Form: 76 Vers: 06 ID#: SIS

The Sister Study
Health Update

**** Please fill out 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 January 2020**.*

Today's Date: ☐☐ / ☐☐ / 2 0 ☐☐
MONTH DAY YEAR

We ask that the Sister Study participant fill out the form. Sometimes this is not possible...

- ○ Mark here if you are the participant filling this out for yourself. → **GO TO QUESTION 1 ON NEXT PAGE**

- ○ Mark here if someone is helping you fill out this questionnaire by either reading the questions to you and/or filling the bubbles for you.
- ○ Mark here if the participant cannot answer the questions for herself and you are completing the questionnaire on her behalf.

IF EITHER OF THESE ARE MARKED, PLEASE ALSO COMPLETE PAGE 7 OF THE INCLUDED "CONTACT INFORMATION UPDATE FORM"

What is your relationship to the participant?

- ○ Spouse/partner
- ○ Sister
- ○ Brother
- ○ Daughter
- ○ Son
- ○ Friend
- ○ Other, specify: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

If the participant cannot answer the questions for herself and you are completing the questionnaire on her behalf, what condition(s) prevented her from answering for herself?

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1. **Since January 2020**, has a doctor or other health professional told you that you had any of the following conditions listed below?

   ○ **No,** there have been no changes in my health **since January 2020**. (I have had no diagnoses or recurrences of any type of cancer, heart attack or myocardial infarction, heart failure, stroke, thyroid disease, autoimmune disease, Parkinson's disease, hypertension or high blood pressure, diabetes, no fractures and no other major illnesses.)

→ **GO TO QUESTION 2 ON PAGE 5**

(Mark only those that apply and for those provide requested diagnosis details.) ***Yes***, a doctor or other health professional told me I have: ↓	**DIAGNOSED BEFORE JAN. 2020**	**DIAGNOSED JAN. 2020 OR LATER**	If Jan. 2020 or later, give month and year of diagnosis. **MONTH/YEAR**
○ Breast cancer *Do not include in situ cancer.*	○	○	☐☐ / 2 0 ☐☐
○ Ductal (breast) carcinoma in situ (DCIS)	○	○	☐☐ / 2 0 ☐☐
○ Lobular (breast) carcinoma in situ (LCIS)	○	○	☐☐ / 2 0 ☐☐
○ Lung cancer	○	○	☐☐ / 2 0 ☐☐
○ Ovarian cancer	○	○	☐☐ / 2 0 ☐☐
○ Cancer of the uterus or endometrium *Please do not include non-cancerous conditions such as fibroids, endometriosis, or pre-cancer.*	○	○	☐☐ / 2 0 ☐☐
○ Cancer of the colon or rectum	○	○	☐☐ / 2 0 ☐☐
○ Thyroid cancer	○	○	☐☐ / 2 0 ☐☐

(Mark only those that apply and for those provide requested diagnosis details.) ***Yes***, a doctor or other health professional told me I have: ↓	**DIAGNOSED BEFORE JAN. 2020**	**DIAGNOSED JAN. 2020 OR LATER**	If Jan. 2020 or later, give month and year of diagnosis. **MONTH/YEAR**
○ Melanoma *Please do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.*	○	○	/ 2 0
○ Any other type of cancer *Please do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.* **If before Jan. 2020, specify type(s):**	○	○ **If Jan. 2020 or later, specify type(s):**	/ 2 0
○ Heart attack or myocardial infarction (MI)	○	○ **Were you a patient in a hospital overnight?** ○ NO ○ YES	/ 2 0
○ Other heart disease, e.g., angina, congestive heart failure, arrhythmias **If before Jan. 2020, specify type(s):**	○	○ **If Jan. 2020 or later, specify type(s):**	/ 2 0
○ Stroke (this does not include TIA or "mini-stroke")	○	○	/ 2 0
○ Mini-stroke or TIA (transient ischemic attack)	○	○	/ 2 0

