



# Sister Study Health Update: Year 3

\* Please return this form even if there are no changes to report. \*

It is important to the Sister Study that we stay updated on your health. Please take a few minutes to fill out this form and let us know if you have been diagnosed with any of the following conditions since August 2010.

Today's date

/  /   
month      day      year

ID #



«StudyID»

Since August 2010, has a doctor or other health professional told you that you had any of the following conditions?

		If YES, give the month and year of diagnosis.	
		YES	MONTH / YEAR
a	Breast cancer <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
b	DCIS (ductal [breast] carcinoma in situ) <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
c	LCIS (lobular [breast] carcinoma in situ) <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
d	Lung cancer <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
e	Ovarian cancer <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
f	Cancer of the uterus or endometrium (please do not include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer) <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
g	Cancer of the colon or rectum <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
h	Malignant melanoma <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
i	Any other type of cancer except non-melanoma skin cancer <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/> What kind? _____
j	Heart attack (myocardial infarction – MI) <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/> Were you a patient in a hospital overnight? <input type="checkbox"/> N <input type="checkbox"/> Y
k	Other heart disease (e.g. angina, congestive heart failure, arrhythmias) <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/> What kind? _____
l	Stroke, mini-stroke, TIA <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
m	Thyroid disease <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
n	Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma, multiple sclerosis, or other) <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/> What kind? _____
o	Asthma <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
p	Hypertension (high blood pressure) <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
q	Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/>
r	Hip, wrist or other fracture <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/> What kind? _____
s	Any other major illness <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> Y	<input type="text"/> / <input type="text"/> 20 <input type="text"/> <input type="text"/> What kind? _____

Thank you for your continued participation in the Sister Study. Please mail this form to:  
**The Sister Study, 1009 Slater Road, Suite 120, Durham, NC 27703.** A postage-paid envelope is provided.  
 Phone: 1-877-4SISTER (1-877-474-7837); email: [update@sisterstudy.org](mailto:update@sisterstudy.org)