Form: 76 Vers: 07 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 2021**.*

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

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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?

☐

1. **Since January 2021**, 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 2021**. (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 6**

| *(Mark only those that apply and for those provide requested diagnosis details.)*<br>***Yes,*** a doctor or other health professional told me I have: ↓ | **DIAGNOSED BEFORE JAN. 2021** | **DIAGNOSED JAN. 2021 OR LATER** | If Jan. 2021 or later, give month and year of diagnosis.<br>**MONTH/YEAR** |
|---|---|---|---|
| ○ Breast cancer<br>*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<br>*Please **DO NOT** include:*<br>• *Adenomyosis*<br>• *Endometrial hyperplasia*<br>• *Endometriosis*<br>• *Pelvic inflammatory disease*<br>• *Pre-cancerous cells*<br>• *Uterine fibroids*<br>• *Uterine polyps*<br>• *Uterine prolapse*<br>• *Uterine tuberculosis* | ○ | ○ | ☐☐ / 2 0 ☐☐ |

| *(Mark only those that apply and for those provide requested diagnosis details.)*<br>***Yes***, a doctor or other health professional told me I have: ↓ | **DIAGNOSED BEFORE JAN. 2021** | **DIAGNOSED JAN. 2021 OR LATER** | If Jan. 2021 or later, give month and year of diagnosis.<br>**MONTH/YEAR** |
|---|---|---|---|
| ○ Cancer of the colon or rectum | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| ○ Thyroid cancer | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| ○ Melanoma<br>*Please do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.* | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| ○ Any other type of cancer<br>*Please do not include non-melanoma skin cancers, such as basal cell carcinoma and squamous cell carcinoma.*<br>**If before Jan. 2021, specify type(s):** | ○ | ○<br>**If Jan. 2021 or later, specify type(s):** | ☐☐ / 2 0 ☐☐ |
| ○ Heart attack or myocardial infarction (MI) | ○ | ○<br>**Were you a patient in a hospital overnight?** ○ NO ○ YES | ☐☐ / 2 0 ☐☐ |
| ○ Other heart disease, e.g., angina, congestive heart failure, arrhythmias<br>**If before Jan. 2021, specify type(s):** | ○ | ○<br>**If Jan. 2021 or later, specify type(s):** | ☐☐ / 2 0 ☐☐ |

| *(Mark only those that apply and for those provide requested diagnosis details.)*<br>***Yes***, a doctor or other health professional told me I have: ↓ | **DIAGNOSED BEFORE JAN. 2021** | **DIAGNOSED JAN. 2021 OR LATER** | If Jan. 2021 or later, give month and year of diagnosis.<br>**MONTH/YEAR** |
|---|---|---|---|
| ○ Stroke (this does not include TIA or "mini-stroke") | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| ○ Mini-stroke or TIA (transient ischemic attack) | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| ○ Thyroid disease, e.g., Graves' disease, overactive thyroid/hyperthyroidism, thyroiditis, underactive thyroid/hypothyroidism, or other<br>**If before Jan. 2021, specify type(s):** | ○ | ○<br>**If Jan. 2021 or later, specify type(s):** | ☐☐ / 2 0 ☐☐ |
| ○ Autoimmune disease, e.g., rheumatoid arthritis, lupus, scleroderma, multiple sclerosis, or other<br>**If before Jan. 2021, specify type(s):** | ○ | ○<br>**If Jan. 2021 or later, specify type(s):** | ☐☐ / 2 0 ☐☐ |
| ○ Parkinson's disease | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| ○ Hypertension or high blood pressure | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| ○ Diabetes | ○ | ○ | ☐☐ / 2 0 ☐☐ |

| *(Mark only those that apply and for those provide requested diagnosis details.)*<br>***Yes***, a doctor or other health professional told me I have: ↓ | **DIAGNOSED BEFORE JAN. 2021** | **DIAGNOSED JAN. 2021 OR LATER** | If Jan. 2021 or later, give month and year of diagnosis.<br>**MONTH/YEAR** |
|---|---|---|---|
| ○ Hip, wrist or other fracture | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| **If before Jan. 2021, specify type(s):** ☐ | | **If Jan. 2021 or later, specify type(s):** ☐ | |
| ○ Any other major illness | ○ | ○ | ☐☐ / 2 0 ☐☐ |
| **If before Jan. 2021, specify type(s):** ☐ | | **If Jan. 2021 or later, specify type(s):** ☐ | |

## COVID-19 ILLNESS

**2.** How many times have you been sick with suspected or confirmed COVID-19, whether or not you were tested for active COVID-19 infection at that time?

| | | |
|---|---|---|
| | | |

# OF TIMES

→ **IF NONE, PLEASE ENTER 0 AND SKIP TO QUESTION 5**

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

- ○ No symptoms
- ○ Mild
- ○ Moderate
- ○ Severe

**4.** 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 →

**4a. 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

**4b. Approximately how many days have you been sick so far?**

| | | |
|---|---|---|
| | | |

# OF DAYS

## COVID-19 VACCINE

**5.** Have you had a vaccine for COVID-19 in the past year?

○ No

○ Yes

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

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email: update@sisterstudy.org