(Mark only those that apply and for those provide requested diagnosis details.) ***Yes***, a doctor or other health professional told me I have: ↓	**DIAGNOSED BEFORE JAN. 2020**	**DIAGNOSED JAN. 2020 OR LATER**	If Jan. 2020 or later, give month and year of diagnosis. **MONTH/YEAR**
○ Thyroid disease, e.g., Graves' disease, overactive thyroid/hyperthyroidism, thyroiditis, underactive thyroid/hypothyroidism, or other **If before Jan. 2020, specify type(s):**	○	○	/ **If Jan. 2020 or later, specify type(s):**
○ Autoimmune disease, e.g., rheumatoid arthritis, lupus, scleroderma, multiple sclerosis, or other **If before Jan. 2020, specify type(s):**	○	○	/ 20 **If Jan. 2020 or later, specify type(s):**
○ Parkinson's disease	○	○	/ 20
○ Hypertension or high blood pressure	○	○	/ 20
○ Diabetes	○	○	/ 20
○ Hip, wrist or other fracture **If before Jan. 2020, specify type(s):**	○	○	/ 20 **If Jan. 2020 or later, specify type(s):**
○ Any other major illness **If before Jan. 2020, specify type(s):**	○	○	/ 20 **If Jan. 2020 or later, specify type(s):**

COVID-19 VACCINE

2. Have you been fully vaccinated against COVID-19? (e.g., received two doses of Pfizer/BioNTech or Moderna or a single dose of Johnson & Johnson/Janssen COVID-19 vaccine)

○ No

○ Yes →

2a. What month and year did you receive your last shot? Do not include booster shots.

MONTH / 2 0 YEAR

3. Have you had one or more booster shots? (any type of COVID-19 booster shot)

○ No

○ Yes →

3a. What month and year did you receive your most recent booster shot?

MONTH / 2 0 YEAR

COVID-19 ILLNESS

4. Have you ever had COVID-19?

○ No → **END SURVEY**

○ Yes →

4a. How many times have you had COVID-19?

OF TIMES

4b. When you were most sick with COVID-19, how would you describe your illness?

○ No symptoms
○ Mild
○ Moderate
○ Severe

4c. Were you ever hospitalized with COVID-19? Do NOT include visits to the Emergency Department only.

○ No
○ Yes

LONG-TERM COVID-19

5. Have you ever had or been told you had long-term COVID-19 (often defined as symptoms lasting, arising, or recurring more than 4 weeks after initial infection)?

○ No

○ Yes →

5a. How long was your long-term COVID-19?

○ 1 month
○ 2 to 3 months
○ 4 to 6 months
○ More than 6 months
○ I am still sick

5b. Approximately how many days have you been sick so far?

OF DAYS

6. When you were <u>most sick</u> with COVID-19, which symptoms did you have or, if you are still sick, do you continue to have?

(Please mark all that apply.)

HEAD/SENSORY

- ○ Difficulty thinking or concentrating
- ○ Dry eyes and mouth
- ○ Loss of sense of taste
- ○ Loss of sense of smell
- ○ Memory loss
- ○ Runny or stuffy nose
- ○ Trouble with vision
- ○ Vertigo or dizziness

PAIN

- ○ Chest pain
- ○ Ear pain or ear discharge
- ○ Headache
- ○ Joint pain
- ○ Muscle pain
- ○ Nerve pain

OTHERS

- ○ Cough
- ○ Chills or shivering
- ○ Diarrhea
- ○ Fatigue
- ○ Fainting
- ○ Feeling feverish
- ○ Insomnia
- ○ Lack of appetite
- ○ Nausea or vomiting
- ○ Rash
- ○ Shortness of breath
- ○ Sore throat or itchy/scratchy throat
- ○ Sweats
- ○ Trouble breathing
- ○ Other symptom(s) you continue to experience due to COVID-19

Please specify other symptoms:

After completing this form, please mail it to the address below.
A postage-paid envelope is provided. Thank you!

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