 6 Direct visualization without microscopic confirmation
- ☐ 7 Radiography and other imaging techniques without microscopic confirmation
- ☐ 8 Clinical diagnosis only (other than 5, 6 or 7)

Confirmation Unknown:

- ☐ 9 Unknown if microscopically confirmed

RV_____KE_____

4. Morphology:



5. Subclassification for Breast Histology 8522: ***(Mark One.)***

- ☐ 0 Not Applicable
- ☐ 1 Ductal in situ plus lobular in situ
- ☐ 2 Ductal invasive plus lobular in situ
- ☐ 3 Ductal invasive plus lobular invasive
- ☐ 4 Lobular invasive plus ductal in situ
- ☐ 5 Invasive cancer, ductal and lobular nos

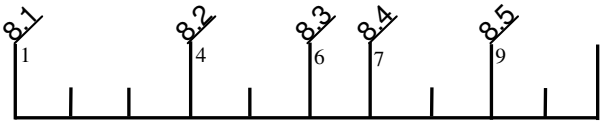
6. Laterality: ***(Mark One.)***

- ☐ 0 Not a paired site
- ☐ 1 Right: origin of primary
- ☐ 2 Left: origin of primary
- ☐ 3 Only one side involved, right or left origin unspecified
- ☐ 4 Bilateral involvement, lateral origin unknown: stated to be single primary
- ☐ 5 Paired site, but no information concerning laterality; midline tumor

7. Reporting Source: ***(Mark one. If more than one category applies, mark the <u>first</u> applicable category.)***

- ☐ 1 Hospital inpatient
- ☐ 2 Hospital outpatient/radiation or chemotherapy facility, surgical center, or clinic
- ☐ 3 Laboratory only (hospital or private) including pathology office
- ☐ 4 Physician's office/private medical practitioner
- ☐ 5 Nursing/convalescent home/hospice
- ☐ 6 Autopsy only
- ☐ 7 Death certificate only

8. EOD (SEER):



9. Summary Stage (SEER): ***(Mark one.)***

- ☐ 1 In situ
- ☐ 2 Localized
- ☐ 3 Regional
- ☐ 4 Distant
- ☐ 9 Unknown

10. Estrogen Receptor Assay: ***(Mark one.)***

- ☐ 1 Positive
- ☐ 2 Negative
- ☐ 3 Borderline
- ☐ 8 Ordered/Results not available
- ☐ 9 Unknown/Not done

10.1. Date: ___-___-___ (M/D/Y)

10.2. Type of assay:

- ☐ 1 fmol/mg protein
- ☐ 2 ICC/IHC
- ☐ 8 Other:_____
- ☐ 9 Unknown

11. Progesterone Receptor Assay: ***(Mark one.)***

- ☐ 1 Positive
- ☐ 2 Negative
- ☐ 3 Borderline
- ☐ 8 Ordered/Results not available
- ☐ 9 Unknown/Not done

11.1. Date: ___-___-___ (M/D/Y)

11.2. Type of assay:

- ☐ 1 fmol/mg protein
- ☐ 2 ICC/IHC
- ☐ 8 Other:_____
- ☐ 9 Unknown

12. Her 2/Neu: ***(Mark one.)***

- ☐ 1 Positive
- ☐ 2 Negative
- ☐ 3 Borderline
- ☐ 8 Ordered/Results not available
- ☐ 9 Unknown/Not done

12.1. Date: ___-___-___ (M/D/Y)

13. CSS Editor Code: ___

OMB #0925-0414 Exp: 5/12

COMMENTS	**- Affix label here-** Member ID: __ __ __ __ - ___ ___ ___ - __ #___
To be completed by CCC Cancer Coder: Date Completed: ☐☐-☐☐-☐☐ (MM/DD/YY) Adjudicator Code: ☐☐-☐☐☐	Central Case No.: ☐☐☐☐☐☐☐ Case Copy No.: ☐☐

Use a separate form for each new diagnosis.

1. Date of Diagnosis: ☐☐-☐☐-☐☐ (MM/DD/YY)

2. Primary cancer site: ***(Mark the one that applies best.)***

Main WHI Cancer Outcomes

- ☐ 50 Breast → **Questions 1–3, 5–14 required.**
- ☐ 56 Ovary
- ☐ 54 Corpus uteri, endometrium
- ☐ 18 Colon (excludes appendix, see below)
- ☐ 20 Rectum
- ☐ 19 Rectosigmoid junction

→ **Questions 1–3, 5–10 required.**

Other Cancer Outcomes → **Questions 1–6 required.**

- ☐ 31 Accessory sinuses
- ☐ 74 Adrenal gland
- ☐ 21 Anus
- ☐ 86* Appendix
- ☐ 24 Biliary tract, parts of [other/unspecified]
- ☐ 67 Bladder
- ☐ 40 Bones, joints & articular cartilage of limbs
- ☐ 41 Bones, joints & articular cartilage [other/unspecified]
- ☐ 71 Brain
- ☐ 72 Central Nervous System (excludes brain)
- ☐ 53 Cervix
- ☐ 49 Connective, subcutaneous & other soft tissues
- ☐ 75 Endocrine glands & related structures [other/unspecified]
- ☐ 15 Esophagus
- ☐ 69 Eye and adnexa
- ☐ 57 Genital organs, female [other/unspecified]
- ☐ 64 Kidney
- ☐ 32 Larynx
- ☐ 42 Leukemia [hematopoietic & reticuloendothelial systems [includes blood; excludes multiple myeloma]
- ☐ 22 Liver
- ☐ 34 Lung (bronchus)
- ☐ 77 Lymph nodes
- ☐ 83* Lymphoma, Hodgkin's disease
- ☐ 82* Lymphoma, non-Hodgkin's disease
- ☐ 44 Melanoma of the skin
- ☐ 85* Multiple myeloma
- ☐ 06 Oral (mouth) [other/unspecified]
- ☐ 05 Palate
- ☐ 25 Pancreas
- ☐ 07 Parotid gland (Stensen's duct)
- ☐ 47 Peripheral nerves & autonomic nervous system
- ☐ 12 Pyriform sinus
- ☐ 39 Respiratory system and intrathoracic organs [other/unspecified]
- ☐ 08 Salivary glands, major [other/unspecified]
- ☐ 16 Stomach
- ☐ 73 Thyroid
- ☐ 02 Tongue, part of [other/unspecified]
- ☐ 68 Urinary organs [other/unspecified]
- ☐ 55 Uterus, not otherwise specified
- ☐ 00 Other ***(Specify site. Enter site code in Qx. 3.)***

_____

3. ICD-0-2 Code: **Complete for Main Cancer site or "Other Cancer" site not already specified in Question 2. (Note to ancillary study coder, complete as requested by CCC.)**

   ☐☐☐.☐

4. Tumor Behavior: **Complete only for an "Other Cancer" diagnosis.** ***(Mark one only.)***

   ☐ 1 Invasive; malignant; infiltrating; micro-invasive

   ☐ 2 In situ; intraepithelial; non-infiltrating; non-invasive; intraductal

   ☐ 3 Borderline malignancy; low malignant potential; uncertain whether benign or malignant; indeterminate malignancy

   ☐ 9 Unknown

5. Reporting Source: ***(Mark one only. If more than one category applies, mark the first applicable category.)***

   ☐ 1 Hospital inpatient

   ☐ 2 Hospital outpatient/radiation or chemotherapy facility, surgical center, or clinic

   ☐ 3 Laboratory only (hospital or private) including pathology office

   ☐ 4 Physician's office/private medical practitioner

   ☐ 5 Nursing/convalescent home/hospice

   ☐ 6 Autopsy only

   ☐ 7 Death certificate only

6. Diagnostic Confirmation Status: ***(Mark one only. If more than one category applies, mark the first applicable category.)***

   Microscopically Confirmed:

   ☐ 1 Positive histology (pathology)

   ☐ 2 Positive exfoliative cytology, no positive histology

   ☐ 3 Positive histology (pathology), regional or distant metastatic site only

   ☐ 4 Positive microscopic confirmation, method not specified

   Not Microscopically Confirmed:

   ☐ 5 Positive laboratory test/marker study

   ☐ 6 Direct visualization without microscopic confirmation

   ☐ 7 Radiography and other imaging techniques without microscopic confirmation

   ☐ 8 Clinical diagnosis only (other than 5, 6 or 7 above)

   Confirmation Unknown:

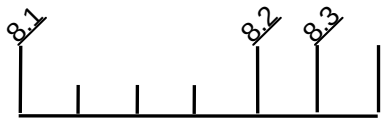
   ☐ 9 Unknown if microscopically confirmed

Complete Questions 7–10 for Main Cancer Outcomes only.

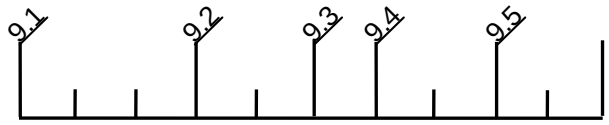
7. Laterality: ***(Mark one only.)***

- ☐ 0 Not a paired site
- ☐ 1 Right: origin of primary
- ☐ 2 Left: origin of primary
- ☐ 3 Only one side involved, right or left origin unspecified
- ☐ 4 Bilateral involvement, lateral origin unknown: stated to be single primary
- ☐ 5 Paired site, but no information concerning laterality; midline tumor

8. Morphology:



9. EOD (SEER):



10. Summary Stage (SEER): ***(Mark one only.)***

- ☐ 1 In situ
- ☐ 2 Localized
- ☐ 3 Regional
- ☐ 4 Distant
- ☐ 9 Unknown

Complete Questions 11–14 for Breast Cancer Only.

11. Complete the subclassification for Breast Histology 8522: ***(Mark one only.)***

- ☐ 0 Not applicable
- ☐ 1 Ductal in situ plus lobular in situ
- ☐ 2 Ductal invasive plus lobular in situ
- ☐ 3 Ductal invasive plus lobular invasive
- ☐ 4 Lobular invasive plus ductal in situ
- ☐ 5 Invasive cancer, ductal and lobular nos

12. Estrogen Receptor Assay:
(Mark one only.)

- ☐ 1 Positive
- ☐ 2 Negative
- ☐ 3 Borderline
- ☐ 8 Ordered/Results not available
- ☐ 9 Unknown/Not done

12.1. Date:
__-__-__
(MM/DD/YY)

12.2. Type of assay:
(Mark one only.)

- ☐ 1 fmol/mg protein
- ☐ 2 ICC/IHC
- ☐ 8 Other:_____
- ☐ 9 Unknown

13. Progesterone Receptor Assay:
(Mark one only.)

- ☐ 1 Positive
- ☐ 2 Negative
- ☐ 3 Borderline
- ☐ 8 Ordered/Results not available
- ☐ 9 Unknown/Not done

13.1. Date:
__-__-__
(MM/DD/YY)

13.2. Type of assay:
(Mark one only.)

- ☐ 1 fmol/mg protein
- ☐ 2 ICC/IHC
- ☐ 8 Other:_____
- ☐ 9 Unknown

14. Her 2/Neu:
(Mark one only.)

- ☐ 1 Positive
- ☐ 2 Negative
- ☐ 3 Borderline
- ☐ 8 Ordered/Results not available
- ☐ 9 Unknown/Not done

14.1. Date:
__-__-__
(MM/DD/YY)

_____
Coder Signature

15. Editor Code: ___

COMMENTS	**-Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
To be completed by Physician Adjudicator: Date Completed: ___-___-___ (M/D/Y) Adjudicator Code: ___	*To be completed by Outcomes Specialist:* Staff person: ___ Adjudication Case No.: ___

Complete this form only if the participant is in the Hormone Replacement Therapy (HRT) component.

1. **Hysterectomy (in HRT only)**

   1.1. Date of hysterectomy: ___-___-___ (M/D/Y)

2. Type of hysterectomy: ***(Mark the one category that applies best.)***

   ☐ 1 Abdominal
   ☐ 2 Vaginal

3. Associated surgery: ***(Mark the one category that applies best.)***

   ☐ 0 None
   ☐ 1 Partial oophorectomy
   ☐ 2 One ovary removed
   ☐ 3 Bilateral oophorectomy

4. Reason for hysterectomy: ***(Mark the one category that applies best.)***

   ☐ 1 Cancer
   ☐ 2 Atypical hyperplasia
   ☐ 3 Bleeding
   ☐ 4 Fibroids (myomas)
   ☐ 5 Endometriosis
   ☐ 6 Descensus (prolapse)
   ☐ 8 Other ***(Specify)***: _____

_____
Responsible Adjudicator Signature

NOTE: If this is a hospitalized event, Form 125 - Summary of Hospitalization Diagnosis must be completed and any other WHI outcomes adjudicated.

RV_____KE_____

COMMENTS	**-Affix label here-** Member ID: __ __ __ __ - ___ ___ ___ - __
To be completed by Physician Adjudicator: Date Completed: ___-___-___ (M/D/Y) Adjudicator Code: ___-___	Central Case No.: _____ Case Copy No.: ___

Complete this form only if the participant is in the Hormone Trial (HT) component.

1. **Hysterectomy (HT only)**

   1.1. Date of hysterectomy: ___-___-___ (M/D/Y)

2. Type of hysterectomy: ***(Mark the one category that applies best.)***

   ☐ 1 Abdominal

   ☐ 2 Vaginal

3. Associated surgery: ***(Mark the one category that applies best.)***

   ☐ 0 None

   ☐ 1 Partial oophorectomy

   ☐ 2 One ovary removed

   ☐ 3 Bilateral oophorectomy

4. Reason for hysterectomy: ***(Mark the one category that applies best.)***

   ☐ 1 Cancer

   ☐ 2 Atypical hyperplasia

   ☐ 3 Bleeding

   ☐ 4 Fibroids (myomas)

   ☐ 5 Endometriosis

   ☐ 6 Descensus (prolapse)

   ☐ 8 Other ***(Specify)*****:** _____

_____

Responsible Adjudicator Signature

RV_____K_____V_____

COMMENTS	**-Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____
To be completed by CCC Adjudicator: Date Completed: ⌊__⌋⌊__⌋-⌊__⌋⌊__⌋-⌊__⌋⌊__⌋ (M/D/Y) Adjudicator Code: ⌊__⌋⌊__⌋⌊__⌋	*To be completed by the CCC:* Central Adjudication Case No. ⌊__⌋⌊__⌋⌊__⌋ Copy No. ⌊__⌋⌊__⌋

Yes **No**

☐ 1 ☐ 0 **1.** **Stroke requiring and/or occurring during hospitalization:** Rapid onset of a persistent neurologic deficit attributable to an obstruction or rupture of the arterial system (including stroke occurring during **or resulting from** a procedure)*. Deficit is not known to be secondary to brain trauma, tumor, infection, or other cause. Deficit must last more than 24 hours, unless death supervenes or there is a demonstrable lesion compatible with acute stroke on CT or MRI scan.

*A stroke is defined as procedure-related if it occurs within 24 hours after any procedure or within 30 days after a cardioversion or invasive cardiovascular procedure

1.1 Date of Admission: ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋ (M/D/Y)

1.2 Diagnosis: ***(Mark the one category that applies best.)***

Hemorrhagic Stroke

☐ 1 Subarachnoid hemorrhage

☐ 2 Intraparenchymal hemorrhage

☐ 3 Other or unspecified intracranial hemorrhage (nontraumatic epidural hemorrhage or non-traumatic subdural hemorrhage)

Ischemic Stroke ***(If selected, complete questions 1.4 – Oxfordshire and 1.5 - TOAST Classification on the next page.)***

☐ 4 Occlusion of cerebral or pre-cerebral arteries with infarction (cerebral thrombosis, cerebral embolism, lacunar infarction)

Other

☐ 5 Acute, but ill-defined, cerebrovascular disease (select this option only if unable to code as hemorrhagic or ischemic)

1.3 Stroke occurred during or resulted from a procedure (defined above*). **(Mark one.)**

☐ 0 No

☐ 1 Yes

☐ 9 Unknown

RV_____KE_____

1.4 Oxfordshire Classification ***(Mark the <u>one</u> category that applies best.)***

- ☐ 1 Total anterior circulation infarct (TACI)
- ☐ 2 Partial anterior circulation infarct (PACI)
- ☐ 3 Lacunar infarction (LACI)
- ☐ 4 Posterior circulation infarct (POCI)

1.5 Trial of Org 10172 in Acute Stroke Treatment (TOAST) Classification
(Mark the <u>one</u> category that applies best.)

	Probable	Possible
Large artery atherosclerosis (embolus/thrombosis)	☐ 1	☐ 5
Cardioembolism (high-risk/medium risk)	☐ 2	☐ 6
Small vessel occlusion (lacune)	☐ 3	☐ 7
Stroke of other determined etiology	☐ 4	☐ 10
Stroke of undetermined etiology ☐ 11 Two or more causes identified ☐ 12 Negative evaluation ☐ 13 Incomplete evaluation		

1.6 Stroke diagnosis based on: ***(Mark the <u>one</u> category that applies best.)***

- ☐ 1 Rapid onset of neurological deficit and CT or MRI scan shows acute focal brain lesion consistent with neurological deficit and without evidence of blood (except mottled cerebral pattern)
- ☐ 2 Rapid onset of localizing neurological deficit with duration ≥ 24 hours but imaging studies are not available
- ☐ 3 Rapid onset of neurological deficit with duration ≥ 24 hours and the only available CT or MRI scan was done early and shows no acute lesion consistent with the neurologic deficit
- ☐ 4 Surgical evidence of ischemic infarction of brain
- ☐ 5 CT or MRI findings of blood in subarachnoid space or intra-parenchymal hemorrhage, consistent with neurological signs or symptoms
- ☐ 6 Positive lumbar puncture (for subarachnoid hemorrhage)
- ☐ 7 Surgical evidence of subarachnoid or intra-parenchymal hemorrhage as the cause of a clinical syndrome consistent with stroke
- ☐ 8 None of the above (e.g., fatal strokes where no imaging studies or clinical evidence are available; or CT/MRI does not show lesion consistent with the neurologic deficit)

1.7 If stroke fatal: ***(Mark all that apply.)***

- ☐ 1 Hospitalized stroke within 28 days of death
- ☐ 2 Previous stroke and no known potentially lethal non-cerebrovascular disease process
- ☐ 3 Stroke diagnosed as cause of death at post-mortem examination
- ☐ 4 Stroke listed as underlying cause of death on death certificate

1.8 Participant's functional status at the time of hospital discharge (Glasgow Outcome Scale): ***(Mark the <u>one</u> category that applies best.)***

- ☐ 1 Good recovery – Patient can lead a full and independent life with or without minimal neurological deficit
- ☐ 2 Moderately disabled – Patient has neurological or intellectual impairment but is independent
- ☐ 3 Severely disabled – Patient conscious but dependent on others to get through daily activities
- ☐ 4 Vegetative survival – Has no obvious cortical functioning
- ☐ 5 Dead
- ☐ 6 Unable to categorize stroke based on available case packet documentation

Yes ☐ 1 **No** ☐ 0 **2. Transient ischemic attack requiring and/or occurring during hospitalization:** One or more episodes of a focal neurologic deficit lasting more than 30 seconds and no longer than 24 hours. Rapid evolution of the symptoms to the maximal deficit in less than 5 minutes, with subsequent complete resolution. No head trauma occurring immediately before the onset of the neurological event.

2.1. Date of Admission ___ - ___ - ___ (M/D/Y)

_____

Responsible Adjudicator Signature

COMMENTS	**-Affix label here-** Member ID: __ __ __ __ - ___ ___ ___ - __
To be completed by Physician Adjudicator: Date Completed: ☐☐-☐☐-☐☐ (M/D/Y) Adjudicator Code: ☐☐-☐☐☐	Central Case No.: ☐☐☐☐☐☐ Case Copy No.: ☐☐

Yes ☐1 **No** ☐0 **1.** **Stroke:** Rapid onset of a persistent neurologic deficit attributable to an obstruction or rupture of the arterial system (including stroke occurring during **or resulting from** a procedure).* Deficit is not known to be secondary to brain trauma, tumor, infection, or other cause. Deficit must last more than 24 hours, unless death supervenes or there is a demonstrable lesion compatible with acute stroke on CT or MRI scan.

*A stroke is defined as procedure-related if it occurs within 24 hours after any procedure or within 30 days after a cardioversion or invasive cardiovascular procedure.

1.1. Date of Admission or diagnosis: ☐☐ - ☐☐ - ☐☐ (M/D/Y)

1.2. Diagnosis: ***(Mark the one category that applies best.)***

Hemorrhagic Stroke

☐1 Subarachnoid hemorrhage

☐2 Intraparenchymal hemorrhage

☐3 Other or unspecified intracranial hemorrhage (e.g., isolated intraventricular hemorrhage)

Ischemic Stroke ***(If selected, complete questions 1.5 – Oxfordshire and 1.6 - TOAST Classification on the next page.)***

☐4 Occlusion of cerebral or pre-cerebral arteries with infarction (cerebral thrombosis, cerebral embolism, lacunar infarction)

Other

☐5 Acute, but ill-defined, cerebrovascular disease (select this option only if unable to code as hemorrhagic or ischemic)

1.3. Stroke occurred during or resulted from a procedure (defined above*). **(Mark one.)**

☐0 No

☐1 Yes

☐9 Unknown

1.4. Was the stroke diagnosed or managed as an outpatient?*

☐0 No

☐1 Yes

*The outpatient setting includes any emergency department or observation unit, short hospital stays of less than 24 hours duration or a direct admission to a rehab facility without an associated admission to an acute care hospital.

RV_____K_____V_____

1.5. Oxfordshire Classification ***(Mark the <u>one</u> category that applies best.)***

☐ 1 Total anterior circulation infarct (TACI)

☐ 2 Partial anterior circulation infarct (PACI)

☐ 3 Lacunar infarction (LACI)

☐ 4 Posterior circulation infarct (POCI)

1.6. Trial of Org 10172 in Acute Stroke Treatment (TOAST) Classification
(Mark the <u>one</u> category that applies best.)

	Probable	Possible
Large artery atherosclerosis (embolus/thrombosis)	☐ 1	☐ 5
Cardioembolism (high-risk/medium risk)	☐ 2	☐ 6
Small vessel occlusion (lacune)	☐ 3	☐ 7
Stroke of other determined etiology	☐ 4	☐ 10
Stroke of undetermined etiology Two or more causes identified ☐ 11 Negative evaluation ☐ 12 Incomplete evaluation ☐ 13		

1.7 Stroke diagnosis based on: ***(Mark the <u>one</u> category that applies best.)***

☐ 1 Rapid onset of neurological deficit and CT or MRI scan shows acute focal brain lesion consistent with neurological deficit and without evidence of blood (except mottled cerebral pattern)

☐ 2 Rapid onset of localizing neurological deficit with duration ≥ 24 hours but imaging studies are not available

☐ 3 Rapid onset of neurological deficit with duration ≥ 24 hours and the only available CT or MRI scan was done early and shows no acute lesion consistent with the neurologic deficit

☐ 4 Surgical evidence of ischemic infarction of brain

☐ 5 CT or MRI findings of blood in subarachnoid space, intra-parenchymal, or intraventricular hemorrhage consistent with neurological signs or symptoms

☐ 6 Positive lumbar puncture (for subarachnoid hemorrhage)

☐ 7 Surgical evidence of subarachnoid or intra-parenchymal hemorrhage as the cause of a clinical syndrome consistent with stroke

☐ 8 None of the above (e.g., fatal strokes where no imaging studies or clinical evidence are available; or CT/MRI does not show lesion consistent with the neurologic deficit)

1.8. If stroke fatal: ***(Mark all that apply.)***

☐ 1 Hospitalized stroke within 28 days of death

☐ 2 Previous stroke and no known potentially lethal non-cerebrovascular disease process

☐ 3 Stroke diagnosed as cause of death at post-mortem examination

☐ 4 Stroke listed as underlying cause of death on death certificate

1.9 Participant's functional status at the time of discharge* (Glasgow Outcome Scale):
(Mark the <u>one</u> category that applies best.)

*Participant may be discharged from the Emergency Department, hospital, or physician's office.

☐ 1 Good recovery – Patient can lead a full and independent life with or without minimal neurological deficit

☐ 2 Moderately disabled – Patient has neurological or intellectual impairment but is independent

☐ 3 Severely disabled – Patient conscious but dependent on others to get through daily activities

☐ 4 Vegetative survival – Has no obvious cortical functioning

☐ 5 Dead

☐ 6 Unable to categorize stroke based on available case packet documentation (for limited use only when adjudicator is unable to categorize above).

Yes ☐ 1 **No** ☐ 0 **2. Transient ischemic attack:** One or more episodes of a focal neurologic deficit lasting more than 30 seconds and no longer than 24 hours. Rapid evolution of the symptoms to the maximal deficit in less than 5 minutes, with subsequent complete resolution. No head trauma occurring immediately before the onset of the neurological event.

2.1. Date of Admission or diagnosis: ___ - ___ - ___ (M/D/Y)

Yes ☐ 1 **No** ☐ 0 **3. Carotid artery disease requiring and/or occurring during hospitalization.** Disease must be **symptomatic and/or requiring intervention** (i.e., vascular or surgical procedure).

3.1. Date of Admission: ___ - ___ - ___ (M/D/Y)

3.2. Diagnosis: ***(Mark one.)***

☐ 1 Carotid artery occlusion and stenosis without documentation of cerebral infarction

☐ 2 Carotid artery occlusion and stenosis with written documentation of cerebral infarction

3.3. **Carotid artery disease based on** (Hospitalization <u>plus</u> one or more of the following):
(Mark all that apply.)

