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: