39033

WHS 5 / ☐☐ - ☐☐☐☐☐☐ - ☐

1. **Birth date:** ☐☐ / ☐☐ / ☐☐ → **Last 6 digits of SSN: (optional)** X X X - ☐☐ - ☐☐☐☐

2. **SINCE YOU LAST RETURNED A QUESTIONNAIRE (approximately 1 year ago), have you been NEWLY DIAGNOSED with any of the following? Please answer NO or YES on each line. IF YES, please mark the bubble to the right that corresponds to the approximate date of the diagnosis/procedure. Only complete a date bubble if you have answered YES to a diagnosis/procedure.**

The first line is provided as an EXAMPLE of someone reporting a "hip replacement" performed in February 2009.

DIAGNOSIS OR PROCEDURE	NO or YES		→	2008 Jan-Jun	2008 Jul-Dec	2009 Jan-Jun	2009 Jul-Dec	Office Use
EXAMPLE: Hip replacement	○ No	● Yes	→	○	○	●	○	○
a. Acute coronary syndrome/unstable angina	○ No	○ Yes	→	○	○	○	○	○
b. Angina pectoris	○ No	○ Yes	→	○	○	○	○	○
If YES, confirmed by: angiogram/cardiac cath?	○ No	○ Yes	stress test?	○ No	○ Yes			
c. Myocardial infarction	○ No	○ Yes	→	○	○	○	○	○
d. Coronary angioplasty (PTCA) or stent	○ No	○ Yes	→	○	○	○	○	○
e. Coronary bypass surgery (CABG)	○ No	○ Yes	→	○	○	○	○	○
f. Congestive heart failure	○ No	○ Yes	→	○	○	○	○	○
g. Ventricular tachycardia	○ No	○ Yes	→	○	○	○	○	○
h. Atrial fibrillation	○ No	○ Yes	→	○	○	○	○	○
i. Intermittent claudication	○ No	○ Yes	→	○	○	○	○	○
j. Peripheral artery disease (not varicose veins)	○ No	○ Yes	→	○	○	○	○	○
k. Pulmonary embolism (PE)	○ No	○ Yes	→	○	○	○	○	○
l. Deep vein thrombosis (DVT)	○ No	○ Yes	→	○	○	○	○	○
m. Stroke	○ No	○ Yes	→	○	○	○	○	○
n. TIA (transient ischemic attack)	○ No	○ Yes	→	○	○	○	○	○
o. Carotid artery surgery (endarterectomy)	○ No	○ Yes	→	○	○	○	○	○
p. Melanoma	○ No	○ Yes	→	○	○	○	○	○
q. Non-melanoma skin cancer What type? ○ basal cell ○ squamous cell ○ unknown type	○ No	○ Yes	→	○	○	○	○	○
r. Breast cancer	○ No	○ Yes	→	○	○	○	○	○
s. Lung cancer	○ No	○ Yes	→	○	○	○	○	○
t. Colon cancer	○ No	○ Yes	→	○	○	○	○	○
u. Other cancer (non-skin) SITE: _____	○ No	○ Yes	→	○	○	○	○	○
v. Colon polyp	○ No	○ Yes	→	○	○	○	○	○
w. Diabetes mellitus	○ No	○ Yes	→	○	○	○	○	○
x. Migraine headaches	○ No	○ Yes	→	○	○	○	○	○

○ 1 ○ 2
Office use

(OVER)