☐ 1 Symptomatic disease with carotid artery disease listed on the hospital discharge summary

☐ 2 Symptomatic disease with abnormal findings (≥ 50% stenosis) on carotid angiogram, MRA, or Doppler flow study

☐ 3 Vascular or surgical procedure to improve flow to the ipsilateral brain

_____
Responsible Adjudicator Signature

Form 134 - Addendum to Medical History Update

Ver. 8.1
OMB #0925-0414 Exp: 5/09

INSTRUCTIONS

Please complete the three questions below.

CORRECT MARK ○●○○ **INCORRECT MARKS** ✓ ✗ ◒ ⊙

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
   ○8 Other **(Specify):**_____

   Please answer the following questions about the participant.

2. Has a doctor **ever** told you that you have Parkinson's disease?

   ○0 No ○1 Yes

3. Has a doctor **ever** told you that you have sugar diabetes or high blood sugar when you were **not** pregnant?

   ○0 No ○1 Yes

OFFICE USE ONLY

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

1. Date Received: ___-___-___ (Month Day Year)

2. Reviewed By: ___-___

3. Contact Type:
   ○1 Phone
   ○2 Mail
   ○8 Other

4. Language:
   ●1 E ○2 S

○ FCA ○ OU1 ○ OU2

SERIAL # ○○○○○○○○○○○○○○○○○○○○○○○○○○○○

PLEASE MAKE NO MARKS IN THIS AREA

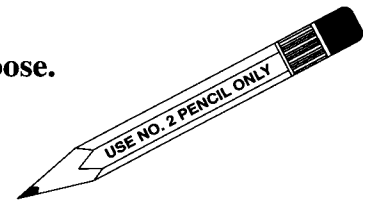
GPO U.S. GOVERNMENT PRINTING OFFICE:2006-576-258/40043

Ver. 3.1
OMB #0925-0414 Exp: 6/00

Form 143 - OS Follow-Up Questionnaire (Year 3)

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 weight is 159:

1	5	9

100 200 300 400 500 600 700
●○○○○○○

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 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
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

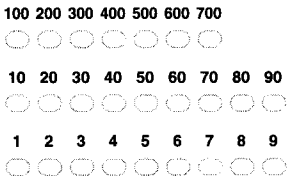
6. Language:

● E ○ S

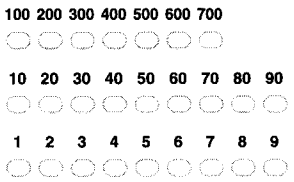
■■■○■■■■○■○■■■■○○■○○○○ 325103

PLEASE MAKE NO MARKS IN THIS AREA

The following questions are about your weight and any weight changes you may have had in the past 2 years.



1. In the past 2 years, what was your highest weight? ⌊_⌊_⌊_⌋ **pounds**



2. In the past 2 years, what was your lowest weight? ⌊_⌊_⌊_⌋ **pounds**

3. In the past 2 years, did you lose five or more pounds on purpose at any time?

⓪ No ① Yes
⑨ Don't know

3.1. What method(s) did you use to lose weight? **(Mark all that apply.)**

① Change in diet
② Increased exercise
③ Redux diet pill (dexfenfluramine)
④ Other diet pill
⑤ Commercial weight loss program
⑥ Started or increased smoking
⑦ Surgical procedure (such as intestinal bypass or stomach balloon)
⑧ Other **(Specify):** _____

4. In the past 2 years, did you lose five or more pounds not on purpose at any time?

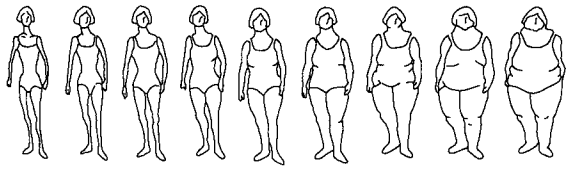
⓪ No ① Yes
⑨ Don't know

4.1. What was the cause of this weight loss? **(Mark all that apply.)**

① Illness
② Depression
③ Stressful time
④ Life events (e.g., change in job or marital status)
⑤ Loss of appetite
⑧ Other **(Specify):** _____
⑨ Don't know

Go to the next page.

5. The figures below are numbered 1-9. Choose a figure to answer each of the questions below.



Choose the figure that:	1	2	3	4	5	6	7	8	9
5.1. reflects how you think you look.	①	②	③	④	⑤	⑥	⑦	⑧	⑨
5.2. reflects how you feel most of the time.	①	②	③	④	⑤	⑥	⑦	⑧	⑨
5.3. is your ideal figure (for you).	①	②	③	④	⑤	⑥	⑦	⑧	⑨
5.4. you think is ideal for women.	①	②	③	④	⑤	⑥	⑦	⑧	⑨
5.5. you think is most preferred by men.	①	②	③	④	⑤	⑥	⑦	⑧	⑨
5.6. you think is most preferred by women.	①	②	③	④	⑤	⑥	⑦	⑧	⑨

Go to the next page.

325103

PLEASE MAKE NO MARKS IN THIS AREA

The following questions are about your usual physical activity and exercise. This includes walking and sports.

6. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? **(Mark only one.)**

- ⓪ Rarely or never
- ① 1-3 times each month
- ② 1 time each week
- ③ 2-3 times each week
- ④ 4-6 times each week
- ⑤ 7 or more times each week

6.1. When you walk outside the home for more than 10 minutes without stopping, for how many minutes do you usually walk?

Less than 20 min.	20-39 min.	40-59 min.	1 hour or more
①	②	③	④

6.2. What is your usual speed?

- ② Casual strolling or walking (less than 2 miles an hour)
- ③ Average or normal (2-3 miles an hour)
- ④ Fairly fast (3-4 miles an hour)
- ⑤ Very fast (more than 4 miles an hour)
- ⑨ Don't know

Go to the next page.

7. Not including walking outside the home, how often each week (7 days) do you usually do the exercises below?

7.1. STRENUOUS OR VERY HARD EXERCISE (You work up a sweat and your heart beats fast). For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.

- ⓪ None
- ① 1 day per week
- ② 2 days per week
- ③ 3 days per week
- ④ 4 days per week
- ⑤ 5 or more days per week

→ 7.2. How long do you usually exercise like this at one time?

- ① Less than 20 min.
- ② 20-39 min.
- ③ 40-59 min.
- ④ 1 hour or more

7.3. MODERATE EXERCISE (Not exhausting). For example, biking outdoors, use of an exercise machine (like a stationary bike or treadmill), calisthenics, easy swimming, popular and folk dancing.

- ⓪ None
- ① 1 day per week
- ② 2 days per week
- ③ 3 days per week
- ④ 4 days per week
- ⑤ 5 or more days per week

→ 7.4. How long do you usually exercise like this at one time?

- ① Less than 20 min.
- ② 20-39 min.
- ③ 40-59 min.
- ④ 1 hour or more

7.5. MILD EXERCISE. For example, slow dancing, bowling, golf.

- ⓪ None
- ① 1 day per week
- ② 2 days per week
- ③ 3 days per week
- ④ 4 days per week
- ⑤ 5 or more days per week

→ 7.6. How long do you usually exercise like this at one time?

- ① Less than 20 min.
- ② 20-39 min.
- ③ 40-59 min.
- ④ 1 hour or more

Go to the next page.

325103

PLEASE MAKE NO MARKS IN THIS AREA

The next set of questions asks about some of your usual activities.

8. About how many hours each week do you usually spend doing heavy (strenuous) indoor household chores such as scrubbing floors, sweeping, or vacuuming?

Less than 1 hour	1-3 hours	4-6 hours	7-9 hours	10 or more hours
①	②	③	④	⑤

9. About how many months during the year do you usually do things in the yard, such as mowing, raking, gardening, or shoveling snow?

Less than 1 month	1-3 months	4-6 months	7-9 months	10 or more months
①	②	③	④	⑤

9.1. When you do these things in the yard, how many hours <u>each week</u> do you do them?

Less than 1 hour	1-3 hours	4-6 hours	7-9 hours	10 or more hours
①	②	③	④	⑤

10. During a usual <u>day and night</u>, about how many hours do you spend sitting? Be sure to include the time you spend sitting at work, sitting at the table eating, driving or riding in a car or bus, and sitting up watching TV or talking.

Less than 4 hours	4-5 hours	6-7 hours	8-9 hours	10-11 hours	12-13 hours	14-15 hours	16 or more hours
①	②	③	④	⑤	⑥	⑦	⑧

11. During a usual <u>day and night</u>, about how many hours do you spend sleeping or lying down? Be sure to include the time you spend sleeping or trying to sleep at night, resting or napping, and lying down watching TV.

Less than 4 hours	4-5 hours	6-7 hours	8-9 hours	10-11 hours	12-13 hours	14-15 hours	16 or more hours
①	②	③	④	⑤	⑥	⑦	⑧

Go to the next page.

The following questions are about strenuous physical activity during your first 29 years of life.

12. Strenuous physical activity means work, exercise or sports that make you breathe hard and make your heart beat faster than usual. Examples are outdoor farm chores, ballet, swimming, basketball, and track and field. On the average, on how many days per week did you do strenuous physical activity for at least 20 minutes per day when you were . . .

	None	1 day per week	2 days per week	3 days per week	4 days per week	5 or more days per week	Don't know
12.1. 5-9 years old?	0	1	2	3	4	5	9
12.2. 10-14 years old?	0	1	2	3	4	5	9
12.3. 15-19 years old?	0	1	2	3	4	5	9
12.4. 20-29 years old?	0	1	2	3	4	5	9

Go to the next page.

325103

PLEASE MAKE NO MARKS IN THIS AREA

The following set of questions are about your use of different fat or oils.

13. In the past three months, what kinds of fat or oil did you usually use to deep fry, pan fry, or sauté foods? **(Mark the one or two used most often. If you did not use fat, mark "Did not use fat.")**

① Butter
② Low calorie margarine
③ Stick margarine
④ Tub margarine
⑤ Solid vegetable fat (e.g., Crisco®)
⑥ Shortening (lard, bacon fat, drippings, salt pork or ham hock)
⑦ Olive oil
⑧ Canola oil
⑨ Peanut oil
⑩ Other vegetable oils (corn, safflower, sunflower)
⑪ Non-stick spray (e.g., Pam®)
⑬ Other fat(s)
⓪ Did not use fat

14. In the past three months, what kinds of fat or oil did you usually use when cooking vegetables, potatoes, beans, or rice? **(Mark the one or two used most often. If you did not use fat, mark "Did not use fat.")**

① Butter
② Low calorie margarine
③ Stick margarine
④ Tub margarine
⑤ Solid vegetable fat (e.g., Crisco®)
⑥ Shortening (lard, bacon fat, drippings, salt pork or ham hock)
⑦ Olive oil
⑧ Canola oil
⑨ Peanut oil
⑩ Other vegetable oils (corn, safflower, sunflower)
⑪ Non-stick spray (e.g., Pam®)
⑬ Other fat(s)
⓪ Did not use fat

15. In the past three months, what kinds of fat or oil did you usually add after cooking vegetables, potatoes, beans, or rice? **(Mark the one or two used most often. If you did not use fat, mark "Did not use fat.")**

① Butter
② Low calorie margarine
③ Stick margarine
④ Tub margarine
⑦ Olive oil
⑧ Canola oil
⑨ Peanut oil
⑩ Other vegetable oils (corn, safflower, sunflower)
⑪ Non-fat or low-fat sour cream
⑫ Regular sour cream
⑬ Other fat(s)
⓪ Did not use fat

16. In the past three months, what kinds of fat or oil did you usually use on breads, bagels, muffins, tortillas, and rolls? **(Mark the one or two used most often. If you did not use fat, mark "Did not use fat.")**

① Butter
② Low calorie margarine
③ Stick margarine
④ Tub margarine
⑦ Olive oil
⑬ Other fat(s)
⓪ Did not use fat

Go to the next page.

The following questions are about coffee, tea, alcoholic drinks and smoking.

17. During the past 3 months, how often did you drink these beverages: **(Mark one for each beverage.)** (For coffee, large or doubles count as 2 cups.)

	Never or less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6 or more per day
17.1. Regular instant (not decaf) coffee (cups)	1	2	3	4	5	6	7	8	9
17.2. Regular (not decaf) espresso or latté (cups)	1	2	3	4	5	6	7	8	9
17.3. Other regular drip coffee (not decaf) - drip, coffee maker, etc. (cups)	1	2	3	4	5	6	7	8	9
17.4. Decaf coffee - any type (cups)	1	2	3	4	5	6	7	8	9
17.5. Regular tea (not herbal, not decaf) (cups)	1	2	3	4	5	6	7	8	9
17.6. Herbal tea (cups)	1	2	3	4	5	6	7	8	9
17.7. Decaf tea (cups)	1	2	3	4	5	6	7	8	9
17.8. Water from the tap (8 ounce glasses)	1	2	3	4	5	6	7	8	9
17.9. Bottled water, carbonated or plain (8 ounce glasses)	1	2	3	4	5	6	7	8	9
17.10. Diet drinks, such as Diet Coke® or diet fruit drinks (12 ounce cans)	1	2	3	4	5	6	7	8	9

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

18. During the past 3 months, have you had any drinks containing alcohol?

⓪ No ① Yes

18.1. In the past 3 months, how often have you had drinks containing alcohol?

① One day per month or less
② 2-3 days per month
③ 1-2 days per week
④ 3-4 days per week
⑤ 5-6 days per week
⑥ Every day or about every day

18.2. In the past 3 months, on the days you drank, how many drinks did you usually have per day? **(A drink is a 12 ounce glass of beer, one 4 ounce glass of wine, or one shot [1 1/4 oz.] of liquor)**

① 1 drink
② 2 drinks
③ 3 drinks
④ 4-5 drinks
⑤ 6-7 drinks
⑥ 8-9 drinks
⑦ 10-11 drinks
⑧ 12 or more drinks

18.3. In the past 3 months, on the days you drank, how many of those drinks did you usually drink that were not around a major meal (not around lunch, not around dinner)?

⓪ None
① 1 drink
② 2 drinks
③ 3 drinks
④ 4-5 drinks
⑤ 6-7 drinks
⑥ 8-9 drinks
⑦ 10-11 drinks
⑧ 12 or more drinks

18.4. Do you drink more than usual on special occasions?

⓪ No ① Yes →

18.5. How often does this happen?

① Less than once per month
② Once a month
③ 2-3 times per month
④ Once a week or more

Go to the next page.

19. Since you enrolled in this study, have you changed your drinking habits?

⓪ No ① Yes

19.1. How have you changed your alcohol drinking? Have you:

Stopped	Decreased	Increased	Started
①	②	③	④

19.2. Why did you make this change? **(Mark one.)**

① Concern about current or past health problems

② Concern about future health

⑧ Other

20. Do you smoke cigarettes now?

⓪ No ① Yes

20.1. How many cigarettes do you usually smoke each day? **(Mark one.)**

① Less than 5

② 5-14

③ 15-24

④ 25-34

⑤ 35-44

⑥ 45 or more

21. Does anyone living with you now smoke cigarettes regularly inside your home?

⓪ No ① Yes

21.1. Please mark all the people who live with you who now smoke cigarettes regularly inside your home: **(Mark all that apply.)**

Husband or partner	Son(s) or daughter(s)	Other person/people
①	②	③

22. Do you now work in a space where people smoke cigarettes?

⓪ No ① Yes

Go to the next page.

The next questions are about your current living situation.

23. What is your current job status? **(Mark the one that best describes you. If more than one describes you, mark both.)**

① Not working
② Retired
③ Homemaker, raising children, care of others
④ Employed (full-time or part-time)
⑤ Disabled, unable to work
⑧ Other **(Specify):** _____

24. What is your current marital status? **(Mark the one that best describes you.)**

① Never married
② Divorced or separated
③ Widowed
④ Presently married
⑤ Living in a marriage-like relationship

24.1. What is your husband's (partner's) current job status? **(Mark one. If more than one applies, mark both.)**

① Not working
② Retired
③ Homemaker, raising children, care of others
④ Employed (full-time or part-time)
⑤ Disabled, unable to work
⑧ Other **(Specify):** _____

25. What was the total family income (before taxes) from all sources within your household in the last year? **(Mark the one that is the best guess.** This information is important for describing the women in the study as a group and is kept strictly confidential.)

① Less than $10,000
② $10,000 to $19,999
③ $20,000 to $34,999
④ $35,000 to $49,999
⑤ $50,000 to $74,999
⑥ $75,000 to $99,999
⑦ $100,000 to $149,999
⑧ $150,000 or more
⑨ Don't know

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

The following questions are about your health and medical care.

26. Do you have a clinic, doctor, nurse or physician assistant who provides your usual medical care?

⓪ No ① Yes

26.1. When did you last visit this clinic or person? **(Please give your best guess.)**

① In the last 3 months
② 4-6 months ago
③ 7-12 months ago
④ Over a year ago

26.2. Has your usual health care provider changed in the past 3 years?

⓪ No ① Yes

27. Do you currently have health insurance? This includes pre-paid private insurance such as a Health Maintenance Organization (HMO), other private insurance, Medicare, Medicaid (including State Medical Assistance, Medi-Cal, or DPA), or Military or Veterans Administration health care coverage.

⓪ No ① Yes

27.1. Which of the following best describes the doctors and hospitals covered by your current health insurance? **(Mark one.)**

① Benefits are the same for any doctor or hospital I choose.
② I can use any doctor or hospital, but I must pay more for those not on a list (or identified with the plan).
③ For my bills to be covered, I must use only the doctors and hospitals on a list (or identified with the plan).

Skip the next page and go to Question 29 on page 15.

28. Do you currently have any of the following types of health insurance: **(Please answer for each type of insurance listed.)**

28.1. Pre-paid private insurance, such as a Health Maintenance Organization (HMO), Kaiser Permanente or other Group Health-type plan?

No ⓪ Yes ①

→ 28.2. Who pays for this insurance? **(Mark all that apply.)**
① Costs are paid by my employer or my spouse's employer
② Costs are paid by me
③ Medicare

28.3. Other private insurance such as Blue Cross, Aetna, etc.?

No ⓪ Yes ①

→ 28.4. Who pays for this insurance? **(Mark all that apply.)**
① Costs are paid by my employer or my spouse's employer
② Costs are paid by me

28.5. Medicare?

No ⓪ Yes ①

→ 28.6. Do you have additional coverage to supplement your Medicare benefits?
⓪ No ① Yes

28.7. Medicaid, including State Medical Assistance, Medi-Cal, or DPA?

No ⓪ Yes ①

28.8. Military or Veterans Administration-sponsored?

No ⓪ Yes ①

28.9. Other?

No ⓪ Yes ①

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

The next set of questions are about female hormones (estrogen or progesterone) you might have used during the past two years. Women's use of hormones has been changing – these questions help us understand your patterns of use.

Question 29 is about natural hormones you get without a doctor's prescription.

29. In the past 2 years, did you use any "natural" hormones that you can get without a doctor's prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, or skin cream.

⓪ No
⑨ Don't know

① Yes

29.1. In the past 2 years, what types of "natural" hormones have you used? (Do not include hormone preparations that need a doctor's prescription.) **(Mark all that apply.)**

① Wild yam or progesterone creams
② Wild yam pills
③ Progesterone suppositories
④ DHEA (dehydroepiandosterone) pills
⑤ Phytoestrogen pills (soy or flax)
⑥ Phytoestrogen creams (soy or flax)
⑦ Phytoestrogen containing foods (tofu, soybeans)
⑧ Other
⑨ Don't know

Go to the next page.

The next questions (30-37) are about female hormones you get with a doctor's prescription.

30. In the past 2 years, did you use female hormones (ESTROGEN or PROGESTERONE) that were prescribed by a doctor? (This may have been in the form of a pill, skin patch, shot, or vaginal cream or suppository.)

① Yes
⓪ No
⑨ Don't know → **Go to Question 38 on the last page.**

31. In the past 2 years, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and progestin (PROGESTERONE) COMBINED in the same pill or package (for example, Prempro, Premphase)? (Do not include use of two separate estrogen and progestin pills used at the same time.)

⓪ No
⑨ Don't know
① Yes

31.1. In the past 2 years, how many months did you use COMBINED female hormone PILLS which contained both ESTROGEN and PROGESTIN?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months
⑤ 13-18 months
⑥ 19-24 months

32. In the past 2 years, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and TESTOSTERONE COMBINED in the same pill (for example, Estratest)?

⓪ No
⑨ Don't know
① Yes

32.1. In the past 2 years, how many months did you use COMBINED female hormone pills which contained both ESTROGEN and TESTOSTERONE?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months
⑤ 13-18 months
⑥ 19-24 months

32.2. In the past 2 years, what type of COMBINED ESTROGEN and TESTOSTERONE pill did you use the longest?

① Estratest
② Estratest HS
⑧ Other

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

33. In the past 2 years, did you use ESTROGEN PILLS which were prescribed by a doctor (for example, Premarin, Estrace, Ogen)? **(Do not include the combined pill of estrogen and progestin or the combined pill of estrogen and testosterone.)**

⓪ No
⑨ Don't know
① Yes

33.1. In the past 2 years, how many months did you use ESTROGEN PILLS?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months
⑤ 13-18 months
⑥ 19-24 months

33.2. In the past 2 years, when you were using ESTROGEN pills, what was the average number of days each month you used the pills?

⓪ Less than 1 day
① 1-7 days
② 8-14 days
③ 15-21 days
④ 22-27 days
⑤ 28 or more days

33.3. In the past 2 years, what type of ESTROGEN pill did you use the longest?

① Premarin or conjugated equine estrogens
② Estrace
③ Ogen
⑧ Other
⑨ Don't know

33.4. What dose did you usually take each day? **(Mark one. If you regularly take more than one dose, mark the lowest dose.)**

① 0.3 mg
② 0.625 mg
③ 0.9 mg
④ 1 mg
⑤ 1.25 mg
⑥ 2 mg
⑦ 2.5 mg
⑧ Other
⑨ Don't know

34. In the past 2 years, did you take shots containing the hormone ESTROGEN?

⓪ No
⑨ Don't know
① Yes

34.1. In the past 2 years, how many months did you take the shots? **(Count each shot as one month.)**

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months
⑤ 13-18 months
⑥ 19-24 months

Go to the next page.

35. In the past 2 years, did you use a vaginal cream or suppository containing ESTROGEN which was prescribed by a doctor?

⓪ No
⑨ Don't know
① Yes

35.1. In the past 2 years, how many months did you use the vaginal cream or suppository?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months
⑤ 13-18 months
⑥ 19-24 months

36. In the past 2 years, did you use a SKIN PATCH containing the hormone ESTROGEN with or without PROGESTERONE (for example, Estraderm, Climera, Vivelle)?

⓪ No
⑨ Don't know
① Yes

36.1. In the past 2 years, how many months did you use the patch?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months
⑤ 13-18 months
⑥ 19-24 months

36.2. In the past 2 years, what type of patch did you use the longest?

① ESTROGEN only (for example, Estraderm, Climara, Vivelle)
② ESTROGEN plus PROGESTERONE
⑧ Other
⑨ Don't know

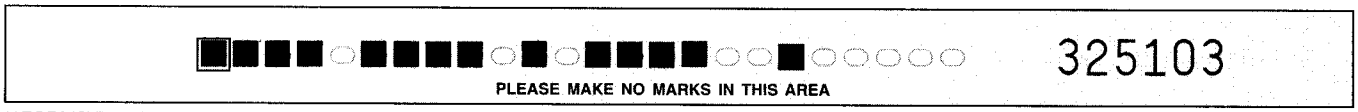
36.3. What dose of ESTROGEN was in the skin patch you usually used?

① 0.05 mg
② 0.1 mg
⑧ Other
⑨ Don't know

36.4. What was the average number of times each week that you changed your skin patch?

① Less than once each week
② 1-2 times each week
③ 3-4 times each week
④ 5 or more times each week

Go to the next page.



Question 37 is about products that contain the hormone PROGESTERONE (progestin) and not ESTROGEN.

37. In the past 2 years, did you use the female hormone PILL called PROGESTERONE or progestin (for example, Provera, Cycrin, Amen, Megace)? **(Do not include the combined pill of estrogen and progestin.)**

① Yes
⓪ No
⑨ Don't know → **Go to question 38 on the next page.**

37.1. In the past 2 years, how many months did you use PROGESTERONE or PROGESTIN pills?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months
⑤ 13-18 months
⑥ 19-24 months

37.2. In the past 2 years, when you were using PROGESTERONE or progestin pills, what was the average number of days each month you used the pills?

① Less than 1 day
② 1-9 days
③ 10-12 days
④ 13-18 days
⑤ 19-27 days
⑥ 28 or more days

37.3. In the past 2 years, what type of PROGESTERONE or progestin pill did you use the longest?

① Provera, Cycrin or Amen (Medroxy Progesterone)
② Megace
③ Micronized Progesterone
⑧ Other
⑨ Don't know

37.4. What dose did you usually take each day? **(Mark one. If you regularly take more than one dose, mark the lowest dose.)**

① 2.5 mg
② 5 mg
③ 7.5 mg
④ 10 mg
⑤ 20 mg
⑥ 40 mg
⑦ More than 40 mg
⑧ Other
⑨ Don't know

Go to the next page.

