



EMPOWER Study Follow-up Questionnaire

_____ / _____ / _____
Country Code Physician Number Patient Number

1. Have you had any of the following illnesses for the first time since we last contacted you in (month/year) such as:

For each item listed below, please tick the appropriate box.

			If "yes", since when?	Were you treated by a physician?	
	No	Yes		Month / Year	Yes
Diseases or conditions:					
New occurrence of hypertension	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
If yes, treated with antihypertensive drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>			
New occurrence of diabetes	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
If yes, treated with insulin injections?	<input type="checkbox"/>	<input type="checkbox"/>			
treated with tablets?	<input type="checkbox"/>	<input type="checkbox"/>			
Angina pectoris.....	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction (heart attack).....	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
Blood clot in your leg or lung	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
Benign breast tumor	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____					
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
Other gynecological cancer	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify _____					
Severe voice deepening	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
Clitoromegaly.....	<input type="checkbox"/>	<input type="checkbox"/> →	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
Other <u>severe</u> illnesses / operations	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, specify: _____		→	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
		→	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>
		→	___ / ___	<input type="checkbox"/>	<input type="checkbox"/>

Please also fill in the reverse side!