2. (continued) NEWLY DIAGNOSED SINCE LAST QUESTIONNAIRE? DIAGNOSIS OR PROCEDURE		NO or YES	2008 Jan-Jun	2008 Jul-Dec	2009 Jan-Jun	2009 Jul-Dec	Office Use
y. Other headaches		○ No ○ Yes →	○	○	○	○	○
z. Kidney disease (other than kidney stones)		○ No ○ Yes →	○	○	○	○	○
aa. Chronic kidney failure		○ No ○ Yes →	○	○	○	○	○
bb. Macular degeneration	**RIGHT eye**	○ No ○ Yes →	○	○	○	○	○
	LEFT eye	○ No ○ Yes →	○	○	○	○	○
cc. Cataract	**RIGHT eye**	○ No ○ Yes →	○	○	○	○	○
	LEFT eye	○ No ○ Yes →	○	○	○	○	○
dd. Cataract extraction	**RIGHT eye**	○ No ○ Yes →	○	○	○	○	○
	LEFT eye	○ No ○ Yes →	○	○	○	○	○
ee. Glaucoma		○ No ○ Yes →	○	○	○	○	○
ff. Dry eye syndrome		○ No ○ Yes →	○	○	○	○	○
gg. Parkinson's disease		○ No ○ Yes →	○	○	○	○	○
hh. Elevated cholesterol (dx by a clinician)		○ No ○ Yes →	○	○	○	○	○
ii. Hypertension (dx by a clinician)		○ No ○ Yes →	○	○	○	○	○
jj. Osteoarthritis		○ No ○ Yes →	○	○	○	○	○
kk. Osteoporosis		○ No ○ Yes →	○	○	○	○	○
ll. Fracture due to osteoporosis		○ No ○ Yes →	○	○	○	○	○
mm. Bone density exam (DEXA)		○ No ○ Yes →	○	○	○	○	○
nn. Joint replacement		○ No ○ Yes →	○	○	○	○	○
oo. Rheumatoid arthritis		○ No ○ Yes →	○	○	○	○	○
pp. Fibromyalgia		○ No ○ Yes →	○	○	○	○	○
qq. Psoriasis		○ No ○ Yes →	○	○	○	○	○
rr. Fibrocystic or other benign breast disease		○ No ○ Yes →	○	○	○	○	○
If YES, confirmed by: breast biopsy? ○ No ○ Yes aspiration? ○ No ○ Yes							

3. Within the PAST 2 YEARS, have you been NEWLY DIAGNOSED with either of the following (Mark all that apply)?

○ Peptic Ulcer ○ Gastrointestinal bleed ○ NEITHER

4. What is your CURRENT blood pressure (mmHg)? → ☐☐☐ / ☐☐☐

systolic / diastolic

○ Don't know my blood pressure

5. What is your CURRENT TOTAL CHOLESTEROL (if checked within the past 2 years)?

○ <140 mg/dl ○ 140-159 ○ 160-179 ○ 180-199 ○ 200-219 ○ 220-239 ○ 240-249
○ 250-259 ○ 260-269 ○ 270-279 ○ 280-299 ○ 300-329 ○ 330+ ○ unknown/not checked in 2 yrs

6. What is your CURRENT HDL-CHOLESTEROL (if checked within the past 2 years)?

○ <30 mg/dl ○ 30-39 ○ 40-49 ○ 50-59 ○ 60-69 ○ 70-79
○ 80-89 ○ 90-99 ○ 100+ ○ unknown/not checked in 2 yrs

7. What is your CURRENT weight? ☐☐☐ pounds

8. Do you CURRENTLY smoke cigarettes? ○ No ○ Yes → If YES: On average, how many cigarettes/day do you smoke (1 pack = 20 cigarettes)? ☐☐ cigs/day

9 . Please indicate your average use of the following beverages DURING THE PAST YEAR:

BEVERAGE		Never or less than 1/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
a. Beer (1 glass or bottle or can)	Regular beer	O	O	O	O	O	O	O	O	O
	Light beer	O	O	O	O	O	O	O	O	O
b. Red wine/sherry/port (4 oz. glass)		O	O	O	O	O	O	O	O	O
c. White wine (4 oz. glass)		O	O	O	O	O	O	O	O	O
d. Liquor (1 drink or shot) (e.g., vodka, rum, gin, brandy, etc.)		O	O	O	O	O	O	O	O	O

10. Did any of these relatives ever have . . . **If YES, please provide AGE when first diagnosed:**

a. Breast cancer?	**Don't know**	**No**	**Yes**		**<50**	**50-59**	**60-69**	**70+**	**Age Unknown**
Mother	O	O	O	→	O	O	O	O	O
Any Sister	O	O	O	→	O	O	O	O	O
Maternal grandmother	O	O	O	→	O	O	O	O	O
Paternal grandmother	O	O	O	→	O	O	O	O	O
b. Endometrial cancer?	**Don't know**	**No**	**Yes**		**<50**	**50-59**	**60-69**	**70+**	**Age Unknown**
Mother	O	O	O	→	O	O	O	O	O
Any Sister	O	O	O	→	O	O	O	O	O
Maternal grandmother	O	O	O	→	O	O	O	O	O
Paternal grandmother	O	O	O	→	O	O	O	O	O

11. Have you EVER had infectious mononucleosis? O Not sure O No O Yes

IF YES: How old were you when diagnosed? O 0-5 O 6-10 O 11-15 O 16-19 O 20-24 O 25-29 O 30+