38. Since you enrolled in this study, has a doctor told you that you have any of the following conditions? **(Please mark one response for each condition.)**

	No	Yes, less than 12 months ago	Yes, 12-23 months ago	Yes, 24 or more months ago
38.1. Cataract(s)	0	1	2	3
38.2. Macular degeneration of the retina	0	1	2	3
38.3. Asthma	0	1	2	3
38.4. Emphysema or chronic bronchitis	0	1	2	3
38.5. Heart failure or congestive heart failure	0	1	2	3
38.6. Angina (chest pains from the heart)	0	1	2	3
38.7. Atrial fibrillation	0	1	2	3
38.8. Kidney or bladder stones (renal or urinary calculi)	0	1	2	3
38.9. Dialysis for kidney or renal failure	0	1	2	3
38.10. Stomach or duodenal ulcer	0	1	2	3
38.11. Diverticulitis	0	1	2	3
38.12. Pancreatitis (inflamed pancreas)	0	1	2	3
38.13. Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)	0	1	2	3
38.14. Overactive thyroid	0	1	2	3
38.15. Underactive thyroid	0	1	2	3
38.16. Alzheimer's disease	0	1	2	3
38.17. Multiple sclerosis	0	1	2	3
38.18. Parkinson's disease	0	1	2	3
38.19. Amyotropic Lateral Sclerosis (ALS, motor neuron disease, or Lou Gehrig's disease)	0	1	2	3

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325103

PLEASE MAKE NO MARKS IN THIS AREA

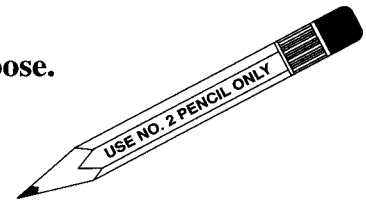
Ver. 1.1
OMB #0925-0414 Exp: 6/00

WOMEN'S HEALTH INITIATIVE

Form 144 - OS Follow-Up Questionnaire (Year 4)

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 weight is 159:

1	5	9

100 200 300 400 500 600 700
○ ● ○ ○ ○ ○ ○

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
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Y 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
⑧ Other

4. Visit Type:

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

6. Language:

● E ○ S

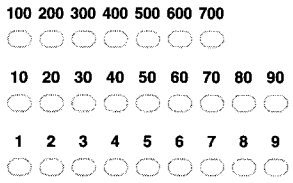
220355

PLEASE MAKE NO MARKS IN THIS AREA

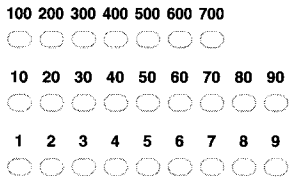
This questionnaire asks you about factors that may affect your health. These include weight changes, physical activity and exercise, exposure to sunlight, smoking habits, types of sweeteners in your diet, use of female hormones and recent medical conditions.

The following questions are about your weight.

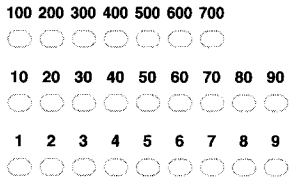
1. What is your current weight? ___ ___ ___ **pounds**



2. In the past year, what was your highest weight? ___ ___ ___ **pounds**



3. In the past year, what was your lowest weight? ___ ___ ___ **pounds**



The following questions are about your usual physical activity and exercise. This includes walking and sports.

4. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? **(Mark only one.)**

- ⓪ Rarely or never
- ① 1-3 times each month
- ② 1 time each week
- ③ 2-3 times each week
- ④ 4-6 times each week
- ⑤ 7 or more times each week

4.1. When you walk outside the home for more than 10 minutes without stopping, for how many minutes do you usually walk?

Less than 20 min.	20-39 min.	40-59 min.	1 hour or more
①	②	③	④

4.2. What is your usual speed?

- ② Casual strolling or walking (less than 2 miles an hour)
- ③ Average or normal (2-3 miles an hour)
- ④ Fairly fast (3-4 miles an hour)
- ⑤ Very fast (more than 4 miles an hour)
- ⑨ Don't know

Go to the next page.

5. Not including walking outside the home, how often each week (7 days) do you usually do the exercises below?

5.1. STRENUOUS OR VERY HARD EXERCISE (You work up a sweat and your heart beats fast). For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

5.2. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

5.3. MODERATE EXERCISE (Not exhausting.) For example, biking outdoors, use of an exercise machine (like a stationary bike or treadmill), calisthenics, easy swimming, popular and folk dancing.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

5.4. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

5.5. MILD EXERCISE. For example, slow dancing, bowling, golf.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

5.6. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA 220355

The following questions are about your exposure to sunlight.

6. After you have been out in the sun for 45 - 60 minutes for the first time during the summer, which describes the reaction of your unprotected skin in exposed areas? **(Mark one.)**

④ Burns but does not tan

③ Burns, then tans a minimal amount

② Burns, then tans

① Tans but does not burn

⓪ No change in skin color

7. On the average, how much time per day did you spend outdoors during daylight hours when you were the ages listed below? Give your best guess.

7.1. **During summer**	Less than 30 minutes	30 minutes to 2 hours	More than 2 hours
7.1.1 During childhood (5-12 years old)	①	②	③
7.1.2 During your teens	①	②	③
7.1.3 During your thirties	①	②	③
7.1.4 This year	①	②	③

7.2. **During other seasons**	Less than 30 minutes	30 minutes to 2 hours	More than 2 hours
7.2.1 During childhood (5-12 years old)	①	②	③
7.2.2 During your teens	①	②	③
7.2.3 During your thirties	①	②	③
7.2.4 This year	①	②	③

8. Did you usually wear dark glasses when you were outdoors in sunlight?

	No	Yes	Don't know
8.1 During childhood (5-12 years old)	⓪	①	⑨
8.2 During your teens	⓪	①	⑨
8.3 During your thirties	⓪	①	⑨
8.4 This year	⓪	①	⑨

9. Did you usually wear a hat with a brim when you were outdoors in sunlight?

		No	Yes	Don't know
9.1	During childhood (5-12 years old)	⓪	①	⑨
9.2	During your teens	⓪	①	⑨
9.3	During your thirties	⓪	①	⑨
9.4	This year	⓪	①	⑨

10. During the past year, when you were outside for more than 10 minutes, did you usually use a sunscreen?

⓪ No ① Yes

10.1. What was the SPF (Sun Protection Factor) you usually used?

2-9	10-14	15-24	25 or more	Don't know
①	②	③	④	⑨

The following questions are about smoking.

11. Do you smoke cigarettes now?

⓪ No ① Yes

11.1. How many cigarettes do you usually smoke each day? **(Mark one.)**

① Less than 5	④ 25-34
② 5-14	⑤ 35-44
③ 15-24	⑥ 45 or more

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

The following questions are about your use of different types of sweeteners.

12. During the past year, about how often did you have the following: **(Please give your best guess.)**

	Less than 1 per week	1-3 per week	4-6 per week	1 per day	2-3 per day	More than 3 per day	Don't know
12.1. Diet soda or fruit drink with Nutrasweet (like Diet Coke®, Diet Pepsi®, Crystal Light®)	1	2	3	4	5	6	9
12.2. Diet soda or fruit drink with saccharine	1	2	3	4	5	6	9
12.3. A drink sweetened with Equal®	1	2	3	4	5	6	9
12.4. A drink sweetened with Sweet N Low®	1	2	3	4	5	6	9
12.5. A dessert made with Equal®	1	2	3	4	5	6	9
12.6. A dessert made with Sweet N Low®	1	2	3	4	5	6	9
12.7. A food with the fat substitute Olestra®	1	2	3	4	5	6	9

13. Ten years ago, about how often did you have: **(Please give your best guess.)**

	1 per week or less	2-6 per week	1 per day or more	Don't know
13.1. Diet soda or fruit drink with Nutrasweet (like Diet Coke®, Diet Pepsi®, Crystal Light®)	1	2	3	9
13.2. Diet soda with saccharine	1	2	3	9
13.3. A drink sweetened with Equal®	1	2	3	9
13.4. A drink sweetened with Sweet N Low®	1	2	3	9
13.5. A dessert made with Equal®	1	2	3	9
13.6. A dessert made with Sweet N Low®	1	2	3	9

14. Twenty years ago, about how often did you have: **(Please give your best guess.)**

	1 per week or less	2-6 per week	1 per day or more	Don't know
14.1. Diet soda with saccharine (like Diet Coke®, Diet Pepsi®)	1	2	3	9
14.2. A drink sweetened with Sweet N Low®	1	2	3	9
14.3. A dessert made with Sweet N Low®	1	2	3	9

The next set of questions are about female hormones (estrogen or progesterone) you might have used during the past year. Women's use of hormones has been changing – these questions help us understand your patterns of use.

Question 15 is about natural hormones you get without a doctor's prescription.

15. In the past year, did you use any "natural" hormones that you can get without a doctor's prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, or skin cream.

⓪ No
⑨ Don't know

① Yes

15.1. In the past year, what types of "natural" hormones have you used? (Do not include hormone preparations that need a doctor's prescription.) **(Mark all that apply.)**

① Wild yam or progesterone creams
② Wild yam pills
③ Progesterone suppositories
④ DHEA (dehydroepiandosterone) pills
⑤ Phytoestrogen pills (soy or flax)
⑥ Phytoestrogen creams (soy or flax)
⑦ Phytoestrogen containing foods (tofu, soybeans)
⑧ Other
⑨ Don't know

Go to the next page.

The next questions (16-23) are about female hormones you get with a doctor's prescription.

16. In the past year, did you use female hormones (ESTROGEN or PROGESTERONE) that were prescribed by a doctor? (This may have been in the form of a pill, skin patch, shot, or vaginal cream or suppository.)

① Yes
⓪ No
⑨ Don't know → **Go to Question 24 on the last page.**

17. In the past year, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and progestin (PROGESTERONE) COMBINED in the same pill or package (for example, Prempro, Premphase)? (Do not include use of two separate estrogen and progestin pills used at the same time.)

⓪ No
⑨ Don't know
① Yes

17.1. In the past year, how many months did you use COMBINED female hormone PILLS which contained both ESTROGEN and PROGESTIN?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

18. In the past year, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and TESTOSTERONE COMBINED in the same pill (for example, Estratest)?

⓪ No
⑨ Don't know
① Yes

18.1. In the past year, how many months did you use COMBINED female hormone pills which contained both ESTROGEN and TESTOSTERONE?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

18.2. In the past year, what type of COMBINED ESTROGEN and TESTOSTERONE pill did you use the longest?

① Estratest
② Estratest HS
⑧ Other

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

19. In the past year, did you use ESTROGEN PILLS which were prescribed by a doctor (for example, Premarin, Estrace, Ogen)? **(Do not include the combined pill of estrogen and progestin or the combined pill of estrogen and testosterone.)**

⓪ No
⑨ Don't know

① Yes

19.1. In the past year, how many months did you use ESTROGEN PILLS?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

19.2. In the past year, when you were using ESTROGEN pills, what was the average number of days each month you used the pills?

⓪ Less than 1 day
① 1-7 days
② 8-14 days
③ 15-21 days
④ 22-27 days
⑤ 28 or more days

19.3. In the past year, what type of ESTROGEN pill did you use the longest?

① Premarin or conjugated equine estrogens
② Estrace
③ Ogen
⑧ Other
⑨ Don't know

19.4. What dose did you usually take each day? **(Mark one. If you regularly take more than one dose, mark the lowest dose.)**

① 0.3 mg
② 0.625 mg
③ 0.9 mg
④ 1 mg
⑤ 1.25 mg
⑥ 2 mg
⑦ 2.5 mg
⑧ Other
⑨ Don't know

20. In the past year, did you take shots containing the hormone ESTROGEN?

⓪ No
⑨ Don't know

① Yes

20.1. In the past year, how many months did you take the shots? **(Count each shot as one month.)**

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

Go to the next page.

21. In the past year, did you use a vaginal cream or suppository containing ESTROGEN which was prescribed by a doctor?

⓪ No
⑨ Don't know
① Yes

21.1. In the past year, how many months did you use the vaginal cream or suppository?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

22. In the past year, did you use a SKIN PATCH containing the hormone ESTROGEN with or without PROGESTERONE (for example, Estraderm, Climara, Vivelle)?

⓪ No
⑨ Don't know
① Yes

22.1. In the past year, how many months did you use the patch?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

22.2. In the past year, what type of patch did you use the longest?

① ESTROGEN only (for example, Estraderm, Climara, Vivelle)
② ESTROGEN plus PROGESTERONE
⑧ Other
⑨ Don't know

22.3. What dose of ESTROGEN was in the skin patch you usually used?

① 0.05 mg
② 0.1 mg
⑧ Other
⑨ Don't know

22.4. What was the average number of times each week that you changed your skin patch?

① Less than once each week
② 1-2 times each week
③ 3-4 times each week
④ 5 or more times each week

Go to the next page.

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PLEASE MAKE NO MARKS IN THIS AREA

Question 23 is about products that contain the hormone PROGESTERONE (progestin) and not ESTROGEN.

23. In the past year, did you use the female hormone PILL called PROGESTERONE or progestin (for example, Provera, Cycrin, Aman, Megace)? **(Do not include the combined pill of estrogen and progestin.)**

① Yes
⓪ No
⑨ Don't know → **Go to question 24 on the next page.**

23.1. In the past year, how many months did you use PROGESTERONE or progestin pills?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

23.2. In the past year, when you were using PROGESTERONE or progestin pills, what was the average number of days each month you used the pills?

⓪ Less than 1 day
① 1-9 days
② 10-12 days
③ 13-18 days
④ 19-27 days
⑤ 28 or more days

23.3. In the past year, what type of PROGESTERONE or progestin pill did you use the longest?

① Provera, Cycrin or Amen (Medroxy Progesterone)
② Megace
③ Micronized Progesterone
⑧ Other
⑨ Don't know

23.4. What dose did you usually take each day? **(Mark one. If you regularly take more than one dose, mark the lowest dose.)**

① 2.5 mg
② 5 mg
③ 7.5 mg
④ 10 mg
⑤ 20 mg
⑥ 40 mg
⑦ More than 40 mg
⑧ Other
⑨ Don't know

24. In the past year, has a doctor told you that you have any of the following conditions? **(Please mark one response for each condition.)**

		No	Yes
24.1.	Cataract(s)	0	1
24.2.	Macular degeneration of the retina	0	1
24.3.	Asthma	0	1
24.4.	Emphysema or chronic bronchitis	0	1
24.5.	Heart failure or congestive heart failure	0	1
24.6.	Angina (chest pains from the heart)	0	1
24.7.	Atrial fibrillation	0	1
24.8.	Kidney or bladder stones (renal or urinary calculi)	0	1
24.9.	Dialysis for kidney or renal failure	0	1
24.10.	Stomach or duodenal ulcer	0	1
24.11.	Diverticulitis	0	1
24.12.	Pancreatitis (inflamed pancreas)	0	1
24.13.	Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)	0	1
24.14.	Overactive thyroid	0	1
24.15.	Underactive thyroid	0	1
24.16.	Alzheimer's disease	0	1
24.17.	Multiple sclerosis	0	1
24.18.	Parkinson's disease	0	1
24.19.	Amyotropic Lateral Sclerosis (ALS, motor neuron disease, or Lou Gehrig's disease)	0	1

The last question is about your current living situation.

25. What is your current marital status? **(Mark the one that best describes you.)**

① Never married
② Divorced or separated
③ Widowed
④ Presently married
⑤ Living in a marriage-like relationship

Thank You. Please take a few minutes to review any questions you may have missed.

* U.S. GOVERNMENT PRINTING OFFICE:1999–789-310/80005

220355

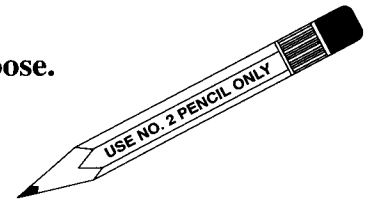
PLEASE MAKE NO MARKS IN THIS AREA

WOMEN'S HEALTH INITIATIVE

Form 145 - OS Follow-Up Questionnaire (Observational Study - Year 5)

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 weight is 159:

1	5	9

100 200 300 400 500 600 700
●○○○○○○

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 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
8 Other

4. Visit Type:

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

6. Language:

●E ○S

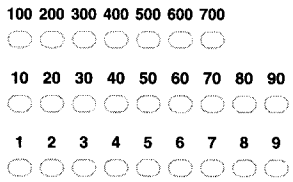
PLEASE MAKE NO MARKS IN THIS AREA

103860

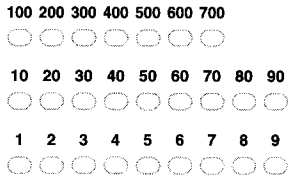
This questionnaire asks you about factors that may affect your health. These include weight changes, physical activity and exercise, smoking habits, your use of computers, recent emotions, religious practices, use of alternative medical treatments, dental health, use of female hormones, and recent medical conditions.

The following questions are about your weight.

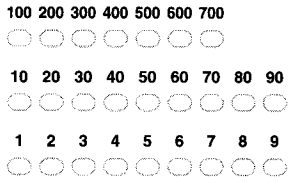
1. What is your current weight? ⌊_⌊_⌊_⌋ **pounds**



2. In the past year, what was your highest weight? ⌊_⌊_⌊_⌋ **pounds**



3. In the past year, what was your lowest weight? ⌊_⌊_⌊_⌋ **pounds**



The following questions are about your usual physical activity and exercise. This includes walking and sports.

4. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? **(Mark only one.)**

⓪ Rarely or never
① 1-3 times each month
② 1 time each week
③ 2-3 times each week
④ 4-6 times each week
⑤ 7 or more times each week

4.1. When you walk outside the home for more than 10 minutes without stopping, for how many minutes do you usually walk?

Less than 20 min.	20-39 min.	40-59 min.	1 hour or more
①	②	③	④

4.2. What is your usual speed?

② Casual strolling or walking (less than 2 miles an hour)
③ Average or normal (2-3 miles an hour)
④ Fairly fast (3-4 miles an hour)
⑤ Very fast (more than 4 miles an hour)
⑨ Don't know

Go to the next page.

5. Not including walking outside the home, how often each week (7 days) do you usually do the exercises below?

5.1. STRENUOUS OR VERY HARD EXERCISE (You work up a sweat and your heart beats fast). For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

5.2. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

5.3. MODERATE EXERCISE (Not exhausting.) For example, biking outdoors, use of an exercise machine (like a stationary bike or treadmill), calisthenics, easy swimming, popular and folk dancing.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

5.4. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

5.5. MILD EXERCISE. For example, slow dancing, bowling, golf.

⓪ None
① 1 day per week
② 2 days per week
③ 3 days per week
④ 4 days per week
⑤ 5 or more days per week

5.6. How long do you usually exercise like this at one time?
① Less than 20 min.
② 20-39 min.
③ 40-59 min.
④ 1 hour or more

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA

103860

The following questions are about smoking.

6. Do you smoke cigarettes now?

⓪ No

① Yes

6.1. How many cigarettes do you usually smoke each day? **(Mark one.)**

① Less than 5
② 5-14
③ 15-24
④ 25-34
⑤ 35-44
⑥ 45 or more

The following questions ask about time spent working at a computer screen.

7. In the past four years, did you ever sit in front of a computer screen within three feet with the power turned "on" (for example, when writing letters)?

⓪ No

① Yes

7.1. In the past four years, what was the average number of days each week that you sat in front of a computer screen with the power turned "on"? **(Mark one.)**

⓪ Less than 1 day each week → **Go to Question 8 on next page.**

① 1 day each week
② 2 days each week
③ 3 days each week
④ 4 days each week
⑤ 5 or more days each week

7.2. On the days that you used a computer, what was the average number of hours that you sat in front of a computer screen with the power turned "on"? **(Mark one.)**

① Less than 1 hour each day
② 1-3 hours each day
③ 4-6 hours each day
④ 7 or more hours each day

Go to the next page.

The following questions are about emotions you may have been feeling. Please mark one box for each statement.

8. How true have the following been for you in this past week (7 days)?

	Not at all	A little bit	Some-what	Quite a bit	Very much
8.1 I feel peaceful.	⓪	①	②	③	④
8.2 I have a reason for living.	⓪	①	②	③	④
8.3 I feel a sense of purpose in my life.	⓪	①	②	③	④
8.4 I am able to reach down deep into myself for comfort.	⓪	①	②	③	④
8.5 I feel a sense of harmony within myself.	⓪	①	②	③	④
8.6 I find comfort in my faith.	⓪	①	②	③	④
8.7 I find strength in my faith.	⓪	①	②	③	④

The following questions are about your religious practices.

9.1. In the past year, how often did you attend regular religious services?

⑤ More than once a week
④ About once a week
③ A few times per month
② A few times per year
① Never attended but watched/listened on TV or radio
⓪ Never attended

9.2. In the past year, how often did you spend time in private religious activities such as prayer, meditation, bible reading, or reading religious literature?

⑤ Every day
④ A few times per week
③ About once per week
② A few times per month
① A few times per year
⓪ Never

The following question is about your use of alternative medical treatments.

10. In the past year, have you used a non-traditional or alternative medicine treatment or technique, such as herbal remedies, mental imagery, spiritual healing, acupressure, acupuncture, or homeopathy?

⓪ No ① Yes ⑨ Don't know

103860

PLEASE MAKE NO MARKS IN THIS AREA

The following questions are about your dental health.

11. How would you describe the condition of your mouth and teeth?

Excellent	Very Good	Good	Fair	Poor
(5)	(4)	(3)	(2)	(1)

12. Does your mouth feel dry when you eat a meal?

(0) No (1) Yes

13. How often have you limited the kinds or amounts of food you eat because of problems with your teeth or dentures?

Always	Often	Sometimes	Seldom	Never
(4)	(3)	(2)	(1)	(0)

14. During the past 3 years, how often have you gone to the dentist or dental hygienist for routine check-ups or cleanings? **(Mark one.)**

(0) I have not gone to the dentist or dental hygienist at all during the past three years for check-ups or cleanings.

(1) 2 or more times per year.

(2) Once per year.

(3) Less than once per year.

(4) Whenever needed, no regular schedule.

15. Has a dentist or dental hygienist ever told you that you had periodontal or gum disease?

(0) No (1) Yes

16. Have you lost ALL of your permanent teeth, both upper and lower?

(0) No (1) Yes

The next set of questions are about female hormones (estrogen or progesterone) you might have used during the past year. Women's use of hormones has been changing – these questions help us understand your patterns of use.

Question 17 is about natural hormones you get without a doctor's prescription.

17. In the past year, did you use any "natural" hormones that you can get without a doctor's prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, or skin cream.

⓪ No
⑨ Don't know

① Yes

17.1. In the past year, what types of "natural" hormones have you used? (Do not include hormone preparations that need a doctor's prescription.) **(Mark all that apply.)**

① Wild yam or progesterone creams
② Wild yam pills
③ Progesterone suppositories
④ DHEA (dehydroepiandosterone) pills
⑤ Phytoestrogen pills (soy or flax)
⑥ Phytoestrogen creams (soy or flax)
⑦ Phytoestrogen containing foods (tofu, soybeans)
⑧ Other
⑨ Don't know

Go to the next page.

The next questions (18-25) are about female hormones you get with a doctor's prescription.

18. In the past year, did you use female hormones (ESTROGEN or PROGESTERONE) that were prescribed by a doctor? (This may have been in the form of a pill, skin patch, shot, or vaginal cream or suppository.)

① Yes
⓪ No
⑨ Don't know → **Go to Question 26 on the last page.**

19. In the past year, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and progestin (PROGESTERONE) COMBINED in the same pill or package (for example, Prempro, Premphase)? (Do not include use of two separate estrogen and progestin pills used at the same time.)

⓪ No
⑨ Don't know
① Yes

19.1. In the past year, how many months did you use COMBINED female hormone PILLS which contained both ESTROGEN and PROGESTIN?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

20. In the past year, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and TESTOSTERONE COMBINED in the same pill (for example, Estratest)?

⓪ No
⑨ Don't know
① Yes

20.1. In the past year, how many months did you use COMBINED female hormone pills which contained both ESTROGEN and TESTOSTERONE?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

20.2. In the past year, what type of COMBINED ESTROGEN and TESTOSTERONE pill did you use the longest?

① Estratest
② Estratest HS
⑧ Other

Go to the next page.

103860

PLEASE MAKE NO MARKS IN THIS AREA

21. In the past year, did you use ESTROGEN PILLS which were prescribed by a doctor (for example, Premarin, Estrace, Ogen)? **(Do not include the combined pill of estrogen and progestin or the combined pill of estrogen and testosterone.)**

⓪ No
⑨ Don't know
① Yes

21.1. In the past year, how many months did you use ESTROGEN PILLS?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

21.2. In the past year, when you were using ESTROGEN pills, what was the average number of days each month you used the pills?

⓪ Less than 1 day
① 1-7 days
② 8-14 days
③ 15-21 days
④ 22-27 days
⑤ 28 or more days

21.3. In the past year, what type of ESTROGEN pill did you use the longest?

① Premarin or conjugated equine estrogens
② Estrace
③ Ogen
⑧ Other
⑨ Don't know

21.4. What dose did you usually take each day? **(Mark one. If you regularly take more than one dose, mark the lowest dose.)**

① 0.3 mg
② 0.625 mg
③ 0.9 mg
④ 1 mg
⑤ 1.25 mg
⑥ 2 mg
⑦ 2.5 mg
⑧ Other
⑨ Don't know

22. In the past year, did you take shots containing the hormone ESTROGEN?

⓪ No
⑨ Don't know
① Yes

22.1. In the past year, how many months did you take the shots? **(Count each shot as one month.)**

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

Go to the next page.

23. In the past year, did you use a vaginal cream or suppository containing ESTROGEN which was prescribed by a doctor?

⓪ No ① Yes
⑨ Don't know

23.1. In the past year, how many months did you use the vaginal cream or suppository?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

24. In the past year, did you use a SKIN PATCH containing the hormone ESTROGEN with or without PROGESTERONE (for example, Estraderm, Climara, Vivelle)?

⓪ No ① Yes
⑨ Don't know

24.1. In the past year, how many months did you use the patch?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

24.2. In the past year, what type of patch did you use the longest?

① ESTROGEN only (for example, Estraderm, Climara, Vivelle)
② ESTROGEN plus PROGESTERONE
⑧ Other
⑨ Don't know

24.3. What dose of ESTROGEN was in the skin patch you usually used?

① 0.05 mg
② 0.1 mg
⑧ Other
⑨ Don't know

24.4. What was the average number of times each week that you changed your skin patch?

① Less than once each week
② 1-2 times each week
③ 3-4 times each week
④ 5 or more times each week

Go to the next page.

103860

PLEASE MAKE NO MARKS IN THIS AREA

Question 25 is about products that contain the hormone PROGESTERONE (progestin) and not ESTROGEN.

25. In the past year, did you use the female hormone PILL called PROGESTERONE or progestin (for example, Provera, Cycrin, Aman, Megace)? **(Do not include the combined pill of estrogen and progestin.)**

① Yes
⓪ No
⑨ Don't know

→ **Go to question 26 on the next page.**

25.1. In the past year, how many months did you use PROGESTERONE or progestin pills?

① Less than 1 month
② 1-6 months
③ 7-10 months
④ 11-12 months

25.2. In the past year, when you were using PROGESTERONE or progestin pills, what was the average number of days each month you used the pills?

① Less than 1 day
② 1-9 days
③ 10-12 days
④ 13-18 days
⑤ 19-27 days
⑥ 28 or more days

25.3. In the past year, what type of PROGESTERONE or progestin pill did you use the longest?

① Provera, Cycrin or Amen (Medroxy Progesterone)
② Megace
③ Micronized Progesterone
⑧ Other
⑨ Don't know

25.4. What dose did you usually take each day? **(Mark one. If you regularly take more than one dose, mark the lowest dose.)**

① 2.5 mg
② 5 mg
③ 7.5 mg
④ 10 mg
⑤ 20 mg
⑥ 40 mg
⑦ More than 40 mg
⑧ Other
⑨ Don't know

26. In the past year, has a doctor told you that you have any of the following conditions? **(Please mark one response for each condition.)**

	No	Yes
26.1. Cataract(s)	0	1
26.2. Macular degeneration of the retina	0	1
26.3. Asthma	0	1
26.4. Emphysema or chronic bronchitis	0	1
26.5. Heart failure or congestive heart failure	0	1
26.6. Angina (chest pains from the heart)	0	1
26.7. Atrial fibrillation	0	1
26.8. Kidney or bladder stones (renal or urinary calculi)	0	1
26.9. Dialysis for kidney or renal failure	0	1
26.10. Stomach or duodenal ulcer	0	1
26.11. Diverticulitis	0	1
26.12. Pancreatitis (inflamed pancreas)	0	1
26.13. Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)	0	1
26.14. Overactive thyroid	0	1
26.15. Underactive thyroid	0	1
26.16. Alzheimer's disease	0	1
26.17. Multiple sclerosis	0	1
26.18. Parkinson's disease	0	1
26.19. Amyotropic Lateral Sclerosis (ALS, motor neuron disease, or Lou Gehrig's disease)	0	1

The last question is about your current living situation.

27. What is your current marital status? **(Mark the one that best describes you.)**

① Never married
② Divorced or separated
③ Widowed
④ Presently married
⑤ Living in a marriage-like relationship

Thank You. Please take a few minutes to review any questions you may have missed.

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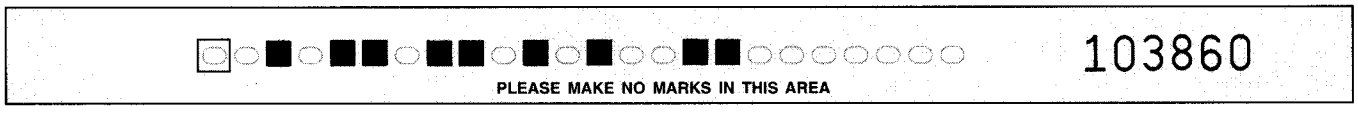
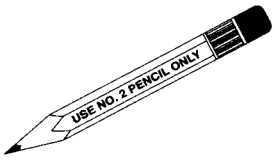


WOMEN'S HEALTH INITIATIVE

Form 146 - OS Follow-Up Questionnaire (Observational Study - Year 6)

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 weight is 159:

1	5	9

100 200 300 400 500 600 700 — ● (150)

10 20 30 40 50 60 70 80 90 — ● (50)

1 2 3 4 5 6 7 8 9 — ● (9)

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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 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

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

3. Contact Type:

1 Phone
2 Mail
3 Visit
8 Other

4. Visit Type:

3 Annual 1 2 3 4 5 6 7 8 9

4 Non-Routine 1 2 3 4 5 6 7 8 9

5. Language:

● E S

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PLEASE MAKE NO MARKS IN THIS AREA

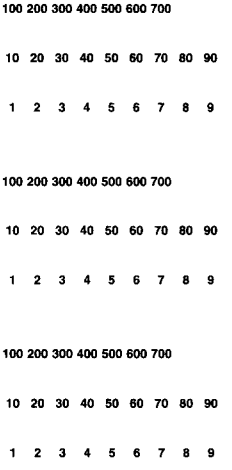
This questionnaire asks you about factors that may affect your health. These include physical activity and exercise, use of alcoholic drinks, smoking habits, use of female hormones, recent medical conditions, and household income.

The following questions are about your weight. (Give your best guess.)

1. What is your current weight? ___ ___ ___ **pounds**

2. In the past year, what was your highest weight? ___ ___ ___ **pounds**

3. In the past year, what was your lowest weight? ___ ___ ___ **pounds**



The following questions are about any weight changes you may have had in the past three years.

4. In the past 3 years, did you lose five or more pounds on purpose at any time?

0 No
9 Don't know
1 Yes

4.1. What method(s) did you use to lose weight? **(Mark all that apply.)**

- 1 Change in diet
- 2 Increased exercise
- 9 Prescription diet pill (e.g., Redux, Meridia, Xenical)
- 10 Over-the-counter diet pill (e.g., Acutrim)
- 5 Commercial weight loss program
- 6 Started or increased smoking
- 7 Surgical procedure (such as intestinal bypass or stomach balloon)
- 8 Other **(Specify):** _____

Go to the next page.

5. In the past 3 years, did you lose five or more pounds not on purpose at any time?

0 No
9 Don't know
1 Yes

5.1. What was the cause of this weight loss? **(Mark all that apply.)**

1 Illness
2 Depression
3 Stressful time
4 Life events (e.g., change in job or marital status)
5 Loss of appetite
6 Loss of taste
8 Other **(Specify):** _____
_____
9 Don't know

The following questions are about your usual physical activity and exercise. This includes walking and sports.

6. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? **(Mark only one.)**

Rarely or never	1-3 times each month	1 time each week	2-3 times each week	4-6 times each week	7 or more times each week
0	1	2	3	4	5

6.1. When you walk outside the home for more than 10 minutes without stopping, for how many minutes do you usually walk?

Less than 20 min.	20-39 min.	40-59 min.	1 hour or more
1	2	3	4

6.2. What is your usual speed?

2 Casual strolling or walking (less than 2 miles an hour)
3 Average or normal (2-3 miles an hour)
4 Fairly fast (3-4 miles an hour)
5 Very fast (more than 4 miles an hour)
9 Don't know

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA

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7. Not including walking outside the home, how often each week (7 days) do you usually do STRENUOUS OR VERY HARD EXERCISE (you work up a sweat and your heart beats fast)? For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.

None	1 day per week	2 days per week	3 days per week	4 days per week	5 or more days per week
0	1	2	3	4	5

7.1. How long do you usually exercise like this at one time?

Less than 20 mins.	20-39 mins.	40-59 mins.	1 hour or more
1	2	3	4

8. Not including walking outside the home, how often each week (7 days) do you usually do MODERATE EXERCISE (not exhausting)? For example, biking outdoors, use of an exercise machine (like stationary bike or treadmill), calisthenics, easy swimming, popular and folk dancing.

None	1 day per week	2 days per week	3 days per week	4 days per week	5 or more days per week
0	1	2	3	4	5

8.1. How long do you usually exercise like this at one time?

Less than 20 mins.	20-39 mins.	40-59 mins.	1 hour or more
1	2	3	4

9. Not including walking outside the home, how often each week (7 days) do you usually do MILD EXERCISE? For example, slow dancing, bowling, golf.

None	1 day per week	2 days per week	3 days per week	4 days per week	5 or more days per week
0	1	2	3	4	5

9.1. How long do you usually exercise like this at one time?

Less than 20 mins.	20-39 mins.	40-59 mins.	1 hour or more
1	2	3	4

Go to the next page.

The next set of questions asks about some of your usual activities.

10. About how many hours each week do you usually spend doing heavy (strenuous) indoor household chores such as scrubbing floors, sweeping, or vacuuming?

Less than 1 hour	1-3 hours	4-6 hours	7-9 hours	10 or more hours
1	2	3	4	5

11. About how many months during the year do you usually do things in the yard, such as mowing, raking, gardening, or shoveling snow?

Less than 1 month	1-3 months	4-6 months	7-9 months	10 or more months
1	2	3	4	5

11.1. When you do these things in the yard, how many hours each week do you do them?

Less than 1 hour	1-3 hours	4-6 hours	7-9 hours	10 or more hours
1	2	3	4	5

12. During a usual day and night, about how many hours do you spend sitting? Be sure to include the time you spend sitting at work, sitting at the table eating, driving or riding in a car or bus, and sitting up watching TV or talking.

Less than 4 hours	4-5 hours	6-7 hours	8-9 hours	10-11 hours	12-13 hours	14-15 hours	16 or more hours
1	2	3	4	5	6	7	8

13. During a usual day and night, about how many hours do you spend sleeping or lying down? Be sure to include the time you spend sleeping or trying to sleep at night, resting or napping, and lying down watching TV.

Less than 4 hours	4-5 hours	6-7 hours	8-9 hours	10-11 hours	12-13 hours	14-15 hours	16 or more hours
1	2	3	4	5	6	7	8

Go to the next page.

The following questions are about coffee, tea, soft drinks, and alcoholic beverages you may drink.

14. During the past 3 months, how often did you drink these beverages: **(Mark one for each beverage.)** (For coffee, large or doubles count as 2 cups.)

	Never or less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6 or more per day
14.1. Caffeinated coffee, either instant or paper-filtered drip (cups)	1	2	3	4	5	6	7	8	9
14.2. Other caffeinated coffee, such as perked, espresso or latté (cups)	1	2	3	4	5	6	7	8	9
14.3. Decaf coffee, either instant or paper-filtered drip (cups)	1	2	3	4	5	6	7	8	9
14.4. Other decaf coffee, such as perked, espresso or latté (cups)	1	2	3	4	5	6	7	8	9
14.5. Regular tea (not decaf) (cups)	1	2	3	4	5	6	7	8	9
14.6. Decaf tea (cups)	1	2	3	4	5	6	7	8	9
14.7. Soft drinks with caffeine (such as Coke®, Diet Pepsi®, Dr. Pepper®, Mountain Dew®) (12 oz. can)	1	2	3	4	5	6	7	8	9
14.8. Soft drinks without caffeine (such as Sprite®, 7-Up®, Diet Sprite®) (12 oz. can)	1	2	3	4	5	6	7	8	9

Go to the next page.

15. During the past 3 months, have you had any drinks containing alcohol?

1 Yes 0 No → **Go to the next page.**

15.1. In the past 3 months, how often have you had drinks containing alcohol?

1 One day per month or less
2 2-3 days per month
3 1-2 days per week
4 3-4 days per week
5 5-6 days per week
6 Every day or about every day

15.2. In the past 3 months, on the days you drank, how many drinks did you usually have per day? **(A drink is a 12 ounce glass of beer, one 4 ounce glass of wine, or one shot [1 1/4 oz.] of liquor)**

1 1 drink
2 2 drinks
3 3 drinks
4 4-5 drinks
5 6-7 drinks
6 8-9 drinks
7 10-11 drinks
8 12 or more drinks

15.3. In the past 3 months, on the days you drank, how many of those drinks did you usually drink that were not around a major meal (not around lunch, not around dinner)?

0 None
1 1 drink
2 2 drinks
3 3 drinks
4 4-5 drinks
5 6-7 drinks
6 8-9 drinks
7 10-11 drinks
8 12 or more drinks

15.4. Do you drink more than usual for special occasions?

0 No 1 Yes →

15.5. How often does this happen?

1 Less than once per month
2 Once a month
3 2-3 times per month
4 Once a week or more

Go to the next page.

337601

PLEASE MAKE NO MARKS IN THIS AREA

16. In the past 3 years have you changed your alcohol drinking habits?

0 No 1 Yes

16.1. How have you changed your alcohol drinking? Have you:

1 Stopped

2 Decreased

3 Increased

4 Started

16.2. Why did you make this change? **(Mark one.)**

1 Concern about current or past health problems

2 Concern about future health

8 Other

The following questions are about cigarette smoking.

17. Do you smoke cigarettes now?

0 No 1 Yes

17.1. How many cigarettes do you usually smoke each day? **(Mark one.)**

1 Less than 5

2 5-14

3 15-24

4 25-34

5 35-44

6 45 or more

18. Does anyone living with you now smoke cigarettes regularly inside your home?

0 No 1 Yes

18.1. Please mark all the people who live with you who now smoke cigarettes regularly inside your home: **(Mark all that apply.)**

1 Husband or partner

2 Son(s) or daughter(s)

3 Other person/people

19. Do you now work in a space where people smoke cigarettes?

0 No 1 Yes

Go to the next page.

The next questions are about your health and medical care.

20. Do you have a clinic, doctor, nurse, or physician assistant who provides your usual medical care?

0 No 1 Yes

20.1. When did you last visit this clinic or person? **(Please give your best guess.)**

1 In the last 3 months
2 4-6 months ago
3 7-12 months ago
4 Over a year ago

20.2. Has your usual health care provider changed in the past 3 years?

0 No 1 Yes

21. Do you currently have health insurance? This includes pre-paid private insurance such as a Health Maintenance Organization (HMO), other private insurance, Medicare, Medicaid (including State Medical Assistance or Medi-Cal), or Military or Veterans Administration health care coverage.

0 No 1 Yes

21.1. Which of the following best describes the doctors and hospitals covered by your current health insurance? **(Mark one.)**

1 Benefits are the same for any doctor or hospital I choose.
2 I can use any doctor or hospital, but I must pay more for those not on a list (or identified with the plan).
3 For my bills to be covered, I must use only the doctors and hospitals on a list (or identified with the plan).

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA 337601

22. Do you currently have any of the following types of health insurance: **(Please answer for each type of insurance listed.)**

22.1. Pre-paid private insurance, such as a Health Maintenance Organization (HMO), Kaiser Permanente or other Group Health-type plan?

No 0 Yes 1 →

22.2. Who pays for this insurance? **(Mark all that apply.)**
- 1 Costs are paid by my employer or my spouse's employer
- 2 Costs are paid by me
- 3 Medicare

22.3. Other private insurance such as Blue Cross, Aetna, etc.?

No 0 Yes 1 →

22.4. Who pays for this insurance? **(Mark all that apply.)**
- 1 Costs are paid by my employer or my spouse's employer
- 2 Costs are paid by me

22.5. Medicare?

No 0 Yes 1 →

22.6. Do you have additional coverage to supplement your Medicare benefits?
- 0 No
- 1 Yes

22.7. Medicaid, including State Medical Assistance (for example, Medi-Cal)?

No 0 Yes 1

22.8. Military or Veterans Administration-sponsored?

No 0 Yes 1

22.9. Other?

No 0 Yes 1

Go to the next page.

The next set of questions are about female hormones (estrogen or progesterone) you might have used during the past year. Women's use of hormones has been changing-these questions help us understand patterns of use.

Question 23 is about natural hormones you get without a doctor's prescription.

23. In the past year, did you use any "natural" hormones that you can get without a doctor's prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, skin cream, or soy-enriched foods.

0 No
9 Don't know
1 Yes

23.1. In the past year, what types of "natural" hormones have you used? (Do not include hormone preparations that need a doctor's prescription.) **(Mark all that apply.)**

1 Wild yam cream
2 Wild yam pills
10 Progesterone cream
3 Progesterone suppositories
4 DHEA (dehydroepiandrosterone) pills
5 Phytoestrogen pills or powder (soy or flax)
6 Phytoestrogen creams (soy or flax)
7 Phytoestrogen enriched foods (tofu, soybeans)
8 Other (Specify: _____)
9 Don't know

Question 24 is about treatment for osteoporosis that you get with a doctor's prescription.

24. In the past year, have you used Fosamax (alendronate) or Calcitonin?

0 No
9 Don't know
1 Yes

24.1. Which one(s)? **(Mark all that apply.)**

1 Alendronate (Fosamax)
2 Calcitonin (Miacalcin)
9 Don't know

Go to the next page.

Question 25 is about non-estrogen treatment for hormone replacement you get with a doctor's prescription.

25. In the past year, did you use any non-estrogen prescription treatments for hormone replacement? These may be prescribed to prevent osteoporosis and breast cancer and are sometimes called "designer estrogens" or selective estrogen receptor modulators (SERMs). Examples are Evista (Raloxifene) and Nolvadex (Tamoxifen).

0 No
9 Don't know

1 Yes

25.1. In the past year, what types of non-estrogen treatments for hormone replacement did you take? **(Mark all that apply.)**

1 Evista (Raloxifene)
2 Nolvadex (Tamoxifen)
8 Other (Specify: _____)
9 Don't know

The next questions (26-30) are about female hormones you get with a doctor's prescription.

26. In the past year, did you use any female hormones (ESTROGEN or PROGESTERONE [also called PROGESTIN]) that were prescribed by a doctor? (This may have been in the form of a pill, skin patch, shots, or vaginal cream or suppository.)

1 Yes

0 No
9 Don't know → **Go to Question 31 on page 16**

Go to the next page.

337601

PLEASE MAKE NO MARKS IN THIS AREA

27. In the past year, did you use female hormone PILLS or PATCHES prescribed by a doctor which contained both ESTROGEN and PROGESTERONE (PROGESTIN) COMBINED in the same pill, patch, or package (for example, Prempro, Premphase)? **(Do not include use of two separate estrogen and progesterone pills used at the same time.)**

0 No 1 Yes
9 Don't know

27.1. In the past year, how many months did you use COMBINED female hormone PILLS or PATCH which contained both ESTROGEN and PROGESTERONE?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

27.2. Which combination did you use the longest?

1 Prempro
2 CombiPatch
3 Premphase
8 Other (Specify: _____)

28. In the past year, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and TESTOSTERONE COMBINED in the same pill (for example, Estratest)?

0 No 1 Yes
9 Don't know

28.1. In the past year, how many months did you use COMBINED female hormone pills which contained both ESTROGEN and TESTOSTERONE?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

28.2. In the past year, what type of COMBINED ESTROGEN and TESTOSTERONE pills did you use the longest?

1 Estratest
2 Estratest HS
8 Other (Specify: _____)
9 Don't know

Go to the next page.

29. In the past year, did you use any ESTROGEN pill, patch, cream, or shots (other than the combinations described in Questions 27 and 28)?

1 Yes

0 No
9 Don't know → **Go to Question 30 on the next page.**

29.1. Did you use an estrogen pill?

0 No 1 Yes →

29.2. For how many months did you use the Estrogen pills?

1 Less than 1 month 3 7-10 months
2 1-6 months 4 11-12 months

29.3. What kind did you take? **(Mark the one used the longest if you used more than one kind.)**

1 Premarin or conjugated equine estrogens
2 Estrace or estradiol
3 Ogen or estropripate
4 Estratab or esterified estrogens
8 Other (Specify: _____)
9 Don't know

29.4. Did you use an estrogen patch?

0 No 1 Yes →

29.5. For how many months did you use the patch?

1 Less than 1 month 3 7-10 months
2 1-6 months 4 11-12 months

29.6. Did you use an estrogen cream?

0 No 1 Yes →

29.7. For how many months did you use the cream?

1 Less than 1 month 3 7-10 months
2 1-6 months 4 11-12 months

29.8. Did you have estrogen shots?

0 No 1 Yes →

29.9. For how many months did you have the shots?

1 Less than 1 month 3 7-10 months
2 1-6 months 4 11-12 months

Go to the next page.

337601

PLEASE MAKE NO MARKS IN THIS AREA

Question 30 is about products that contain the hormone PROGESTERONE (progestin) alone.

30. In the past year, did you use any PROGESTERONE or PROGESTIN pill, cream, or shots (other than the combinations described in Question 27)?

1 Yes

0 No
9 Don't know → **Go to Question 31 on the next page.**

30.1. Did you use a progesterone or progestin pill or capsule?

0 No 1 Yes →

30.2. For how many months did you use the pill or capsule?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

30.3. What kind did you take **(Mark the one used the longest if you used more than one kind)?**

1 Provera, Cycrin, Amen, or Medroxyprogesterone Acetate (MPA)
3 Prometrium or micronized progesterone
8 Other (Specify: _____)
9 Don't know

30.4. How many days per month did you use it?

1 Less than 1 day
2 1-9 days
3 10-12 days
4 13-18 days
5 19-27 days
6 28 or more days

30.5. Did you use a progesterone or progestin cream?

0 No 1 Yes →

30.6. For how many months did you use progesterone or progestin cream?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

30.7. Did you have progesterone or progestin shots?

0 No 1 Yes →

30.8. For how many months did you have progesterone or progestin shots?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

Go to the next page.

The next question is about your medical condition in the past year.

31. In the past year, has a doctor told you that you have any of the following conditions? **(Please mark one response for each condition.)**

		No	Yes
31.1.	Cataract(s)	0	1
31.2.	Macular degeneration of the retina	0	1
31.3.	Asthma	0	1
31.4.	Emphysema or chronic bronchitis	0	1
31.5.	Heart failure or congestive heart failure	0	1
31.6.	Angina (chest pains from the heart)	0	1
31.7.	Atrial fibrillation	0	1
31.8.	Kidney or bladder stones (renal or urinary calculi)	0	1
31.9.	Dialysis for kidney or renal failure	0	1
31.10.	Stomach or duodenal ulcer	0	1
31.11.	Diverticulitis	0	1
31.12.	Pancreatitis (inflamed pancreas)	0	1
31.13.	Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)	0	1
31.14.	Overactive thyroid	0	1
31.15.	Underactive thyroid	0	1
31.16.	Alzheimer's disease	0	1
31.17.	Multiple sclerosis	0	1
31.18.	Parkinson's disease	0	1
31.19.	Amyotropic Lateral Sclerosis (ALS, motor neuron disease, or Lou Gehrig's disease)	0	1

32. Has any member of your biological family (mother, father, sister, or brother) been diagnosed with Alzheimer's disease or senile dementia?

0 No 1 Yes →

32.1. Which family member? **(Please mark all that apply.)**

1 Mother 3 Any brother

2 Father 4 Any sister

Go to the next page.

337601

PLEASE MAKE NO MARKS IN THIS AREA

The next questions are about your current living situation.

33. What is your current job status? **(Mark the one that best describes you. If more than one describes you, mark both.)**

    1 Not working

    2 Retired

    3 Homemaker, raising children, care of others

    4 Employed (full-time or part-time)

    5 Disabled, unable to work

    8 Other **(Specify:** _____ **)**

34. What is your current marital status? **(Mark the one that best describes you.)**

Never married	Divorced or separated	Widowed	Presently married	Living in a marriage like relationship
1	2	3	4	5

34.1. What is your husband's (partner's) current job status? **(Mark one. If more than one applies, mark both.)**

    1 Not working

    2 Retired

    3 Homemaker, raising children, care of others

    4 Employed (full-time or part-time)

    5 Disabled, unable to work

    8 Other **(Specify:** _____ **)**

Go to the next page.

The following questions are about family finances. We know from other research that financial strain is common and very important to consider in understanding women's health. This information is important for describing the women in the study as a group and is kept strictly confidential. As always, answering the questions below is voluntary, and if you choose not to answer them, your participation in WHI is not affected.

35. How many people, including yourself, live in your household as members of your family (whom you support or who contribute to supporting your family)?

One	Two	Three	Four	Five or more
1	2	3	4	5

35.1. How many of these people are under 18 years old?

None	One	Two	Three	Four	Five or more
0	1	2	3	4	5

35.2. How many are between 18 and 64 years old (including yourself)?

None	One	Two	Three	Four	Five or more
0	1	2	3	4	5

35.3. How many are 65 years or older (including yourself)?

None	One	Two	Three	Four	Five or more
0	1	2	3	4	5

Go to the next page.

337601

PLEASE MAKE NO MARKS IN THIS AREA

36. What was the total family income (before taxes) from all sources within your household (including paychecks, social security, retirement income, and public assistance) in the last year? **(Mark the one that is your best guess.)**

1 Less than $7,000	8 $30,000 to $34,999
2 $7,000 to $9,999	9 $35,000 to $49,999
3 $10,000 to $11,999	10 $50,000 to $74,999
4 $12,000 to $15,999	11 $75,000 to $99,999
5 $16,000 to $19,999	12 $100,000 to $149,999
6 $20,000 to $24,999	13 $150,000 or more
7 $25,000 to $29,999	99 Don't know

36.1. If you lost the sources of household income listed in Question 36, how long could you continue to live at your current address and standard of living? **(Mark the one that is your best guess.)**

1 Less than 1 month	4 7 to 12 months
2 1 to 2 months	5 More than 1 year
3 3 to 6 months	

37. Altogether, what is your current total family savings, assets, retirement and pensions plans, and property from all sources within your household? (Include the total value of your home and car(s) minus the amounts still owed.) **(Mark the one that is your best guess.)**

1 Less than $500	6 $50,000 to $99,999
2 $500 to $4,999	7 $100,000 to $199,999
3 $5,000 to $9,999	8 $200,000 to $499,999
4 $10,000 to $24,999	9 $500,000 or more
5 $25,000 to $49,999	99 Don't know

38. What is the total family debt within your household from such things as credit card charges, medical or legal bills, and loans from banks or relatives? (Do not include mortgage or car loans.) **(Mark the one that is your best guess.)**

1 Less than $2000	5 $20,000 to $49,999
2 $2,000 to $4,999	6 $50,000 to $99,999
3 $5,000 to $9,999	7 $100,000 or greater
4 $10,000 to $19,999	9 Don't know

Go to the next page.

