



Sister Study Health Update

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 September 2003.

1. Since September 2003, has a doctor or other health professional told you that you had any of the following conditions?

	NO	YES	Month and year of diagnosis:
a. Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
b. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
c. Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
d. Cancer of the colon or rectum	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
e. Malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
f. Skin cancer (not malignant melanoma)	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
g. Any other type of cancer	<input type="checkbox"/>	<input type="checkbox"/>	→ { <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/> } What kind: _____
h. Heart attack (myocardial infarction)	<input type="checkbox"/>	<input type="checkbox"/>	→ { <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/> } Were you a patient in a hospital overnight? NO <input type="checkbox"/> YES <input type="checkbox"/>
i. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
j. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
k. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
l. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
m. Hip fracture	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
n. Wrist fracture	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/>
o. Any other major illness	<input type="checkbox"/>	<input type="checkbox"/>	→ { <input type="text"/> / <input type="text"/> 2 0 0 <input type="text"/> } What kind: _____

2. Have you had surgery since Sept. 2003? NO YES → { / 2 | 0 | 0 | }
What kind: _____

3. Today's date: / / 2 | 0 | 0 |
(month) (day) (year) → { / 2 | 0 | 0 | }
What kind: _____

Thank you for your continued participation in the Sister Study. Please mail this form to us at the address below. A postage-paid envelope is provided.

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phone: 1-877-4SISTER (1-877-474-7837); email: update@sisterstudy.org

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