Did it require you to miss school or work? O No O Yes O Not sure

Was the diagnosis confirmed by "mono spot", "heterophile antibody" or any other lab test? O No O Yes O Not sure

12. Have you EVER been diagnosed with a uterine fibroid? O Not sure O No O Yes → Year of diagnosis: ☐☐☐☐

13. Has your sister or mother EVER been diagnosed with a uterine fibroid? O Not sure O No O Yes

14. Have you EVER had an abnormal Pap smear test? O Not sure O No O Yes

IF YES: Was the Pap smear test persistently abnormal, or followed up by a non-Pap-smear test (for example, a colposcopy and/or biopsy)? O Not sure O No O Yes

15. In the LAST 12 MONTHS did you have unpleasant leg sensations (crawling, paraesthesias, or pain) combined with motor restlessness and an urge to move? O No O Yes

IF YES: Do these symptoms occur only at rest and does moving improve them? O No O Yes

Are these symptoms worse in the evening/night compared to the morning? O No O Yes

How often do these symptoms occur? O Daily O 3-6/week O 1-2/week O 1-3/month O < 1/month O Rarely/never

Have you EVER been specifically diagnosed with "restless legs syndrome" by a physician? O No O Yes

16. IN THE PAST MONTH, on approximately how many DAYS did you take any of the following? Please answer on each line.

	DAYS USED IN THE PAST MONTH				
	None	1-3	4-10	11-20	21+
a. Acetaminophen (e.g., Tylenol, Excedrin P.M.)	O	O	O	O	O
b. Aspirin (e.g., Bayer, Bufferin, Anacin, Excedrin, Ecotrin)	O	O	O	O	O
On days taking, TOTAL DOSE per day: O <100 mg O 100-499 mg O 500-999 mg O 1000+ mg O unknown					
c. Medications containing aspirin (e.g., Alka-Seltzer, Doan's Pills, Fiorinal)	O	O	O	O	O
d. COX-2 inhibitors (e.g., Celebrex)	O	O	O	O	O
e. Other non-steroidal, anti-inflammatory agents (e.g., Motrin, Advil, Aleve)	O	O	O	O	O
f. Multivitamins	O	O	O	O	O
g. SINGLE supplements of omega-3 fatty acids (fish oil)	O	O	O	O	O
h. SINGLE supplements of calcium (include elemental calcium in Tums)	O	O	O	O	O
What dose per day (elemental calcium)? O <400 mg O 400-900 mg O 901-1300 mg O 1301+ mg O unknown					
i. SINGLE supplements of vitamin D (in calcium supplements or separately)?	O	O	O	O	O
What dose per day? O <300 IU O 300-500 IU O 600-900 IU O 1000 IU or more O unknown					

17. Are you CURRENTLY taking any of the following medications REGULARLY? Please indicate NO/YES for each.

a. Antihypertensives (e.g., diuretic, calcium channel, angiotensin receptor or b-blockers, ACE inhibitor)	O No	O Yes
b. Statin cholesterol-lowering medications (e.g., Lipitor, Zocor, Mevacor, Pravachol, Crestor, Lescol)	O No	O Yes
c. Other non-statin lipid-lowering medications (e.g., niacin, Lopid, Questran, Colestid, Zetia)	O No	O Yes
d. Fosamax for prevention/treatment of bone loss	O No	O Yes
If YES, for how many years have you been taking Fosamax regularly? O < 1 yr O 1-2 yrs O 3-4 yrs O 5+ yrs		

18. IN THE PAST YEAR, have you had any of the following tests or procedures?

(Please answer on each line)	No	Yes, for symptoms	Yes, for screening
a. Fasting blood sugar	O	O	O
b. Colonoscopy	O	O	O
c. Sigmoidoscopy	O	O	O
d. Mammogram	O	O	O
e. Eye exam	O	O	O

19. Have you had a hysterectomy? O No O Yes

IF YES: At what age ? ☐☐

20. In general, would you say your health is:

O Excellent O Very good O Good O Fair O Poor

PLEASE COMPLETE THE CONTACT INFORMATION IN THE RIGHT COLUMN. THANK YOU.

THE INFORMATION BELOW ASSISTS US IN MAINTAINING FOLLOW-UP.

HOME PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

CELL PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

WORK PHONE: (☐☐☐) - ☐☐☐ - ☐☐☐☐

Name, address and phone of someone at a different address than you whom we may contact if we are unable to reach you:

NAME: _____

STREET: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE NO: _____

IS THIS CONTACT:

O Relative O Friend O Neighbor O Other