39. In any of the last 3 years, did you have a hard time making ends meet (paying rent, buying food, paying for other necessities)? **(Mark one for each time period.)**

	No	Yes
39.1. 1 year ago	0	1
39.2. 2 years ago	0	1
39.3. 3 years ago	0	1

40. Compared to this year, were your finances better off, the same, or worse off in any of the last 3 years? **(Mark one for each time period.)**

	Better Off Than Now	The Same As Now	Worse Off Than Now
40.1. 1 year ago	1	2	3
40.2. 2 years ago	1	2	3
40.3. 3 years ago	1	2	3

41. Which one of these statements best describes the food eaten in your household in the last year?

1 We had enough food to eat and the kinds of food we wanted to eat.

2 We had enough food to eat but NOT always the kinds of food we wanted to eat.

3 Sometimes we didn't have enough food to eat.

4 Often we didn't have enough food to eat.

42. A number of programs are listed below that help supply food to individuals and households. Please mark all the programs that you and others in your household have used at some time in the last year.

0 None

1 Meals on Wheels

2 Free or reduced cost meals for the elderly

3 USDA or government commodity foods

4 Food stamps, free or reduced cost school lunches, WIC (Women, Infant, and Children Feeding Program), or free or reduced-cost meals at day care or Head Start

5 Community Food Bank or Pantry or other free food or food vouchers

Thank you. Please take a few minutes to review for any questions you may have missed.

* U.S. GOVERNMENT PRINTING OFFICE:2003-589-322/40017

337601

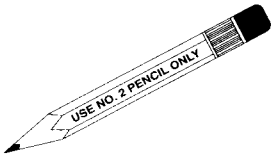
PLEASE MAKE NO MARKS IN THIS AREA

WOMEN'S HEALTH INITIATIVE

Form 147 - OS Follow-Up Questionnaire (Observational Study - Year 7)

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 weight is 159:

1	5	9

100 200 300 400 500 600 700 ●

10 20 30 40 50 60 70 80 90 ●

1 2 3 4 5 6 7 8 9 ●

Public reporting burden for this collection of information is estimated to average 10 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_____

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 1 2 3 4 5 6 7 8 9 10 20 30
Y 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
8 Other

4. Visit Type:
4 Annual
5 Non Routine

5. Form Administration:
1 Self 2 Group 3 Interview 4 Assistance

6. Language:
● E S

PLEASE MAKE NO MARKS IN THIS AREA

188954

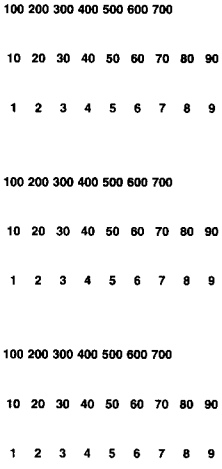
This questionnaire asks you about factors that may affect your health. These include weight changes, physical activity and exercise, use of female hormones, recent medical conditions, and family origin.

The following questions are about your weight. (Give your best guess.)

1. What is your current weight? ___ ___ ___ **pounds**

2. In the past year, what was your highest weight? ___ ___ ___ **pounds**

3. In the past year, what was your lowest weight? ___ ___ ___ **pounds**



The following questions are about your usual physical activity and exercise. This includes walking and sports.

4. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? **(Mark only one.)**

   0 Rarely or never
   1 1-3 times each month
   2 1 time each week
   3 2-3 times each week
   4 4-6 times each week
   5 7 or more times each week

   4.1. When you walk outside the home for more than 10 minutes without stopping, for how many minutes do you usually walk?

Less than 20 min.	20-39 min.	40-59 min.	1 hour or more
1	2	3	4

   4.2. What is your usual speed?

   2 Casual strolling or walking (less than 2 miles an hour)
   3 Average or normal (2-3 miles an hour)
   4 Fairly fast (3-4 miles an hour)
   5 Very fast (more than 4 miles an hour)
   9 Don't know

Go to the next page.

5. Not including walking outside the home, how often <u>each week</u> (7 days) do you usually do STRENUOUS OR VERY HARD EXERCISE (you work up a sweat and your heart beats fast)? For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.

None	1 day per week	2 days per week	3 days per week	4 days per week	5 or more days per week
0	1	2	3	4	5

5.1. How long do you usually exercise like this at one time?

Less than 20 min.	20-39 mins.	40-59 mins.	1 hour or more
1	2	3	4

6. Not including walking outside the home, how often <u>each week</u> (7 days) do you usually do MODERATE EXERCISE (not exhausting)? For example, biking outdoors, use of an exercise machine (like a stationary bike or treadmill), calisthenics, easy swimming, popular and folk dancing.

None	1 day per week	2 days per week	3 days per week	4 days per week	5 or more days per week
0	1	2	3	4	5

6.1. How long do you usually exercise like this at one time?

Less than 20 min.	20-39 mins.	40-59 mins.	1 hour or more
1	2	3	4

Go to the next page.

188954

PLEASE MAKE NO MARKS IN THIS AREA

7. Not including walking outside the home, how often <u>each week</u> (7 days) do you usually do MILD EXERCISE? For example, slow dancing, bowling, golf.

None 0 | 1 day per week 1 | 2 days per week 2 | 3 days per week 3 | 4 days per week 4 | 5 or more days per week 5

7.1. How long do you usually exercise like this at one time?

Less than 20 min. 1 | 20-39 mins. 2 | 40-59 mins. 3 | 1 hour or more 4

8. Do you smoke cigarettes now?

0 No | 1 Yes

8.1. How many cigarettes do you usually smoke each day? **(Mark one.)**

1 Less than 5
2 5-14
3 15-24
4 25-34
5 35-44
6 45 or more

9. In the past year, have you taken any of the following prescription weight loss medications for at least 2 months? **(Mark all that apply.)**

9.1.	Meridia (Sibutramine)	0 No	1 Yes
9.2.	Xenical (Orlistat)	0 No	1 Yes
9.3.	Phentermine (Fastin)	0 No	1 Yes
9.4.	Other prescription weight loss medication	0 No	1 Yes

(specify: _____)

Go to the next page.

The next set of questions are about female hormones (estrogen or progesterone) you might have used during the past year. Women's use of hormones has been changing – these questions help us understand patterns of use.

Question 10 is about natural hormones you get without a doctor's prescription.

10. In the past year, did you use any "natural" hormones that you can get without a doctor's prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, skin cream, or soy-enriched foods.

0 No
9 Don't know
1 Yes

10.1. In the past year, what types of "natural" hormones have you used? (Do not include hormone preparations that need a doctor's prescription.) **(Mark all that apply.)**

1 Wild yam creams
2 Wild yam pills
10 Progesterone cream
3 Progesterone suppositories
4 DHEA (dehydroepiandrosterone) pills
5 Phytoestrogen pills or powder (soy or flax)
6 Phytoestrogen creams (soy or flax)
7 Phytoestrogen enriched foods (tofu, soybeans)
8 Other (Specify: _____)
9 Don't know

Question 11 is about non-estrogen treatment for hormone replacement you get with a doctor's prescription.

11. In the past year, did you use any non-estrogen prescription treatments for hormone replacement? These may be prescribed to prevent osteoporosis and breast cancer and are sometimes called "designer estrogens" or selective estrogen receptor modulators (SERMs). Examples are Evista (Raloxifene) and Nolvadex (Tamoxifen).

0 No
9 Don't know
1 Yes

11.1. In the past year, what types of non-estrogen treatments for hormone replacement did you take? **(Mark all that apply.)**

1 Evista (Raloxifene)
2 Nolvadex (Tamoxifen)
8 Other (Specify: _____)
9 Don't know

Go to the next page.

188954

PLEASE MAKE NO MARKS IN THIS AREA

The next questions (12-16) are about female hormones you get with a doctor's prescription.

12. In the past year, did you use any female hormones (ESTROGEN or PROGESTERONE [also called PROGESTIN]) that were prescribed by a doctor? (This may have been in the form of a pill, skin patch, shot, or vaginal cream or suppository.)

    1 Yes
    0 No
    9 Don't know → **Go to Question 17 on page 9.**

13. In the past year, did you use female hormones PILLS or PATCHES prescribed by a doctor which contained both ESTROGEN and PROGESTERONE (PROGESTIN) COMBINED in the same pill, patch, or package (for example, Prempro, Premphase)? **(Do not include use of two separate estrogen and progesterone pills used at the same time.)**

    0 No
    9 Don't know
    1 Yes

    13.1. In the past year, how many months did you use COMBINED female hormone PILLS or PATCH which contained both ESTROGEN and PROGESTERONE?

    1 Less than 1 month
    2 1-6 months
    3 7-10 months
    4 11-12 months

    13.2. Which combination did you use the longest?

    1 Prempro
    2 CombiPatch
    3 Premphase
    8 Other (Specify: _____)

14. In the past year, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and TESTOSTERONE COMBINED in the same pill (for example, Estratest)?

    0 No
    9 Don't know
    1 Yes

    14.1. In the past year, how many months did you use COMBINED female hormone pills which contained both ESTROGEN and TESTOSTERONE?

    1 Less than 1 month
    2 1-6 months
    3 7-10 months
    4 11-12 months

    14.2. In the past year, what type of COMBINED ESTROGEN and TESTOSTERONE pills did you use the longest?

    1 Estratest
    2 Estratest HS
    8 Other (Specify: _____)
    9 Don't know

Go to the next page.

15. In the past year, did you use any ESTROGEN pill, patch, cream, or shots (other than the combinations described in Questions 13 and 14)?

1 Yes
0 No
9 Don't know → **Go to Question 16 on the next page.**

15.1. Did you use an estrogen pill?

0 No 1 Yes →

15.2. For how many months did you use the estrogen pills?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

15.3. What kind did you take **(mark the one used the longest if you used more than one kind)?**

1 Premarin or conjugated equine estrogens
2 Estrace or estradiol
3 Ogen or estropripate
4 Estratab or esterified estrogens
8 Other (Specify: _____)
9 Don't know

15.4. Did you use an estrogen patch?

0 No 1 Yes →

15.5. For how many months did you use the patch?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

15.6. Did you use an estrogen cream?

0 No 1 Yes →

15.7. For how many months did you use the cream?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

15.8. Did you have estrogen shots?

0 No 1 Yes →

15.9. For how many months did you have the shots?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

Go to the next page.

Question 16 is about products that contain the hormone PROGESTERONE (progestin) alone.

16. In the past year, did you use any PROGESTERONE or PROGESTIN pill, cream, or shots (other than the combinations described in Question 13)?

1 Yes
0 No
9 Don't know → **Go to Question 17 on the next page.**

16.1. Did you use a progesterone or progestin pill or capsule?

0 No
1 Yes →

16.2. For how many months did you use the pill or capsule?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

16.3. What kind did you take **(mark the one used the longest if you used more than one kind)?**

1 Provera, Cycrin, Amen, or Medroxyprogesterone Acetate (MPA)
3 Prometrium or micronized progesterone
8 Other (Specify: _____)
9 Don't know

16.4. How many days per month did you use it?

1 Less than 1 day
2 1-9 days
3 10-12 days
4 13-18 days
5 19-27 days
6 28 or more days

16.5. Did you use a progesterone or progestin cream?

0 No
1 Yes →

16.6. For how many months did you use progesterone or progestin cream?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

16.7. Did you have progesterone or progestin shots?

0 No
1 Yes →

16.8. For how many months did you have progesterone or progestin shots?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA

188954

The next question is about your medical condition in the past year.

17. In the past year, has a doctor told you that you have any of the following conditions? **(Please mark one response for each condition.)**

		No	Yes
17.1.	Cataract(s)	0	1
17.2.	Macular degeneration of the retina	0	1
17.3.	Asthma	0	1
17.4.	Emphysema or chronic bronchitis	0	1
17.5.	Heart failure or congestive heart failure	0	1
17.6.	Angina (chest pains from the heart)	0	1
17.7.	Atrial fibrillation	0	1
17.8.	Kidney or bladder stones (renal or urinary calculi)	0	1
17.9.	Dialysis for kidney or renal failure	0	1
17.10.	Stomach or duodenal ulcer	0	1
17.11.	Diverticulitis	0	1
17.12.	Pancreatitis (inflamed pancreas)	0	1
17.13.	Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)	0	1
17.14.	Overactive thyroid	0	1
17.15.	Underactive thyroid	0	1
17.16.	Alzheimer's disease	0	1
17.17.	Multiple sclerosis	0	1
17.18.	Parkinson's disease	0	1
17.19.	Amyotropic Lateral Sclerosis (ALS, motor neuron disease, or Lou Gehrig's disease)	0	1

18. Have you ever been diagnosed with breast cancer?

0 No
9 Don't know

1 Yes

18.1. At what age were you diagnosed?

___ years old

10 20 30 40 50 60 70 80 90

1 2 3 4 5 6 7 8 9

Go to the next page.

Below is a list of some difficult things that sometimes happen to people. Please try to think back over the past year to remember if any of these things happened. Mark the answer that seems best.

Over the past year:

		No	Yes, and it upset me: Not too much	Moderately (Medium)	Very much
19.1.	Did your spouse or partner die?	0	1	2	3
19.2.	Did your spouse or partner have a serious illness?	0	1	2	3
19.3.	Did a close friend or family member die or have a serious illness (other than your spouse or partner)?	0	1	2	3
19.4.	Did you have any major problems with money?	0	1	2	3
19.5.	Did you have a divorce or break-up with a spouse or partner?	0	1	2	3
19.6.	Did a family member or close friend have a divorce or break-up?	0	1	2	3
19.7.	Did you have a major conflict with children or grandchildren?	0	1	2	3
19.8.	Do you have any major accident, disasters, muggings, unwanted sexual experiences, robberies, or similar events?	0	1	2	3
19.9.	Did you or a family member or close friend lose their job or retire?	0	1	2	3
19.10.	Were you physically abused by being hit, slapped, pushed, shoved, punched, or threatened with a weapon by a family member or close friend?	0	1	2	3
19.11.	Were you verbally abused by being made fun of, severely criticized, told you were a stupid or worthless person, or threatened with harm to yourself, your possessions, or your pets, by a family member or close friend?	0	1	2	3
19.12.	Did a pet die?	0	1	2	3

20. Are you now helping at least one sick, limited, or frail family member or friend on a regular basis?

0 No 1 Yes →

20.1. In the past 4 weeks, how often have you helped this friend or family member?

Less than once a week	1-2 times a week	3-4 times a week	5 or more times a week
1	2	3	4

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA

188954

The next set of questions asks about where your parents were born. This refers to the parents who raised you, whether or not they were your birth parents. If you do not know the information asked for, please give your best guess.

21. Was your mother born in the United States or outside of the United States?

1 In the United States → 21.1. Which region?

1 Northeast
(Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, Washington DC, West Virginia)

2 South
(Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, or Texas)

3 Midwest
(Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin)

4 West
(Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming)

2 Outside the United States → 21.2. Which area?

1 Canada
2 Europe
3 Eastern Europe
4 Middle East or North Africa
5 Africa (not including North Africa)
6 Caribbean or West Indies
7 Mexico
8 Central or South America
9 Cuba
10 Puerto Rico
11 China
12 Japan
13 Southeast Asia
14 Australia and Oceania
88 Other

21.3. Was this your biological (birth) mother? 0 No 1 Yes

Go to the next page.

22. Was your father born in the United States or outside of the United States?

1 In the United States

22.1. Which region?

1 Northeast
(Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, Washington DC, West Virginia)

2 South
(Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, or Texas)

3 Midwest
(Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin)

4 West
(Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming)

2 Outside the United States

22.2. Which area?

1 Canada
2 Europe
3 Eastern Europe
4 Middle East or North Africa
5 Africa (not including North Africa)
6 Caribbean or West Indies
7 Mexico
8 Central or South America
9 Cuba
10 Puerto Rico
11 China
12 Japan
13 Southeast Asia
14 Australia and Oceania
88 Other

22.3. Was this your biological (birth) father? 0 No 1 Yes

23. What is your current marital status? **(Mark the one that best describes you.)**

1 Never married
2 Divorced or separated
3 Widowed
4 Presently married
5 Living in a marriage-like relationship

Thank you. Please take a few minutes to review for any questions you may have missed.

* U.S. GOVERNMENT PRINTING OFFICE:2003-589-322/40017

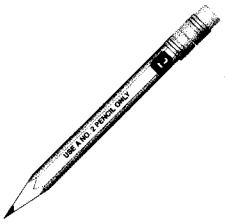
PLEASE MAKE NO MARKS IN THIS AREA

188954

WOMEN'S HEALTH INITIATIVE

Form 148 - OS Follow-Up Questionnaire (Observational Study - Year 8)

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 you weigh 159 pounds:

1	5	9

100 200 300 400 500 600 700 ●
10 20 30 40 50 60 70 80 90 ●
1 2 3 4 5 6 7 8 9 ●

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 1 2 3 4 5 6 7 8 9
Y 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
8 Other

4. Visit Type:
3 Annual
4 Non-Routine
7 8 9 10 11 12

5. Form Administration:
1 Self 2 Group 3 Interview 4 Assistance

6. Language:
E ● S 2

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

PLEASE MAKE NO MARKS IN THIS AREA

79151

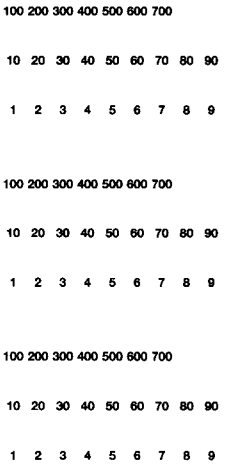
This questionnaire asks you about factors that may affect your health. These include weight changes, physical activity and exercise, use of coffee, tea, and soft drinks, use of female hormones, and recent medical conditions.

The following questions are about your weight. (Give your best guess.)

1. What is your current weight? |_|_|_| **pounds**

2. In the past year, what was your highest weight? |_|_|_| **pounds**

3. In the past year, what was your lowest weight? |_|_|_| **pounds**



The following questions are about your usual physical activity and exercise. This includes walking and sports.

4. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? **(Mark only one.)**

- 0 Rarely or never
- 1 1-3 times each month
- 2 1 time each week
- 3 2-3 times each week
- 4 4-6 times each week
- 5 7 or more times each week

4.1. When you walk outside the home for more than 10 minutes without stopping, for how many minutes do you usually walk?

Less than 20 min.	20-39 min.	40-59 min.	1 hour or more
1	2	3	4

4.2. What is your usual speed?

- 2 Causal strolling or walking (less than 2 miles an hour)
- 3 Average or normal (2-3 miles an hour)
- 4 Fairly fast (3-4 miles an hour)
- 5 Very fast (more than 4 miles an hour)
- 9 Don't know

Go to the next page.

5. Not including walking outside the home, how often <u>each week</u> (7 days), do you usually do STRENUOUS OR VERY HARD EXERCISE (you work up a sweat and your heart beats fast)? For example, aerobics, aerobic dancing, jogging, tennis, swimming laps.

None 0 | 1 day per week 1 | 2 days per week 2 | 3 days per week 3 | 4 days per week 4 | 5 or more days per week 5

5.1. How long do you usually exercise like this at one time?

Less than 20 mins. 1 | 20-39 mins. 2 | 40-59 mins. 3 | 1 hour or more 4

6. Not including walking outside the home, how often <u>each week</u> (7 days) do you usually do MODERATE EXERCISE (not exhausting)? For example, biking outdoors, use of an exercise machine (like a stationary bike or treadmill), calisthenics, easy swimming, popular and folk dancing.

None 0 | 1 day per week 1 | 2 days per week 2 | 3 days per week 3 | 4 days per week 4 | 5 or more days per week 5

6.1. How long do you usually exercise like this at one time?

Less than 20 mins. 1 | 20-39 mins. 2 | 40-59 mins. 3 | 1 hour or more 4

Go to the next page.

7. Not including walking outside the home, how often <u>each week</u> (7 days), do you usually do MILD EXERCISE? For example, slow dancing, bowling, golf.

None 0 | 1 day per week 1 | 2 days per week 2 | 3 days per week 3 | 4 days per week 4 | 5 or more days per week 5

7.1. How long do you usually exercise like this at one time?

Less than 20 mins. 1 | 20-39 mins. 2 | 40-59 mins. 3 | 1 hour or more 4

8. Do you smoke cigarettes now?

0 No | 1 Yes

8.1. How many cigarettes do you usually smoke each day? **(Mark one.)**

1 Less than 5
2 5-14
3 15-24
4 25-34
5 35-44
6 45 or more

9. In the past year, have you taken any of the following prescription weight loss medications for at least 2 months? **(Mark all that apply.)**

9.1.	Meridia (Sibutramine)	0 No	1 Yes
9.2.	Xenical (Orlistat)	0 No	1 Yes
9.3.	Phentermine (Fastin)	0 No	1 Yes
9.4.	Other prescription weight loss medication	0 No	1 Yes

(Specify:_____)

Go to the next page.

The following questions are about coffee, tea, and soft drinks you may drink.

10. During the past 3 months, how often did you drink these beverages: **(Mark one for each beverage.)** (For coffee, large or doubles count as 2 cups.)

	Never or less than 1 per month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	6 or more per day
10.1. Caffeinated coffee, either instant or paper-filtered drip (cups)	1	2	3	4	5	6	7	8	9
10.2. Other caffeinated coffee, such as perked, espresso, or latté (cups)	1	2	3	4	5	6	7	8	9
10.3. Decaf coffee, either instant or paper-filtered drip (cups)	1	2	3	4	5	6	7	8	9
10.4. Other decaf coffee, such as perked, espresso, or latté (cups)	1	2	3	4	5	6	7	8	9
10.5. Regular tea (not decaf) (cups)	1	2	3	4	5	6	7	8	9
10.6. Decaf tea (cups)	1	2	3	4	5	6	7	8	9
10.7. Soft drinks with caffeine (such as Coke®, Diet Pepsi®, Dr. Pepper®, Mountain Dew®) (12 oz. can)	1	2	3	4	5	6	7	8	9
10.8. Soft drinks without caffeine (such as Sprite®, 7-Up®, Diet Sprite®) (12 oz. can)	1	2	3	4	5	6	7	8	9

Go to the next page.

PLEASE DO NOT WRITE IN THIS AREA 79151

The next set of questions are about female hormones (estrogen or progesterone) you might have used during the past year. Women's use of hormones has been changing—these questions help us understand patterns of use.

Question 11 is about natural hormones you can get without a doctor's prescription.

11. In the past year, did you use any "natural" hormones that you can get without a doctor's prescription? These are usually made from plants and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, skin cream, or soy-enriched foods.

0 No
1 Yes
9 Don't know

11.1. In the past year, what types of "natural" hormones have you used? (Do not include hormone preparations that need a doctor's prescription.) **(Mark all that apply.)**

1 Wild yam creams
2 Wild yam pills
10 Progesterone cream
3 Progesterone suppositories
4 DHEA (dehydroepiandrosterone) pills
5 Phytoestrogen pills or powder (soy or flax)
6 Phytoestrogen creams (soy or flax)
7 Phytoestrogen enriched foods (tofu, soybeans)
8 Other (Specify:_____)
9 Don't know

The next questions (12-13) are about medications you get with a doctor's prescription.

12. In the past year, have you used any treatments for **osteoporosis** or other bone conditions that you get with a doctor's prescription? Examples are Fosamax, Miacalcin, and Actonel. **(Do not include use of selective estrogen receptor modulators (SERMs) such as Evista (Raloxifene) which are covered in Question 13.)**

0 No
1 Yes
9 Don't know

12.1. Which one(s)? **(Mark all that apply.)**

1 Alendronate (Fosamax)
2 Calcitonin (Miacalcin)
3 Risedronate (Actonel)
4 Pamidronate (Aredia)
5 Zolendronate
6 Parathyroid hormone (PTH) (Forteo)
8 Other (Specify:_____)
9 Don't know

Go to the next page.

13. In the past year, did you use any non-estrogen prescription treatments for hormone replacement? These may be prescribed to prevent osteoporosis and breast cancer and are sometimes called "designer estrogens" or selective estrogen receptor modulators (SERMs). Examples are Evista (Raloxifene) and Nolvadex (Tamoxifen).

0 No
9 Don't know

1 Yes

13.1. In the past year, what types of selective estrogen receptor modulators did you take? **(Mark all that apply.)**

1 Evista (Raloxifene)
2 Nolvadex (Tamoxifen)
8 Other (Specify:_____)
9 Don't know

The next questions (14-18) are about other female hormones you get with a doctor's prescription.

14. In the past year, did you use any female hormones (ESTROGEN or PROGESTERONE [also called PROGESTIN]) that were prescribed by a doctor? (This may have been in the form of a pill, skin patch, shot, or vaginal cream or suppository.)

1 Yes

0 No
9 Don't know → **Go to Question 19 on page 11.**

Go to the next page.

15. In the past year, did you use female hormones PILLS or PATCHES prescribed by a doctor which contained both ESTROGEN and PROGESTERONE (PROGESTIN) COMBINED in the same pill, patch, or package (for example, Prempro, Premphase)? **(Do not include the use of two separate estrogen and progesterone pills used at the same time.)**

0 No
9 Don't know

1 Yes

15.1. In the past year, how many months did you use COMBINED female hormone PILLS or PATCH which contained both ESTROGEN and PROGESTERONE?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

15.2. Which combination did you use the longest?

1 Prempro
2 CombiPatch
3 Premphase
4 Activella
5 FemHRT
6 Ortho-Prefest
8 Other (Specify:_____)

16. In the past year, did you use female hormone PILLS prescribed by a doctor which contained both ESTROGEN and TESTOSTERONE COMBINED in the same pill (for example, Estratest)?

1 Yes

0 No
9 Don't know → **Go to Question 17 on the next page.**

16.1. In the past year, how many months did you use COMBINED female hormone pills which contained both ESTROGEN and TESTOSTERONE?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

16.2. In the past year, what type of COMBINED ESTROGEN and TESTOSTERONE pills did you use the longest?

1 Estratest
2 Estratest HS
8 Other (Specify:_____)
9 Don't know

Go to the next page.

17. In the past year, did you use any ESTROGEN pill, patch, cream, or shots (other than the combinations described in Questions 15 and 16)?

1 Yes

0 No
9 Don't know → **Go to Question 18 on the next page.**

17.1. Did you use an estrogen pill?

0 No 1 Yes →

17.2. For how many months did you use the estrogen pills?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

17.3. What kind did you take? **(Mark the one used the longest if you used more than one kind.)**

1 Premarin or conjugated equine estrogens
2 Estrace or estradiol
3 Ogen or estropripate
4 Estratab or esterified estrogens
8 Other (Specify:_____)
9 Don't know

17.4. Did you use an estrogen patch?

0 No 1 Yes →

17.5. For how many months did you use the patch?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

17.6. Did you use an estrogen cream?

0 No 1 Yes →

17.7. For how many months did you use the cream?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

17.8. Did you have estrogen shots?

0 No 1 Yes →

17.9. For how many months did you have the shots?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

Go to the next page.

Question 18 is about products that contain the hormone PROGESTERONE (progestin) alone.

18. In the past year, did you use any PROGESTERONE or PROGESTIN pill, cream, or shots (other than the combinations described in Question 15)?

1 Yes
0 No
9 Don't know → **Go to Question 19 on the next page.**

18.1. Did you use a progesterone or progestin pill or capsule?

0 No
1 Yes →

18.2. For how many months did you use the pill or capsule?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

18.3. What kind did you take? **(Mark the one used the longest if you used more than one kind.)**

1 Provera, Cycrin, Amen, or Medroxyprogesterone Acetate (MPA)
3 Prometrium or micronized progesterone
8 Other (Specify: _____)
9 Don't know

18.4. How many days per month did you use it?

1 Less than 1 day
2 1-9 days
3 10-12 days
4 13-18 days
5 19-27 days
6 28 or more days

18.5. Did you use a progesterone or progestin cream?

0 No
1 Yes →

18.6. For how many months did you use the progesterone or progestin cream?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

18.7. Did you have progesterone or progestin shots?

0 No
1 Yes →

18.8. For how many months did you have progesterone or progestin shots?

1 Less than 1 month
2 1-6 months
3 7-10 months
4 11-12 months

Go to the next page.

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79151

Question 19 is about your medical conditions in the past year.

19. In the past year, has a doctor told you that you have any of the following conditions? **(Please mark one response for each condition.)**

		No	Yes
19.1.	Cataract(s)	0	1
19.2.	Macular degeneration of the retina	0	1
19.3.	Asthma	0	1
19.4.	Emphysema or chronic bronchitis	0	1
19.5.	Heart failure or congestive heart failure	0	1
19.6.	Angina (chest pains from the heart)	0	1
19.7.	Atrial fibrillation	0	1
19.8.	Kidney or bladder stones (renal or urinary calculi)	0	1
19.9.	Dialysis for kidney or renal failure	0	1
19.10.	Stomach or duodenal ulcer	0	1
19.11.	Diverticulitis	0	1
19.12.	Pancreatitis (inflamed pancreas)	0	1
19.13.	Liver disease (chronic active hepatitis, cirrhosis, or yellow jaundice)	0	1
19.14.	Overactive thyroid	0	1
19.15.	Underactive thyroid	0	1
19.16.	Alzheimer's disease	0	1
19.17.	Multiple sclerosis	0	1
19.18.	Parkinson's disease	0	1
19.19.	Amyotropic Lateral Sclerosis (ALS, motor neuron disease, or Lou Gehrig's disease)	0	1

Go to the next page.

20. Has any member of your family (mother, father, full-blooded sister or brother) been diagnosed with Alzheimer's disease or senile dementia?

0 No
9 Don't know

1 Yes →

20.1. Who? **(Please mark all that apply.)**

1 Mother
2 Father
3 Any brother
4 Any sister

The last question is about your current living situation.

21. What is your current marital status? **(Mark one that <u>best</u> describes you.)**

1 Never married
2 Divorced or separated
3 Widowed
4 Presently married
5 Living in a marriage-like relationship

Thank you. Please take a few minutes to review for any questions you may have missed. Feel free to write any comments here.

* U.S. GOVERNMENT PRINTING OFFICE:2003-589-322/40017

PLEASE DO NOT WRITE IN THIS AREA

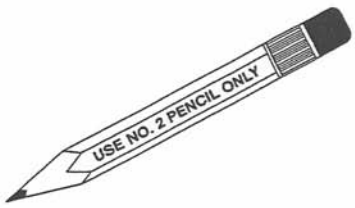
79151

WOMEN'S HEALTH INITIATIVE

Form 149 - Supplement to OS Follow-Up 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: How old are you?

| 7 | 5 |

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 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
⑧ Other

4. Form Administration:
① Self ② Group ③ Interview ④ Assistance

5. Language:
● E ○ S

PLEASE MAKE NO MARKS IN THIS AREA

22010

The first question is about your current caregiving responsibilities.

1. Are you now helping at least one sick, limited, or frail family member or friend on a regular basis?

⓪ No → **Go to the next page.**

① Yes →

1.1. In the past 4 weeks, how often have you helped this friend or family member?

Less than once a week	1-2 times a week	3-4 times a week	5 or more times a week
①	②	③	④

Go to the next page.

Below is a list of some difficult things that sometimes happen to people. Please try to think back over the past year to remember if any of these things happened. Mark the answer that seems best.

Over the past year:	**No**	**Yes**, and it upset me: Not too much	Moderately (Medium)	Very much
2.1. Did your spouse or partner die?	0	1	2	3
2.2. Did your spouse or partner have a serious illness?	0	1	2	3
2.3. Did a close friend or family member die or have a serious illness (other than your spouse or partner)?	0	1	2	3
2.4. Did you have any major problems with money?	0	1	2	3
2.5. Did you have a divorce or break-up with a spouse or partner?	0	1	2	3
2.6. Did a family member or close friend have a divorce or break-up?	0	1	2	3
2.7. Did you have a major conflict with children or grandchildren?	0	1	2	3
2.8. Did you have any major accidents, disasters, muggings, unwanted sexual experiences, robberies, or similar events?	0	1	2	3
2.9. Did you or a family member or close friend lose their job or retire?	0	1	2	3
2.10. Were you physically abused by being hit, slapped, pushed, shoved, punched, or threatened with a weapon by a family member or close friend?	0	1	2	3
2.11. Were you verbally abused by being made fun of, severely criticized, told you were a stupid or worthless person, or threatened with harm to yourself, your possessions, or your pets, by a family member or close friend?	0	1	2	3
2.12. Did a pet die?	0	1	2	3

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA 22010

The next questions are about your health history and weight loss medication use.

3. Have you ever been diagnosed with breast cancer?

- (0) No
- (9) Don't know
- (1) Yes → 3.1. At what age were you diagnosed?

  ___ years old

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

4. In the past year, have you taken any of the following prescription weight loss medications for at least 2 months?

4.1.	Meridia (Sibutramine)	(0) No	(1) Yes
4.2.	Xenical (Orlistat)	(0) No	(1) Yes
4.3.	Phentermine (Fastin)	(0) No	(1) Yes
4.4.	Other prescription weight loss medication	(0) No	(1) Yes

(Specify: _____
_____)

Go to the next page.

The next set of questions asks about where your parents were born. This refers to the parents who raised you, whether or not they were your birth parents. If you do not know the information asked for, please give your best guess.

5. Was your mother born in the United States or outside of the United States?

① In the United States

5.1. Which region?

① Northeast

(Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, Washington DC, West Virginia)

② South

(Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, or Texas)

③ Midwest

(Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin)

④ West

(Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming)

② Outside the United States

5.2. Which area?

1 Canada

2 Europe

3 Eastern Europe

4 Middle East or North Africa

5 Africa (not including North Africa)

6 Caribbean or West Indies

7 Mexico

8 Central or South America

9 Cuba

10 Puerto Rico

11 China

12 Japan

13 Southeast Asia

14 Australia and Oceania

88 Other

5.3. Was this your biological (birth) mother?

0 No

1 Yes

Go to the next page.

6. Was your father born in the United States or outside of the United States?

① In the United States

6.1. Which region?

① Northeast

(Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, Washington DC, West Virginia)

② South

(Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, or Texas)

③ Midwest

(Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin)

④ West

(Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming)

② Outside the United States

6.2. Which area?

① Canada

② Europe

③ Eastern Europe

④ Middle East or North Africa

⑤ Africa (not including North Africa)

⑥ Caribbean or West Indies

⑦ Mexico

⑧ Central or South America

⑨ Cuba

⑩ Puerto Rico

⑪ China

⑫ Japan

⑬ Southeast Asia

⑭ Australia and Oceania

⑧⑧ Other

6.3. Was this your biological (birth) father?

⓪ No

① Yes

Go to the next page.

PLEASE MAKE NO MARKS IN THIS AREA 22010

Thank you.

Please take a few minutes to review for any questions you may have missed.

★ U.S. GOVERNMENT PRINTING OFFICE:2004–689-279/40020

PLEASE MAKE NO MARKS IN THIS AREA

22010

Ver. 9
OMB #0925-0414 Exp: 5/12

WOMEN'S HEALTH INITIATIVE

Form 150 – Hormone Use 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 medications that you've had in the last year. This information is important for understanding more about women's health after they stop taking hormone study pills.

OFFICE USE ONLY

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

1. Date Received:
Month Day Year

2. Reviewed By:

3. Contact Type:
○1 Phone
○2 Mail
○8 Other

4. Language:
●1 E ○2 S

○ FCA ○ OU1 ○ OU2

215600

PLEASE MAKE NO MARKS IN THIS AREA

GPO U.S. GOVERNMENT PRINTING OFFICE:2009-576-179/40055

1. In the past year, have you used any medications that you get with a doctor's prescription to treat or prevent **osteoporosis** or other bone conditions? Examples are Fosamax, Miacalcin, and Actonel. **(Do not include use of female hormones or selective estrogen receptor modulators (SERMs), such as raloxifene (Evista), which are covered in Question 2.)**

○ 0 No
○ 9 Don't know
○ 1 Yes

1.1. In the past year, which one(s) did you use? **(Mark all that apply.)**

○ 1 Alendronate (Fosamax)
○ 2 Calcitonin (Miacalcin)
○ 3 Residronate (Actonel)
○ 4 Pamidronate (Aredia)
○ 5 Zolendronate (Zometa)
○ 6 Parathyroid hormone (PTH, Forteo)
○ 8 Other **(Specify:** _____)
○ 9 Don't know

2. In the past year, did you use any selective estrogen receptor modulators (SERMs)? (These may be prescribed to prevent osteoporosis and breast cancer and are sometimes called "designer estrogens". Examples are raloxifene [Evista] and tamoxifen [Nolvadex].)

○ 0 No
○ 9 Don't know
○ 1 Yes

2.1. In the past year, what SERMs did you take? **(Mark all that apply.)**

○ 1 Raloxifene (Evista)
○ 2 Tamoxifen (Nolvadex)
○ 8 Other **(Specify:** _____)
○ 9 Don't know

Form 150 – Hormone Use Update
WHI Extension

The next questions are about female hormones (estrogen or progesterone [also called progestin]) that you might have used during the past year. Women's use of hormones has been changing—these questions help us understand patterns of use.

Question 3 is about hormones you can get without a doctor's prescription.

3. In the past year, did you use any "natural" hormones that you can get without a doctor's prescription? These are usually made from plants or herbs and often obtained from health food stores or by mail order. They may be in the form of a pill, vaginal cream or suppository, skin cream, or soy-enriched foods.

○0 No
○9 Don't know
○1 Yes

3.1. In the past year, what types of "natural" hormones have you used? (Do not include hormone preparations that need a doctor's prescription.) **(Mark all that apply.)**

○1 Wild yam cream
○2 Wild yam pills
○10 Progesterone cream
○3 Progesterone suppositories
○4 DHEA pills (dehydroepiandrosterone)
○5 Phytoestrogen pills or powder (soy or flax)
○6 Phytoestrogen creams (soy or flax)
○7 Phytoestrogen-enriched foods (tofu, soybeans)
○8 Other **(Specify:** _____ **)**
○9 Don't know

The next questions are about female hormones you got with a doctor's prescription in the last year, even if you are not taking them right now.

4. In the past year, did you use any female hormones (ESTROGEN or PROGESTERONE [also called PROGESTIN]) that were prescribed by a doctor? (These may have been in the form of a pill, skin patch, shot, cream, vaginal ring or suppository, or bio-identical compound.)

○0 No
○9 Don't know
○1 Yes

→ **You are finished with this form.**
Please review any questions you may have missed.

4.1. What were your reasons for taking this hormone prescription? **(Mark all that apply.)**

○1 To treat symptoms
○2 To look better
○3 To feel better
○4 To treat or prevent osteoporosis
○5 To treat or prevent other diseases
○6 Advice from family or friend
○7 Advice from health care provider
○8 Information on the Internet (World Wide Web)
○9 Results from saliva, urine, or blood test
○10 Information in the media (for example, newspaper, magazine, or television)
○88 Other reason **(Specify:** _____ **)**

PLEASE DO NOT WRITE IN THIS AREA

215600

5. In the past year, did you use female hormone PILLS or PATCHES prescribed by a doctor containing both ESTROGEN and PROGESTERONE (PROGESTIN) COMBINED in the same pill, patch, package (for example, Prempro, Premphase), vaginal ring, or bio-identical compound? **(Do not include the use of two separate estrogen and progesterone pills taken at the same time.)**

○0 No
○9 Don't know
○1 Yes

5.1. Did you use a pill combination?

○0 No
○1 Yes →

5.1.1. For how many months did you use the pill combination?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

5.2. Did you use a patch combination?

○0 No
○1 Yes →

5.2.1. For how many months did you use the patch combination?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

5.3. Did you use some other combination that was not a pill or patch?

○0 No
○1 Yes →

5.3.1. For how many months did you use the other combination?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

6. In the past year, did you use female hormone PILLS prescribed by a doctor containing both ESTROGEN and TESTOSTERONE COMBINED in the same pill (for example, Estratest)?

○0 No
○9 Don't know
○1 Yes

6.1. In the past year, how many months did you use COMBINED female hormone pills containing both ESTROGEN and TESTOSTERONE?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

6.2. In the past year, what type of COMBINED ESTROGEN and TESTOSTERONE pills did you use longest?

○1 Estratest or Estratest HS
○8 Other **(Specify:** _____ **)**
○9 Don't know

7. In the past year, did you use any ESTROGEN that was prescribed by a doctor (other than the combinations described in Questions 5 and 6)? (These may have been in the form of a pill, skin patch, shot, skin cream, bio-identical compound, or vaginal cream, ring, tablet, or suppository.)

○1 Yes
○0 No
○9 Don't know → **Go to Question 8 on the next page.**

7.1. Did you use an oral estrogen pill that you take by mouth?

○0 No
○1 Yes →

7.1.1. For how many months did you use the oral estrogen pills?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

7.1.2. What kind did you take? **(Mark the one used the longest if you used more than one kind.)**

○1 Conjugated equine estrogens (Premarin)
○2 Estradiol (Estrace)
○3 Estropipate (Ogen)
○4 Esterified estrogens (Estratab)
○8 Other **(Specify:** _____ **)**
○9 Don't know

7.2. Did you use an estrogen skin patch?

○0 No
○1 Yes →

7.2.1. For how many months did you use the patch?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

7.3. Did you use an estrogen skin cream?

○0 No
○1 Yes →

7.3.1. For how many months did you use the skin cream?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

7.4. Did you have estrogen shots?

○0 No
○1 Yes →

7.4.1. For how many months did you have the shots?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

7.5. Did you use an estrogen vaginal cream, ring, capsule, or suppository?

○0 No
○1 Yes →

7.5.1. For how many months did you use any of these vaginal forms of estrogen?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

These next questions are about PROGESTERONE OR PROGESTIN that was prescribed by a doctor. If you did not use any PROGESTERONE, you are finished with this form. Please review any questions you may have missed.

8. In the past year, did you use any PROGESTERONE or PROGESTIN that was prescribed by a doctor (other than the combinations described in Question 5)? (These may have been in the form of a pill, skin cream, shot, vaginal cream, vaginal capsule or suppository, IUD [intra-uterine device], or bio-identical compound.)

○1 Yes ○0 No ○9 Don't know → **You are finished with this form. Please review any questions you may have missed.**

8.1. Did you use a progesterone or progestin pill?

○0 No
○1 Yes →

8.1.1. For how many months did you use the pill?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

8.1.2. What kind did you take?

○1 Medroxyprogesterone acetate (MPA, Provera, Cycrin, Amen)
○3 Micronized progesterone (Prometrium)
○8 Other **(Specify:** _____)
○9 Don't know

8.1.3. How many days per month did you use it?

○1 Less than 1 day
○2 1-9 days
○3 10-12 days
○4 13-18 days
○5 19-27 days
○6 28 or more days

8.2. Did you use a progesterone or progestin skin cream?

○0 No
○1 Yes →

8.2.1. For how many months did you use the skin cream?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

8.3. Did you have progesterone or progestin shots?

○0 No
○1 Yes →

8.3.1. For how many months did you have the shots?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

8.4. Did you use a progesterone or progestin vaginal cream or vaginal capsule?

○0 No
○1 Yes →

8.4.1. For how many months did you use the vaginal cream or vaginal capsule?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

8.5. Did you use an intrauterine progestin device (IUD)?

○0 No
○1 Yes →

8.5.1. For how many months did you use the IUD?

○1 Less than 1 month
○2 1-6 months
○3 7-10 months
○4 11-12 months

Thank you.

Please take a few minutes to review this form for any questions you may have missed.

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WOMEN'S HEALTH INITIATIVE

Form 151– Activities of Daily Life

Ver. 9
OMB #0925-0414 Exp: 5/12

This form has questions about your current experiences. Please answer the questions as honestly as you can, using your first thoughts about each question. You should not go back later to "figure out" answers. Please answer the questions on both sides. Your answers will be kept confidential and will never be put with your name in a published report, but they will help us to understand the health of women like you. Thank you for your help.

1. In general, would you say your health is: **(Mark one circle only.)**

Excellent	Very good	Good	Fair	Poor
○1	○2	○3	○4	○5

2. Overall, how would you rate your quality of life? **(Mark one circle below.)**

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

Worst — Halfway — Best

As bad or worse than being dead — Best quality of life

3. Does the place (home, apartment, assisted living facility) where you live have special services for older people (such as help with transportation, meals, medicines, or bathing)?

○0 No ○1 Yes →

3.1. Are you currently receiving any of these services?
○0 No ○1 Yes

4. In the past year, have you stayed in a nursing home?
○0 No ○1 Yes

5. What aid, if any, do you usually use to walk on a level surface? **(Mark one.)**

I do not use any aid	I use a cane	I use crutches	I use a walker	I use a wheelchair
○1	○2	○3	○4	○5

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

OFFICE USE ONLY

1. **Date Received:** Month – Day – Year

2. **Reviewed By:**

3. **Contact Type:**
○1 Phone
○2 Mail
○8 Other ○ FCA ○ OU1 ○ OU2

4. **Language:** ●1 E ○2 S

621601

PLEASE MAKE NO MARKS IN THIS AREA

GPO U.S. GOVERNMENT PRINTING OFFICE:2009-576-179/40055

6. Are you taking a calcium supplement such as Oscal, Viactiv, or Tums?

○ 0 No ○ 1 Yes

The following are questions about a typical (or usual) day's activities. Does your health now limit you in these activities and, if so, how much? (Mark one circle for each question.)

	No, not limited at all	Yes, limited a little	Yes, limited a lot
7. Vigorous activities, such as running, lifting heavy objects, or strenuous sports	○ 3	○ 2	○ 1
8. Moderate activities, such as moving a table, vacuuming, bowling, or golfing	○ 3	○ 2	○ 1
9. Lifting or carrying groceries	○ 3	○ 2	○ 1
10. Climbing several flights of stairs	○ 3	○ 2	○ 1
11. Climbing one flight of stairs	○ 3	○ 2	○ 1
12. Bending, kneeling, stooping	○ 3	○ 2	○ 1
13. Walking more than a mile	○ 3	○ 2	○ 1
14. Walking several blocks	○ 3	○ 2	○ 1
15. Walking one block	○ 3	○ 2	○ 1
16. Bathing or dressing yourself	○ 3	○ 2	○ 1

These next questions ask about how much help (if any) you need to do routine activities <u>for yourself</u>. Help can be defined as getting assistance from another person or using a device. (Mark one circle for each question.)

I can do this activity:	By myself without help	With some help	Completely unable to do this by myself
17. Can you feed yourself?	○ 1	○ 2	○ 3
18. Can you dress and undress yourself?	○ 1	○ 2	○ 3
19. Can you get in and out of bed yourself?	○ 1	○ 2	○ 3
20. Can you take a bath or shower?	○ 1	○ 2	○ 3
21. Can you do your own grocery shopping?	○ 1	○ 2	○ 3
22. Can you keep track of and take your medicines?	○ 1	○ 2	○ 3

WOMEN'S HEALTH INITIATIVE

Form 151– Activities of Daily Life

Ver. 9
OMB #0925-0414 Exp: 5/12

This form has questions about your current experiences. Please answer the questions as honestly as you can, using your first thoughts about each question. You should not go back later to "figure out" answers. Please answer the questions on both sides. Your answers will be kept confidential and will never be put with your name in a published report, but they will help us to understand the health of women like you. Thank you for your help.

1. In general, would you say your health is: **(Mark one circle only.)**

Excellent	Very good	Good	Fair	Poor
○1	○2	○3	○4	○5

2. Overall, how would you rate your quality of life? **(Mark one circle below.)**

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

Worst — Halfway — Best

As bad or worse than being dead — Best quality of life

3. Does the place (home, apartment, assisted living facility) where you live have special services for older people (such as help with transportation, meals, medicines, or bathing)?

○0 No ○1 Yes →

3.1. Are you currently receiving any of these services?
○0 No ○1 Yes

4. In the past year, have you stayed in a nursing home?
○0 No ○1 Yes

5. What aid, if any, do you usually use to walk on a level surface? **(Mark one.)**

I do not use any aid	I use a cane	I use crutches	I use a walker	I use a wheelchair
○1	○2	○3	○4	○5

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

OFFICE USE ONLY

1. **Date Received:** Month Day Year

2. **Reviewed By:**

3. **Contact Type:**
○1 Phone
○2 Mail
○8 Other ○ FCA ○ OU1 ○ OU2

4. **Language:** ●1 E ○2 S

621602

PLEASE MAKE NO MARKS IN THIS AREA

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Form 151– Activities of Daily Life

Ver. 9
OMB #0925-0414 Exp: 5/12

6. Are you taking a calcium supplement such as Oscal, Viactiv, or Tums?

○0 No ○1 Yes

The following are questions about a typical (or usual) day's activities. Does your health now limit you in these activities and, if so, how much? (Mark one circle for each question.)

	No, not limited at all	Yes, limited a little	Yes, limited a lot
7. Vigorous activities, such as running, lifting heavy objects, or strenuous sports	○3	○2	○1
8. Moderate activities, such as moving a table, vacuuming, bowling, or golfing	○3	○2	○1
9. Lifting or carrying groceries	○3	○2	○1
10. Climbing several flights of stairs	○3	○2	○1
11. Climbing one flight of stairs	○3	○2	○1
12. Bending, kneeling, stooping	○3	○2	○1
13. Walking more than a mile	○3	○2	○1
14. Walking several blocks	○3	○2	○1
15. Walking one block	○3	○2	○1
16. Bathing or dressing yourself	○3	○2	○1

These next questions ask about how much help (if any) you need to do routine activities <u>for yourself</u>. Help can be defined as getting assistance from another person or using a device. (Mark one circle for each question.)

I can do this activity:	By myself without help	With some help	Completely unable to do this by myself
17. Can you feed yourself?	○1	○2	○3
18. Can you dress and undress yourself?	○1	○2	○3
19. Can you get in and out of bed yourself?	○1	○2	○3
20. Can you take a bath or shower?	○1	○2	○3
21. Can you do your own grocery shopping?	○1	○2	○3
22. Can you keep track of and take your medicines?	○1	○2	○3

Form 153 – Medication and Supplement Inventory
WHI Extension Study

Date Received: ☐☐-☐☐-☐☐ (MM/DD/YY) 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	☐FCA ☐OUI ☐OU2 Language: ☐1 English ☐2 Spanish
OFFICE USE ONLY		

Instructions:

To help us learn about the health of WHI participants, we would like to know about the medications and supplements you take.

This form asks about all of the prescription medications you are currently taking, and some of the over-the-counter medications and dietary supplements you may be taking.

If you would like to have a WHI staff member at the Clinical Coordinating Center complete this form with you over the phone, please feel free to call 1-800-218-8415.

Section A: Prescription Medications

This first section asks about **prescription medications** you are currently taking. This includes medications that you only take as needed, such as nitroglycerin. A prescription medication is one that is written (or phoned in) by your health care provider and must be filled at a pharmacy or drug store.

1. **Are you currently taking any medications that require a prescription from a doctor or health care provider**?

   ☐ 0 No → **Go to Section B on Page 6**

   ☐ 1 Yes → **Continue below**

For this section, you will need information from the labels on bottles or packaging that your prescription medications came in. To get started, please gather together all of your prescription medications so that this information is readily available as you complete the form. These medications may be in your medicine cabinet, refrigerator, or purse. It is important to include all of your prescriptions.

For each prescription medication, please answer the questions on the next page, including the medication's name and strength. You will find this information on the label of the pill bottle or container. An example of a prescription label and a completed medication question are shown below.

Example of a prescription label

Walgreens, Seattle, WA 98028
(DD/) Ph: 866-254-1669
RX#4599773 Sept. 6, 2005 Fill 1 of 1

DOE, JANE 206-566-0442
Take one capsule by mouth as directed in morning and at bedtime
Discard after Sept. 6, 2006 Mfr_____
Qty: 60 CAP Kroll, Phil MD
Phenytoin NA (Dilantin) 100 MG CAP

On the example prescription label, the medication name **Phenytoin NA (Dilantin)**, strength **100 MG**, and type **CAP** are all on one line.

Example of a completed question using the label example above

Prescription Medication	Write in Information Below:
Name of the medication (as written on label)	PHENYTOIN NA (DILANTIN)
Strength of the medication (as written on label)	100 MG
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	CAPSULE
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ■ 3 More than 1 year → **How many years?** 013

Please go to next page

2. For each of the prescription medications you are currently taking, please answer the questions below **using the label on the prescription bottle**. Please **print** clearly. You can use your best estimate about how long you have been taking the medication.

Complete all of the information in the table for *each* medication you take. There are enough boxes to write up to 10 different medications. When you have completed the information for all of your prescription medications, please go to **Section B** of the questionnaire on **page 6.**

Prescription Medication #1	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #2	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #3	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Continue on the next page, <u>or</u> go to Section B on page 6 if you have listed all your medications

Prescription Medication #4	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #5	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #6	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #7	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Prescription Medication #8	**Write in Information Below**:
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #9	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐
Prescription Medication #10	**Write in Information Below:**
Name of the medication (as written on label)	
Strength of the medication (as written on label)	
Medication type (examples: capsule, tablet, cream, liquid, suppository, inhaler, injection)	
About how long have you been taking this medication? (If you're not sure, please use your best guess.)	☐ 1 Less than 1 month ☐ 2 1 to12 months ☐ 3 More than 1 year → **How many years?** ☐☐

Continue on the next page, or go to Section B on page 6 if you have listed all your medications

3. In the previous question there was room to write up to 10 prescription medications. If you take more than 10, please list the names of those medications below. List only their names, and do not include any medications you already told us about in the prescription medications table. You may receive a call from the WHI Clinical Coordinating Center to gather more detailed information on these medications. If you do not take more then 10, skip to question 4.

a._____ f. _____

b._____ g. _____

c. _____ h. _____

d. _____ i. _____

e. _____ j. _____

Section B: Barriers to Prescription Medications

4. Have any of the following barriers prevented you from obtaining or taking any medications that have been prescribed for you? **(Please check all that apply.)**

- ☐ 1 My health insurance would not cover the medication.
- ☐ 2 The medication or copayment cost too much.
- ☐ 3 It is a problem for me to get to the medical facility/physician.
- ☐ 4 Taking the medication would be inconvenient.
- ☐ 5 I was concerned about possible side effects or complications from the medication.
- ☐ 6 I was concerned about missing work due to taking the medication.
- ☐ 7 My family discouraged me from taking the medication.
- ☐ 8 My friends discouraged me from taking the medication.
- ☐ 9 I am taking too many medications.
- ☐ 10 I don't like taking medications.
- ☐ 0 I have not experienced any barriers to taking prescription medications.

Please go to next page

Section C: Non-Prescription Medications

The next set of questions ask about certain **non-prescription medicines** you have taken **at least once a week in the past two weeks**. These are medicines that you can buy **over-the-counter without a prescription** from your health care provider.

5. **Please answer the following questions about the non-prescription medicines listed below.** For each type of medicine that you are taking, please write in the name and strength from the product label, how often you take it, and how long you have taken it. **For some types listed below, there is space to write in two products. If you are taking more than two, please write in just the two products that you take most often.** Note that the brand names provided below are just examples; write in the brand of the medicine you are taking.

5.1 Are you taking Aspirin, for example, Bayer, St. Josephs, Bufferin, Anacin, Excedrin, BC powder, baby aspirin, Doan's? (This does not include aspirin-free drugs such as Tylenol or Advil.)

☐ 1 Yes → / ☐ 0 No ↓	**Name of the product** (listed on the bottle or package)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.2 Are you taking Anti-Inflammatory pain medicines, such as Advil, Aleve, Ibuprofen, Motrin, Naprosyn, Naproxen, Nuprin, Anaprox, or Orudis KT?

☐ 1 Yes → / ☐ 0 No ↓	**Name of the product** (listed on the bottle or package)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

Please go to next page

5.3 Are you taking a second type of Anti-Inflammatory pain medicine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.4 Are you taking an Antacid or heartburn medicine, such as Axid, Pepcid AC, Prilosec, Tagamet, Zantac, Cimetidine, Famotidine, Omeprazole, or Ranitidine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

5.5 Are you taking a second type of Antacid or heartburn medicine?

	Name of the product (listed on the bottle or package)	How often do you take it?	How long have you been taking it?
☐ 1 Yes → ☐ 0 No	_____ _____ **Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ☐☐

Please go to next page

5.6 Are you taking natural female hormones, herbal estrogens, or phytoestrogens, such as Remifemin, DHEA pills, wild yam, soy or flax products, dong quai, or black cohosh?

☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle or package) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

5.7 Are you taking a second type of natural female hormones, herbal estrogens, or phytoestrogens?

☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle or package) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week ☐ 5 1-3 days a month	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

6. In most states, some types of insulin can be purchased over-the-counter without a prescription. If you are currently taking insulin and you haven't included it on the list of your prescription medicines in Section A, please write it in question 6.1 below.

6.1 Are you taking <u>over-the-counter insulin</u>? If you listed insulin as a prescription medication in Section A, do not include it again here.

☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle or package) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 Less than once a day	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

Please go to next page

Section D: Dietary Supplements

In this final section, we ask about certain **vitamin or mineral supplements** you have taken **at least once a week in the past two weeks.**

7. Please answer the following questions about the **vitamin or mineral supplements** listed below. For each vitamin supplement that you are taking, please write in the name from the bottle/package, how often, and how long you have been taking it. Although you may be taking other supplements at this time, we are asking only for information on the supplements listed.

7.1 Are you taking a Daily Multi-Vitamin Supplement that has 10 or more vitamins and/or minerals in one pill? Examples are One-A-Day, Centrum, Theragran, Geritol.

☐ 1 Yes → / ☐ 0 No ↓	**Product name and/or brand** (listed on the bottle)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

7.2 Are you taking Calcium/Vitamin D supplement mixture? This is a pill that contains both Calcium and Vitamin D, but not in a multi-vitamin with several vitamins and minerals.

☐ 1 Yes → / ☐ 0 No ↓	**Name of the product** (listed on the bottle)	**How often do you take it?**	**How long have you been taking it?**
	_____ _____ **Calcium Strength:** _____ **Vitamin D Strength:** _____	☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

Please go to next page

7.3 Are you taking Calcium as a single mineral supplement containing no other vitamins or minerals?			
☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

7.4 Are you taking Vitamin D (Calciferol) as a single vitamin supplement containing no other vitamin or mineral?			
☐ 1 Yes → ☐ 0 No	**Name of the product** (listed on the bottle) _____ _____ **Strength:** _____	**How often do you take it?** ☐ 1 Once a day or more ☐ 2 4-6 days a week ☐ 3 2-3 days a week ☐ 4 Once a week	**How long have you been taking it?** ☐ 1 Less than 1 month ☐ 2 1 to 12 months ☐ 3 More than 1 year → **Number of years?** ⌊__⌋

8. What is the date that you completed this form? ⌊__⌋-⌊__⌋-⌊__⌋
Month Day Year

Thank you.
Please take a moment to review
any questions you may have missed.

Form 154 – Breast Health Supplement to the Medication Inventory
WHI Extension Study

Date Received: ⌊__⌋⌊__⌋-⌊__⌋⌊__⌋-⌊__⌋⌊__⌋(MM/DD/YY) 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	☐FCA ☐OUI ☐OU2 Language: ☐1 English ☐2 Spanish
OFFICE USE ONLY		

Instructions:

To help us learn about the health of WHI participants, we would like to know more about some of the medications you may take.

As part of your participation in the Women's Health Initiative, you previously reported a diagnosis of breast cancer or breast cancer in situ. This form asks about medications that you may have used to <u>treat</u> breast cancer.

If you would like to have a WHI staff member at the Clinical Coordinating Center complete this form with you over the phone, please feel free to call 1-800-218-8415.

The first set of questions asks about medications known as **SERMS (selective estrogen receptor modulators)**. These medications include tamoxifen (Nolvadex®), raloxifene (Evista®), and toremifene (Fareston®).

Since your breast cancer diagnosis:

1. Have you ever taken **tamoxifen (Nolvadex®)**?

☐ 0 No
☐ 1 Yes → 1.1 How long did you take or have you taken tamoxifen? **(Use your best estimate; mark only one.)**
☐ 9 Don't know

☐ 1 Less than 1 month ☐ 4 1-2 years
☐ 2 1-5 months ☐ 5 3-4 years
☐ 3 6-11 months ☐ 6 5 or more years

2. Have you ever taken **raloxifene (Evista®)**?

☐ 0 No
☐ 1 Yes → 2.1 How long did you take or have you taken raloxifene? **(Use your best estimate; mark only one.)**
☐ 9 Don't know

☐ 1 Less than 1 month ☐ 4 1-2 years
☐ 2 1-5 months ☐ 5 3-4 years
☐ 3 6-11 months ☐ 6 5 or more years

3. Have you ever taken **toremifene (Fareston®)**?

☐ 0 No
☐ 1 Yes → 3.1 How long did you take or have you taken toremifene? **(Use your best estimate; mark only one.)**
☐ 9 Don't know

☐ 1 Less than 1 month ☐ 4 1-2 years
☐ 2 1-5 months ☐ 5 3-4 years
☐ 3 6-11 months ☐ 6 5 or more years

Please go to next page

These next questions ask about medications known as **anti-estrogen therapies** or **aromatase inhibitors**. These medications include anastrozole (Arimidex®), exemestane (Aromasin®), and letrozole (Femara®).

Since your breast cancer diagnosis:

4. Have you ever taken **anastrozole (Arimidex®)**?

☐ 0 No
☐ 1 Yes → 4.1 How long did you take or have you taken anastrozole? **(Use your best estimate; mark only one.)**
☐ 9 Don't know

☐ 1 Less than 1 month ☐ 4 1-2 years
☐ 2 1-5 months ☐ 5 3-4 years
☐ 3 6-11 months ☐ 6 5 or more years

5. Have you ever taken **exemestane (Aromasin®)**?

☐ 0 No
☐ 1 Yes → 5.1 How long did you take or have you taken exemestane? **(Use your best estimate; mark only one.)**
☐ 9 Don't know

☐ 1 Less than 1 month ☐ 4 1-2 years
☐ 2 1-5 months ☐ 5 3-4 years
☐ 3 6-11 months ☐ 6 5 or more years

6. Have you ever taken **letrozole (Femara®)**?

☐ 0 No
☐ 1 Yes → 6.1 How long did you take or have you taken letrozole? **(Use your best estimate; mark only one.)**
☐ 9 Don't know

☐ 1 Less than 1 month ☐ 4 1-2 years
☐ 2 1-5 months ☐ 5 3-4 years
☐ 3 6-11 months ☐ 6 5 or more years

Please go to next page

7. Have you ever taken any **SERM** or **aromatase inhibitor** that is not listed above, or that you may not recall the name of?

☐ 0 No
☐ 1 Yes → 7.1 How long did you take or have you taken this medication? **(Use your best estimate; mark only one.)**
☐ 9 Don't know

- ☐ 1 Less than 1 month
- ☐ 2 1-5 months
- ☐ 3 6-11 months
- ☐ 4 1-2 years
- ☐ 5 3-4 years
- ☐ 6 5 or more years

8. Have any of the following barriers prevented you from obtaining or taking the prescribed breast cancer medications previously asked about (i.e., tamoxifen, raloxifene, toremifene, anastrazole, exemestane, and letrozole)? **(Please check all that apply.)**

☐ 1 I did not experience any barriers to taking these medications.
☐ 2 I have never heard of these medications.
☐ 3 My health insurance would not cover these medications.
☐ 4 These medications or copayments cost too much.
☐ 5 It is a problem for me to get to my medical facility/physician.
☐ 6 Taking these medications would be inconvenient.
☐ 7 I was concerned about possible side effects or complications from these medications.
☐ 8 I was concerned about missing work due to taking these medications.
☐ 9 My family discouraged me from taking these medications.
☐ 10 My friends discouraged me from taking these medications.
☐ 11 I am taking too many medications.
☐ 12 I don't like taking medications.
☐ 13 My physician did not recommend these medications for my particular type of breast disease.
☐ 14 Other:_____

9. What is the date you finished answering this form? ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋ - ⌊__⌋⌊__⌋
Month Day Year

Thank you.
Please take a moment to review any questions you may have missed.

Ver. 1
OMB #0925-0414 Exp: 07/13

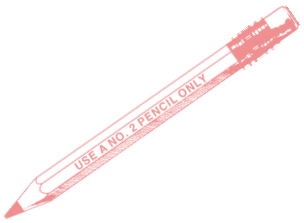
WOMEN'S HEALTH INITIATIVE

Form 155 - Lifestyle Questionnaire

This booklet has questions about your behavior, feelings, and experiences. Please answer each question as honestly as you can. No one will see your answers except for the scientists and staff at WHI. Your answers will be kept secret and will never be put with your name in a report. Please answer using you first thoughts about each question. Do not go back later to 'figure out' answers. Your answers will help us to understand the health of women like you.

Thank you for your help.

MARKING INSTRUCTIONS



- **Use a pencil.**
- **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**

Center Perf

OFFICE USE ONLY

AFFIX LABEL BETWEEN LINES
BAR CODE HERE

1. Date Received: Month Day Year

2. Reviewed By:

3. Contact Type:
- 1 Phone
- 2 Mail
- 8 Other

FCA OU1 OU2

5. Language: 1 E 2 S

SERIAL #

PLEASE MAKE NO MARKS IN THIS AREA

These first questions ask about your general health.

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is:	○ 1	○ 2	○ 3	○ 4	○ 5

	Much better now than 1 year ago	Somewhat better now than 1 year ago	About the same	Somewhat worse now than 1 year ago	Much worse now than 1 year ago
2. Compared to one year ago, how would you rate your health in general now?	○ 1	○ 2	○ 3	○ 4	○ 5

3. Overall, how would you rate your quality of life? **(Mark one circle below.)**

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○
Worst					Halfway					Best

As bad or worse than being dead — **Best quality of life**

4. How would you describe **(Mark one circle on each line.)**	Excellent	Very good	Average	Poor	Very poor
4.1 Your hearing?	○ 1	○ 2	○ 3	○ 4	○ 5
4.2 The condition of your mouth and teeth?	○ 1	○ 2	○ 3	○ 4	○ 5
4.3 Your vision (corrected with glasses or lenses as needed)?	○ 1	○ 2	○ 3	○ 4	○ 5
4.4 Your appetite?	○ 1	○ 2	○ 3	○ 4	○ 5
4.5 Your balance?	○ 1	○ 2	○ 3	○ 4	○ 5

5. Are you taking a calcium supplement such as Oscal, Viactiv, or Tums?

○ 0 No ○ 1 Yes

The next question is about female hormones you got <u>with</u> a doctor's prescription in the <u>last year</u>, even if you are not taking them right now.

6. **<u>In the past year</u>**, did you use any of the following female hormones—ESTROGEN, PROGESTERONE (also called PROGESTIN), or TESTOSTERONE—that were prescribed by a doctor? (These may have been in the form of a pill; skin patch; shot; cream; vaginal ring, pellet, or suppository; or bioidentical compound.)

○ 0 No ○ 1 Yes ○ 9 Don't know

7. Have you lost 10 pounds or more **in the past year**?

○ 0 No ○ 1 Yes

8. Do you smoke cigarettes now?

○ 0 No ○ 1 Yes →

8.1 How many cigarettes do you usually smoke each day?

- ○ 1 Less than 1
- ○ 2 1 - 4
- ○ 3 5 - 14
- ○ 4 15 - 24
- ○ 5 25 - 34
- ○ 6 35 - 44
- ○ 7 45 or more

9. In the **past 3 months**, how often have you had drinks containing alcohol?

- ○ 0 Never
- ○ 1 Less than once per week
- ○ 2 1 or 2 times per week
- ○ 3 3 or 4 times per week
- ○ 4 5 or 6 times per week
- ○ 5 Every day

The following are questions about a typical (or usual) day's activities. Does your health now limit you in these activities and, if so, how much? (Mark one circle on each line.)

	No, not limited at all	Yes, limited a little	Yes, limited a lot
10. Vigorous activities, such as running, lifting heavy objects, or strenuous sports	○ 3	○ 2	○ 1
11. Moderate activities, such as moving a table, vacuuming, bowling, or golfing	○ 3	○ 2	○ 1
12. Lifting or carrying groceries	○ 3	○ 2	○ 1
13. Climbing several flights of stairs	○ 3	○ 2	○ 1
14. Climbing one flight of stairs	○ 3	○ 2	○ 1
15. Bending, kneeling, stooping	○ 3	○ 2	○ 1
16. Walking more than a mile	○ 3	○ 2	○ 1
17. Walking several blocks	○ 3	○ 2	○ 1
18. Walking one block	○ 3	○ 2	○ 1
19. Bathing or dressing yourself	○ 3	○ 2	○ 1

PLEASE MAKE NO MARKS IN THIS AREA

SERIAL #

Center Perf

The next questions are about your usual physical activity and exercise.

20. Think about the walking you do outside the home. How often do you walk outside the home **for more than 10 minutes without stopping**? **(Mark only one.)**

- ○ 0 Rarely or never → Go to Question 21 below.
- ○ 1 1 to 3 times each month
- ○ 2 1 time each week
- ○ 3 2 to 3 times each week
- ○ 4 4 to 6 times each week
- ○ 5 7 or more times each week

When you walk outside the home for more than 10 minutes without stopping,

20.1 How many minutes do you usually walk?

- ○ 1 Less than 20 minutes
- ○ 2 20 to 39 minutes
- ○ 3 40 to 59 minutes
- ○ 4 1 hour or more

20.2 What is your usual speed?

- ○ 2 Casual strolling (2 miles per hour)
- ○ 3 Average or normal (2-3 miles an hour)
- ○ 4 Fairly fast (3-4 miles an hour)
- ○ 5 Very fast (more than 4 miles an hour)
- ○ 9 Don't know

21. Not counting walking outside the home, how often **each week** (7 days) do you usually do the exercises listed below?

21.1 **Moderate or strenuous exercise.** For example, biking outdoors, using an exercise machine (like a stationary bike or treadmill), aerobics, swimming, folk or popular dancing, jogging, tennis.

- ○ 0 None → Go to the next page.
- ○ 1 1 day per week
- ○ 2 2 days per week
- ○ 3 3 days per week
- ○ 4 4 days per week
- ○ 5 5 or more days per week

21.2 How long do you usually exercise like this at one time?

- ○ 1 Less than 20 minutes
- ○ 2 20 to 39 minutes
- ○ 3 40 to 59 minutes
- ○ 4 1 hour or more

21.3 Mild exercise. For example, slow dancing, bowling or golf.

- ○ 0 None → Go to Question 22 below.
- ○ 1 1 day per week
- ○ 2 2 days per week
- ○ 3 3 days per week
- ○ 4 4 days per week
- ○ 5 5 or more days per week

21.4 How long do you usually exercise like this at one time?

- ○ 1 Less than 20 minutes
- ○ 2 20 to 39 minutes
- ○ 3 40 to 59 minutes
- ○ 4 1 hour or more

These next questions ask about how much help (if any) you need to do routine activities <u>for yourself</u>. Help can be defined as getting assistance from another person or using a device. (Mark one circle for each line.)

I can do this activity:	By myself without help	With some help	Completely unable to do this by myself
22. Can you feed yourself?	○ 1	○ 2	○ 3
23. Can you dress and undress yourself?	○ 1	○ 2	○ 3
24. Can you get in and out of bed yourself?	○ 1	○ 2	○ 3
25. Can you take a bath or shower?	○ 1	○ 2	○ 3
26. Can you do your own grocery shopping?	○ 1	○ 2	○ 3
27. Can you keep track of and take your medicines?	○ 1	○ 2	○ 3

	I do not use any aid	I use a cane	I use crutches	I use a walker	I use a wheelchair
28. What aid, if any, do you usually use to walk on a level surface? **(Mark one.)**	○ 1	○ 2	○ 3	○ 4	○ 5

PLEASE MAKE NO MARKS IN THIS AREA

SERIAL #

The next questions are about your living conditions.

29. Do you live alone?

○ 0 Yes ○ 1 No

29.1 Who lives with you? **(Mark all that apply.)**

- ○ 1 I live with my husband or partner
- ○ 2 I live with my children
- ○ 3 I live with other relatives
- ○ 4 I live with friends
- ○ 8 Other (please describe): _____

30. Does the place where you live have special services for older people (such as help with meals, medicines, bathing, or transportation)?

○ 0 No ○ 1 Yes →

30.1 Are you currently receiving any of these services?

○ 0 No ○ 1 Yes

31. **<u>In the past year</u>**, have you stayed in a nursing home?

○ 0 No ○ 1 Yes

Now some questions about your social activities. How often, if at all, do you do any of the following activities? (Mark one circle on each line.)

	At least once a week	Several times a month	Once a month	Rarely or never
32. Eat out of the house	○ 4	○ 3	○ 2	○ 1
33. Go shopping	○ 4	○ 3	○ 2	○ 1
34. Go to a cultural event such as a movie, concert, play, or lecture	○ 4	○ 3	○ 2	○ 1
35. Meet with family or friends who do not live with you	○ 4	○ 3	○ 2	○ 1
36. Communicate with family or friends by phone or email	○ 4	○ 3	○ 2	○ 1
37. Go to a church or other religious center	○ 4	○ 3	○ 2	○ 1

People sometimes look to others for help, friendship, or other types of support. Next are some questions about the support that you have. How often is each of the following kinds of support available to you if you need it? (Mark one circle on each line.)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
38. Someone you can count on to listen to you when you need to talk	○ 1	○ 2	○ 3	○ 4	○ 5
39. Someone to give you good advice about a problem	○ 1	○ 2	○ 3	○ 4	○ 5
40. Someone to take you to the doctor if you need it	○ 1	○ 2	○ 3	○ 4	○ 5
41. Someone to have a good time with	○ 1	○ 2	○ 3	○ 4	○ 5
42. Someone to help you understand a problem when you need it	○ 1	○ 2	○ 3	○ 4	○ 5
43. Someone to help with daily chores if you are sick	○ 1	○ 2	○ 3	○ 4	○ 5
44. Someone to share your most private worries and fears	○ 1	○ 2	○ 3	○ 4	○ 5
45. Someone to do something fun with	○ 1	○ 2	○ 3	○ 4	○ 5
46. Someone to love you and make you feel wanted	○ 1	○ 2	○ 3	○ 4	○ 5

With growing older, we may rely on <u>others</u> more to help us with everyday care (meals or bathing or transportation, etc.).

47. How often **<u>in the past 4 weeks</u>** have you felt that people you rely on for everyday care have neglected your needs?

- ○ 0 Does not apply. I don't need help with my everyday care
- ○ 1 Almost no problems with obtaining everyday care
- ○ 2 Occasional problems with obtaining everyday care
- ○ 3 Frequent problems with obtaining everyday care

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PLEASE MAKE NO MARKS IN THIS AREA

SERIAL #

Below are some hard things that sometimes happen to people. Please try to think back over the past year to remember if any of these things happened. Mark the answer that seems best.

Over the past year:	**No**	**Yes, and it upset me: Not too much**	**Moderately (Medium)**	**Very much**
48. Did your spouse or partner have a serious illness?	○ 0	○ 1	○ 2	○ 3
49. Did a close friend or family member die or have a serious illness (other than your spouse or partner)?	○ 0	○ 1	○ 2	○ 3
50. Did you have any major problems with money?	○ 0	○ 1	○ 2	○ 3
51. Did you have a divorce or break-up with a spouse or partner?	○ 0	○ 1	○ 2	○ 3
52. Did a family member or close friend have a divorce or break-up?	○ 0	○ 1	○ 2	○ 3
53. Did you have a major conflict with children or grandchildren?	○ 0	○ 1	○ 2	○ 3
54. Did you have any major accidents, disasters, mugging, unwanted sexual experiences, robberies, or similar events?	○ 0	○ 1	○ 2	○ 3
55. Did you or a family member or close friend lose their job or retire?	○ 0	○ 1	○ 2	○ 3
56. Were you physically abused by being hit, slapped, pushed, shoved, punched or threatened with a weapon by a family member or close friend?	○ 0	○ 1	○ 2	○ 3
57. Were you verbally abused by being made fun of, severely criticized, told you were a stupid or worthless person, or threatened with harm to yourself, your possessions, or your pets, by a family member or close friend?	○ 0	○ 1	○ 2	○ 3
58. Did a pet die?	○ 0	○ 1	○ 2	○ 3
59. Did your spouse or partner die? →	○ 0	○ 1	○ 2	○ 3

If you answered yes to Question 59, please mark the answer that best describes how you feel right now about the person who died.	**Never**	**Rarely**	**Some-times**	**Often**	**Always**
59.1 I feel myself longing or yearning for my spouse or partner who died—I miss them so much it's hard to care about anything else.	○ 0	○ 1	○ 2	○ 3	○ 4
59.2 I think about this person so much that it's hard for me to do the things I normally do.	○ 0	○ 1	○ 2	○ 3	○ 4

Below is a list of symptoms women sometimes have as they become older or after menopause. For each item, mark the one circle that best describes how bothersome the symptom was **over the past year.** **Be sure to mark one circle on each line**.

If you did not have the problem, please mark the circle under "symptom did not occur."
If you had the symptom, use the following key to indicate how bothersome it was:

Mild = symptom did not interfere with usual activities
Moderate = symptom interfered somewhat with usual activities
Severe = symptom was so bothersome that usual activities could not be performed

	Symptom did not occur	Symptom occurred and was: Mild	Moderate	Severe
60. Night sweats	○ 0	○ 1	○ 2	○ 3
61. General aches or pains	○ 0	○ 1	○ 2	○ 3
62. Breast tenderness	○ 0	○ 1	○ 2	○ 3
63. Hot flashes	○ 0	○ 1	○ 2	○ 3
64. Mood swings	○ 0	○ 1	○ 2	○ 3
65. Irritability	○ 0	○ 1	○ 2	○ 3
66. Feeling tired	○ 0	○ 1	○ 2	○ 3
67. Forgetfulness	○ 0	○ 1	○ 2	○ 3
68. Skin dryness or scaling	○ 0	○ 1	○ 2	○ 3
69. Headaches or migraines	○ 0	○ 1	○ 2	○ 3
70. Difficulty concentrating	○ 0	○ 1	○ 2	○ 3
71. Joint pain or stiffness	○ 0	○ 1	○ 2	○ 3
72. Uncontrolled leaking of urine	○ 0	○ 1	○ 2	○ 3
73. Uncontrolled leaking of feces	○ 0	○ 1	○ 2	○ 3
74. Vaginal or genital irritation or itching	○ 0	○ 1	○ 2	○ 3
75. Vaginal or genital dryness	○ 0	○ 1	○ 2	○ 3
76. Other *(Specify)*: _____	○ 0	○ 1	○ 2	○ 3

During the past 4 weeks, how intensively did you suffer from the following?

	Not at all	Symptom occurred and was: Mild	Moderate	Severe
77. Cold hands or feet	○ 0	○ 1	○ 2	○ 3
78. Feeling too warm	○ 0	○ 1	○ 2	○ 3
79. Perspiring (without exercise)	○ 0	○ 1	○ 2	○ 3
80. "Gooseflesh" or shivering	○ 0	○ 1	○ 2	○ 3
81. Generally uncomfortable with the temperature	○ 0	○ 1	○ 2	○ 3

In the past 4 weeks, how often have you felt:	Never	Almost never	Sometimes	Fairly often	Very often
82. That you were unable to control the important things in your life?	○ 0	○ 1	○ 2	○ 3	○ 4
83. Confident about your ability to handle your personal problems?	○ 0	○ 1	○ 2	○ 3	○ 4
84. That things were going your way?	○ 0	○ 1	○ 2	○ 3	○ 4
85. That difficulties were piling up so high that you could not overcome them?	○ 0	○ 1	○ 2	○ 3	○ 4

In general…	Strongly disagree	Disagree somewhat	Disagree slightly	Agree slightly	Agree somewhat	Agree strongly
86. I tend to bounce back quickly after hard times.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
87. It does not take me long to recover from a stressful event.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
88. I have a hard time making it through stressful events.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

PLEASE MAKE NO MARKS IN THIS AREA

SERIAL #

The next questions are about your sleep habits and experiences. Pick the answer that best describes how often you experienced the situation <u>in the past 4 weeks</u>.

	No, not in past 4 weeks	Yes, less than once a week	Yes, 1 or 2 times a week	Yes, 3 or 4 times a week	Yes, 5 or more times a week
89. Did you take any kind of medication or alcohol at bedtime to help you sleep?	○ 1	○ 2	○ 3	○ 4	○ 5
90. Did you fall asleep during quiet activities like reading, watching TV, or riding in a car?	○ 1	○ 2	○ 3	○ 4	○ 5
91. Did you nap during the day?	○ 1	○ 2	○ 3	○ 4	○ 5
92. Did you have trouble falling asleep?	○ 1	○ 2	○ 3	○ 4	○ 5
93. Did you wake up several times at night?	○ 1	○ 2	○ 3	○ 4	○ 5
94. Did you wake up earlier than you planned to?	○ 1	○ 2	○ 3	○ 4	○ 5
95. Did you have trouble getting back to sleep after you woke up too early?	○ 1	○ 2	○ 3	○ 4	○ 5

96. Overall, was your typical night's sleep **<u>during the past 4 weeks</u>**:

Very sound or restful	Sound or restful	Average quality	Restless	Very restless
○ 5	○ 4	○ 3	○ 2	○ 1

97. About how many hours of sleep did you get on a typical night **<u>during the past 4 weeks</u>**?

5 or less hours	6 hours	7 hours	8 hours	9 hours	10 or more hours
○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

The next questions ask about how you feel and how things have been during the past 4 weeks. Give one answer that comes closest to the way you have been feeling.

How much of the time **during the past 4 weeks…**

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
98.	Did you feel full of pep?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
99.	Have you been a very nervous person?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
100.	Have you felt so down in the dumps that nothing could cheer you up?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
101.	Have you felt calm and peaceful?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
102.	Did you have a lot of energy?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
103.	Have you felt downhearted and blue?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
104.	Did you feel worn out?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
105.	Have you been happy?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6
106.	Did you feel tired?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6

During the past 4 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days
107.	Feeling nervous, anxious, on edge, or worrying a lot about different things	○ 0	○ 1	○ 2
108.	Feeling restless so that it is hard to sit still	○ 0	○ 1	○ 2
109.	Getting tired very easily	○ 0	○ 1	○ 2
110.	Muscle tension aches or soreness	○ 0	○ 1	○ 2
111.	Trouble falling asleep or staying asleep	○ 0	○ 1	○ 2
112.	Trouble concentrating on things, such as reading a book or watching TV	○ 0	○ 1	○ 2
113.	Becoming easily annoyed or irritable	○ 0	○ 1	○ 2
114.	Having an anxiety attack—suddenly feeling fear or panic	○ 0	○ 1	○ 2

PLEASE MAKE NO MARKS IN THIS AREA

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	None	Very mild	Mild	Moderate (Medium)	Severe
115. **During the past 4 weeks**, how much bodily pain have you had?	○ 0	○ 2	○ 3	○ 4	○ 5

	Not at all	A little bit	Moderate (Medium)	Quite a bit	Extremely (A lot)
116. **During the past 4 weeks**, how much did pain interfere with your normal work (both outside your home and at home)?	○ 1	○ 2	○ 3	○ 4	○ 5

Questions 117-122 ask about your feelings during the past week. For each of the statements, please indicate the choice that tells how often you felt this way.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
117. You felt depressed (blue or down)	○ 0	○ 1	○ 2	○ 3
118. Your sleep was restless	○ 0	○ 1	○ 2	○ 3
119. You enjoyed life	○ 0	○ 1	○ 2	○ 3
120. You had crying spells	○ 0	○ 1	○ 2	○ 3
121. You felt sad	○ 0	○ 1	○ 2	○ 3
122. You felt that people disliked you	○ 0	○ 1	○ 2	○ 3

123. **In the past year**, have you had **2 weeks** or more during which you felt sad, blue or depressed, or lost pleasure in things that you usually cared about or enjoyed?

○ 0 No ○ 1 Yes

124. Have you had **2 years** or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?

○ 0 No ○ 1 Yes →

124.1 If yes, have you felt depressed or sad much of the time in the past year?

○ 0 No ○ 1 Yes

The following are about emotions you may have been feeling. Please mark one circle for each line.

How true have the following been for you **in this past week**?

	Not at all	A little bit	Somewhat	Quite a bit	Very much
125. I am not interested in activities that will expand my horizons.	○ 0	○ 1	○ 2	○ 3	○ 4
126. I think it is important to have new experiences that challenge how you think about yourself and the world.	○ 0	○ 1	○ 2	○ 3	○ 4
127. When I think about it, I haven't really improved much as a person over the years.	○ 0	○ 1	○ 2	○ 3	○ 4
128. I have the sense that I have developed a lot as a person over time.	○ 0	○ 1	○ 2	○ 3	○ 4
129. For me, life has been a continuous process of learning, changing, and growth.	○ 0	○ 1	○ 2	○ 3	○ 4
130. I gave up trying to make big improvements or changes in my life a long time ago.	○ 0	○ 1	○ 2	○ 3	○ 4
131. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.	○ 0	○ 1	○ 2	○ 3	○ 4
132. I live life one day at a time and don't really think about the future.	○ 0	○ 1	○ 2	○ 3	○ 4
133. I have a sense of direction and purpose in life.	○ 0	○ 1	○ 2	○ 3	○ 4
134. I don't have a good sense of what it is I'm trying to accomplish in life.	○ 0	○ 1	○ 2	○ 3	○ 4
135. My daily activities often seem trivial and unimportant to me.	○ 0	○ 1	○ 2	○ 3	○ 4
136. I enjoy making plans for the future and working to make them a reality.	○ 0	○ 1	○ 2	○ 3	○ 4
137. I am an active person in carrying out the plans I set for myself.	○ 0	○ 1	○ 2	○ 3	○ 4

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How true have the following been for you **in the past week**?

	Not at all	A little bit	Somewhat	Quite a bit	Very much
138. Some people wander aimlessly through life, but I am not one of them.	0	1	2	3	4
139. I sometimes feel as if I've done all there is to do in life.	0	1	2	3	4
140. I felt peaceful.	0	1	2	3	4
141. I had a reason for living.	0	1	2	3	4
142. My life has been productive.	0	1	2	3	4
143. I had trouble feeling peace of mind.	0	1	2	3	4
144. I felt a sense of purpose in my life.	0	1	2	3	4
145. I was able to reach down deep into myself for comfort.	0	1	2	3	4
146. I felt a sense of harmony within myself.	0	1	2	3	4
147. My life lacked meaning and purpose.	0	1	2	3	4
148. I found comfort in my faith or spiritual beliefs.	0	1	2	3	4
149. I found strength in my faith or spiritual beliefs.	0	1	2	3	4
150. I am always hopeful about my future.	0	1	2	3	4

Center Perf

The last questions are about emotions you may have been feeling. Please mark one circle on each line.

Mark the answer that best corresponds to how much you agree with each statement.

		Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
151.	In most ways my life is close to my ideal.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
152.	The conditions of my life are excellent.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
153.	I am satisfied with my life.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
154.	So far I have gotten the important things I want in life.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
155.	If I could live my life over, I would change almost nothing.	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Please take a few minutes to review this form for any questions you may have missed.

Thank you for taking the time to complete this questionnaire

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SERIAL #

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Form 156 – Supplemental Questionnaire

MARKING INSTRUCTIONS

- Use a Pencil.
- 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 questionnaire asks about you, your home, your phone and computer use, and your health care. Your answers will help us understand the health of women like you.

OFFICE USE ONLY

1. What year was your mother born? 1 ____
2. What year was your father born? 1 ____
3. What is your current weight? ____ lbs.

	0	1-2	3-4	5-6	7-9	10 or more
4. How many close friends do you have?	○0	○1	○2	○3	○4	○5
5. How many close relatives do you have?	○0	○1	○2	○3	○4	○5

6. As people grow older they sometimes need to make changes to their home so that it is a safer and easier place to live. Please read the list below and mark any **changes** or **additions** you have made to your home for yourself or someone else. Be sure to **mark all that apply**.

- ○1 Railings or banisters
- ○2 Grab bars
- ○3 Indoor or outdoor ramps
- ○4 Non-slip surfaces
- ○5 Tacking down carpets/rugs
- ○6 Decreasing clutter
- ○7 Increasing lighting
- ○8 Sink/counter heights
- ○9 Other
- ○10 No changes

7. In the last year, did you fall at home? ○1 Yes ○0 No
8. Do you wear a device around your neck or wrist for contacting emergency help? ○1 Yes ○0 No

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Date Received: ____ - ____ - ____
Month Day Year

Reviewed By: ____

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Form 156 – Supplemental Questionnaire

	No	Yes	Don't know/ Not sure
9. During the past 12 months, have you had a seasonal flu shot?	○0	○1	○2
10. A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's life and is different from the flu shot. Have you ever had a pneumonia shot?	○0	○1	○2
11. Have you had the shingles vaccine (also known as the zoster vaccine)?	○0	○1	○2

12. As an adult, have you had pneumonia diagnosed by a physician?

○1 Yes → 12.1 How long ago was your last pneumonia diagnosed?
○1 Less than 6 months ○3 1 to 3 years ago
○2 6 to 12 months ago ○4 Greater than 3 years ago

○0 No

○2 Don't know/ Not sure

13. Has a health care provider ever told you that you had a urinary tract infection (bladder infection, cystitis, kidney infection, pyelonephritis)?

○1 Yes → 13.1 How long ago was your last urinary tract infection?
○1 Less than 6 months ○3 1 to 3 years ago
○2 6 to 12 months ago ○4 Greater than 3 years ago

○0 No

○2 Don't know/ Not sure

14. Have you ever had shingles?

○1 Yes → 14.1 How long ago did you have shingles?
○1 Less than 6 months ○3 1 to 3 years ago
○2 6 to 12 months ago ○4 Greater than 3 years ago

○0 No

○2 Don't know/ Not sure

15. When was the last time you saw an eye doctor?

○1 1 year ago
○2 1-2 years ago
○3 More than 2 years ago
○4 I do not see an eye doctor

16. Have you ever been told by an eye doctor that you have glaucoma?

○1 Yes →
16.1 How old were you when diagnosed with glaucoma?
○1 < 45 ○2 45-54 ○3 55-64 ○4 65-74 ○5 75-84 ○6 ≥ 85
16.2 Has your glaucoma been treated with any of the following? **(Mark all that apply.)**
○1 Eye drops ○2 Laser treatment ○3 Other surgery

○0 No

CENTER PERF

17. Have you ever had surgery to remove cataracts?

○1 Yes → 17.1 How old were you when you had your first cataract extraction surgery?
○1 < 45 ○2 45-54 ○3 55-64 ○4 65-74 ○5 75-84 ○6 ≥ 85

○0 No

18. Have you ever been told by an eye doctor that you have diabetic retinopathy?

○1 Yes → 18.1 How old were you when diagnosed with diabetic retinopathy?
○1 < 45 ○2 45-54 ○3 55-64 ○4 65-74 ○5 75-84 ○6 ≥ 85

18.2 Has your retinopathy been treated with any of the following? **(Mark all that apply.)**
○1 Laser treatment ○2 Surgery/vitrectomy ○3 Nutritional supplement

○0 No

19. Have you ever been told by an eye doctor that you have dry eye syndrome?

○1 Yes → 19.1 How old were you when diagnosed with dry eye syndrome?
○1 < 45 ○2 45-54 ○3 55-64 ○4 65-74 ○5 75-84 ○6 ≥ 85

19.2 Has your dry eye been treated with any of the following? **(Mark all that apply.)**
○1 Over-the-counter artificial tears
○2 Medicating drops (e.g., Restasis®)
○3 Fish oil or omega-3 supplements

○0 No

The next set of questions asks about advanced health care planning. This can cover becoming too sick to live on your own, being very sick and you cannot speak for yourself, or being near the end of your life and you cannot speak for yourself.

20. Have you chosen a specific person you trust to make health care decisions for you in case you cannot speak for yourself?

○1 Yes → 20.1 Who did you choose to make health care decisions for you? **(Mark one.)**
○1 My spouse or partner
○2 Another family member
○3 My family as a group
○4 My doctor
○5 A friend or non-family member

20.2 Have you talked to the person you chose about the type of health care you want if you were very sick or near the end of your life? **(Mark one.)**
○1 Yes, we had a very detailed discussion about my wishes
○2 Yes, but we just had a general discussion
○3 No, because I assume my decision maker knows what I want
○4 No, for other reason

○0 No

21. Have you made plans for what should happen if you become too sick to live on your own? **(Mark one.)**
○1 Yes, I have made plans
○2 No, I haven't given it much thought
○3 No, I don't have plans but I have thought about it

CENTER PERF

22. An Advance Directive or Living Will are documents that let a person choose how she wants to be treated if she gets very sick and is near the end of her life. Have you filled out a written Advance Directive or Living Will?

○1 Yes ○0 No ○2 Not sure

23. In the past year, has a health care provider refused to have you as a patient because you are on Medicare?

○1 Yes ○0 No ○2 Don't know / Not sure ○3 Not on Medicare

The next five questions are about your eating habits.	**No**	**Yes**
24. I eat fewer than 2 meals per day.	○0	○1
25. I eat alone most of the time.	○0	○1
26. I have tooth or mouth problems that make it hard for me to eat.	○0	○1
27. I am not always physically able to shop, cook and/or feed myself.	○0	○1
28. I don't always have enough money to buy the food I need.	○0	○1

This last set of questions is about your use of phones and computers.

29. Do you own a cell phone?

○1 Yes → 29.1 Do you send or receive text messages on your phone?
○1 Yes ○0 No

○0 No

30. Do you use a computer (either at home or away from home)?

○1 Yes → 30.1 Do you use it for email?
○0 No ○1 Yes

30.2 Do you use it for the Internet?
○0 No ○1 Yes

○0 No

	No	**Yes**
31. Even if you do not use a computer, do you use a "smart phone," iPad, or other device for email or the Internet?	○0	○1
32. Do you use the Internet to look for health information?	○0	○1
33. Have you looked at the WHI website (www.whi.org)?	○0	○1

Thank you. Please take a moment to review any questions you may have missed.

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WOMEN'S HEALTH INITIATIVE

Form 157
Supplemental Questionnaire 2014-2015

This booklet has questions about your behavior, feelings, and experiences. Please answer each question as honestly as you can. No one will see your answers except for the scientists and staff at WHI.

1. Do you live alone? ○ 0 No ○ 1 Yes

2. Please mark the circle that best describes your current living arrangement:

○ 1 Independently in the community (for example in your home or apartment)
○ 2 With a family member other than your spouse, such as a sibling or daughter/son
○ 3 In an assisted living facility
○ 4 In a skilled nursing facility
○ 5 Other type of living arrangement **(Specify:** _____**)**

3. Has any member of your family (mother, father, full-blooded sister or brother) been diagnosed with Alzheimer's disease or senile dementia?

○ 0 No
○ 9 Don't know
○ 1 Yes →

3.1. Who? Please mark all that apply.
○ 1 Mother
○ 2 Father
○ 3 Any brother
○ 4 Any sister

The next questions ask about companionship.

		Hardly Ever	Some of the time	Often
4.1	How often do you feel that you lack companionship?	○ 1	○ 2	○ 3
4.2	How often do you feel left out?	○ 1	○ 2	○ 3
4.3	How often do you feel isolated from others?	○ 1	○ 2	○ 3

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Form 157 – Supplemental Questionnaire

5. Please answer the following questions about yourself. Try not to let an answer to one question affect your answer to other questions. ***Mark one circle on each line.***

	Strongly Disagree	Disagree	Neutral (In-between)	Agree	Strongly Agree
5.1 In unclear times, I usually expect the best.	○ 1	○ 2	○ 3	○ 4	○ 5
5.2 If something can go wrong for me, it will.	○ 1	○ 2	○ 3	○ 4	○ 5
5.3 I'm always hopeful about my future.	○ 1	○ 2	○ 3	○ 4	○ 5
5.4 I hardly ever expect things to go my way.	○ 1	○ 2	○ 3	○ 4	○ 5
5.5 I rarely count on good things happening to me.	○ 1	○ 2	○ 3	○ 4	○ 5
5.6 Overall, I expect more good things to happen to me than bad.	○ 1	○ 2	○ 3	○ 4	○ 5

6. This set of questions asks you to think about the future.

	Absolutely Agree	Somewhat Agree	Neutral (In-between)	Somewhat Disagree	Absolutely Disagree
6.1 I feel that it is impossible to reach the goals I would like to strive for.	○ 0	○ 1	○ 2	○ 3	○ 4
6.2 The future seems to me to be hopeless, and I can't believe that things are changing for the better.	○ 0	○ 1	○ 2	○ 3	○ 4

7. Rate how intensely you felt each emotion during the past 24 hours by marking a circle on each line.

	Not at all	A little bit	Moderately	A great deal	Extremely
7.1 Amusement	○ 1	○ 2	○ 3	○ 4	○ 5
7.2 Awe	○ 1	○ 2	○ 3	○ 4	○ 5
7.3 Gratitude	○ 1	○ 2	○ 3	○ 4	○ 5
7.4 Hope	○ 1	○ 2	○ 3	○ 4	○ 5
7.5 Interest	○ 1	○ 2	○ 3	○ 4	○ 5
7.6 Joy	○ 1	○ 2	○ 3	○ 4	○ 5
7.7 Love	○ 1	○ 2	○ 3	○ 4	○ 5
7.8 Pride	○ 1	○ 2	○ 3	○ 4	○ 5
7.9 Serenity	○ 1	○ 2	○ 3	○ 4	○ 5

Thank you for taking the time to complete this questionnaire.

Form 158
Supplemental Questionnaire 2017

This questionnaire has questions about your experiences. Please answer each question as honestly as you can. No one will see your answers except for the scientists and staff at WHI. **(Use a pencil or blue or black pen only.)**

– Barcode ID Label –

1. Are you willing to provide your email address as an additional way for us to contact you?
   ○1 Yes _____
   Print your email address on the line above.
   ○0 No

These questions are about pregnancies.

2. Have you ever been pregnant?
   ○0 No → **Go to question 3.** ○1 Yes →

   2.1 Were any of your babies born 3 weeks early or sooner?
   ○0 No ○1 Yes ○9 Don't know

   2.2 During any of your pregnancies, did you have preeclampsia (toxemia, high blood pressure during and/or right after pregnancy also associated with protein in the urine) or eclampsia (preeclampsia AND seizures/convulsions)?
   ○0 No ○1 Yes ○9 Don't know

   2.3 During any of your pregnancies, did you have high blood pressure (gestational hypertension, pregnancy-induced hypertension) not related to preeclampsia?
   ○0 No ○1 Yes ○9 Don't know

   2.4 During any of your pregnancies, were you told you had gestational diabetes or high blood sugar, or sugar in the urine?
   ○0 No ○1 Yes ○9 Don't know

   2.5 Have you ever given birth to a baby that weighed less than 5 pounds, 8 ounces (less than 2,500 grams)?
   ○0 No ○1 Yes ○9 Don't know

   2.6 Have you ever given birth to a baby that weighed more than 9 pounds, 14 ounces (more than 4,500 grams)?
   ○0 No ○1 Yes ○9 Don't know

These questions are about dental health.

3. How would you describe the condition of your mouth and teeth?
   ○1 Excellent ○2 Very good ○3 Good ○4 Fair ○5 Poor

4. During the past 3 years, how often have you gone to the dentist or dental hygienist for routine check-ups or cleanings?
   ○1 Never ○2 Once or less per year ○3 Twice or more per year ○4 As needed

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5. Has a dentist or dental hygienist ever told you that you had periodontal or gum disease?
   ○0 No ○1 Yes ○9 Don't know

6. Have you lost all of your permanent teeth, both upper and lower?
   ○0 No ○1 Yes

These questions are about memory and changes in mental functioning.

7. Do you feel like your memory is becoming worse?
   ○0 No ○1 Yes, but this does not worry me ○2 Yes, and this worries me

This next set of questions asks you to rate any change in your abilities, daily functioning and activities. Fill in the circle for each question that best fits your current ability level compared to 5 years ago.

Select the one best choice for each item and *please do not skip any questions*.	No change	Minimal change	Some change	Clearly noticeable change	Much worse
7.1 Recalling information when I really try:	○1	○2	○3	○4	○5
7.2 Remembering names and faces of new people I meet:	○1	○2	○3	○4	○5
7.3 Remembering things that have happened recently:	○1	○2	○3	○4	○5
7.4 Recalling conversations a few days later:	○1	○2	○3	○4	○5
7.5 Remembering where things are usually kept:	○1	○2	○3	○4	○5
7.6 Remembering new information told to me:	○1	○2	○3	○4	○5
7.7 Remembering where I placed familiar objects:	○1	○2	○3	○4	○5
7.8 Remembering what I intended to do:	○1	○2	○3	○4	○5
7.9 Remembering names of family members and friends:	○1	○2	○3	○4	○5
7.10 Remembering without notes and reminders:	○1	○2	○3	○4	○5
7.11 People who know me would find that my memory is:	○1	○2	○3	○4	○5
7.12 Remembering things compared to my age group:	○1	○2	○3	○4	○5

This question is about your birth name.

8. U.S. census records have important historical information about the environment during your childhood, which may impact health. We would like to link your name to publicly available census records. Are you willing to provide your full birth name for this purpose?

○1 Yes → Print your first, middle and last name as it appears **on your birth certificate**.

○0 No

First name _____ Middle name _____ Last name at birth (maiden name) _____

Thank you for taking the time to complete this questionnaire.