For office use only
ID #
MR #
Initial Visit ___/___/___ MM/DD/YY

Health History Questionnaire

Family Risk Assessment

This questionnaire has been developed by the Fox Chase Cancer Center in conjunction with the Fox Chase Network to collect information about your family history and your personal health. This information will help us identify medical or family history information that is important in understanding cancers that may run in a family. Participation is voluntary and you can withdraw at any time. All the information that you provide will be kept confidential. A code number will be used to track any information and your name will not be used. If you do participate, you will receive a family tree called a pedigree and feedback about your family history. Your participation will benefit you and your family by helping you better understand your risk for cancer. Please sign below, if you agree to participate in this Family Risk Assessment. Thank you.

_____ _____

Signature Date

Section A -- Personal History

Name: _____

(first) (middle) (last)

Address: _____

(street)

_____

(city) (state) (zip)

Telephone: **Home** ( ) _____ **Work** ( ) _____

1. How old are you? _____ years

2. What is your date of birth?

_____/_____/_____
month day year

3. Are you:

- ❑ Male
- ❑ Female

4. What is the highest level of education you have completed?

- 1❑ Less than 8 years
- 2❑ 8 to 11 years (without graduation)
- 3❑ High school graduation/G.E.D.
- 4❑ Vocational or technical school
- 5❑ Some college or university
- 6❑ Bachelor's degree
- 7❑ Graduate degree

5. Are you currently:

- 1❑ Never married
- 2❑ Married or living as married
- 3❑ Divorced
- 4❑ Separated
- 5❑ Widowed

6. In which country were you, your parents and your grandparents born?

	Country of Birth
You	_____
Your mother	_____
Your father	_____
Your mother's mother	_____
Your mother's father	_____
Your father's mother	_____
Your father's father	_____

7. Please check the religion into which you, your parents and your grandparents were born:

		You	Your Mother	Your Father	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Protestant	1	❑	❑	❑	❑	❑	❑	❑
Catholic	2	❑	❑	❑	❑	❑	❑	❑
Buddhism	3	❑	❑	❑	❑	❑	❑	❑
Ashkenazi Jewish	4	❑	❑	❑	❑	❑	❑	❑
Sephardic Jewish	5	❑	❑	❑	❑	❑	❑	❑
Other Jewish	6	❑	❑	❑	❑	❑	❑	❑
Hinduism	7	❑	❑	❑	❑	❑	❑	❑
Eastern Orthodox	8	❑	❑	❑	❑	❑	❑	❑
Muslim	9	❑	❑	❑	❑	❑	❑	❑
Mormon	10	❑	❑	❑	❑	❑	❑	❑
7th Day Adventists	11	❑	❑	❑	❑	❑	❑	❑
None	12	❑	❑	❑	❑	❑	❑	❑
Other (please specify) _____	13	❑	❑	❑	❑	❑	❑	❑
Don't Know	99	❑	❑	❑	❑	❑	❑	❑

8. Please check the religion which you currently practice.

1❑ Protestant
2❑ Catholic
3❑ Buddhism
4❑ Ashkenazi Judaism
5❑ Sephardic Jewish
6❑ Other Jewish
7❑ Hinduism
8❑ Eastern Orthodox
9❑ Muslim
10❑ Mormon
11❑ 7th Day Adventists
12❑ None
13❑ Other (please specify)_____

9. What is your ethnic background? (please check as many as apply).

1❑ White
2❑ Black (African, Caribbean)
3❑ Hispanic/Latino
4❑ Southeast Asian (**circle one:** Vietnamese, Cambodian, Laotian)
5❑ South Asian (Indian, Pakistani, Bangladeshi)
6❑ Native American (Indian, Inuit)
7❑ Chinese
8❑ Japanese
9❑ Korean
10❑ Other (please specify) _____
99❑ Don't Know

SECTION B -- FAMILY HISTORY OF CANCER

Part 1 -- You, Your Spouse, Your Parents and Your Grandparents

- Fill in the full name, "Date of Birth" and "Date of Death" (where applicable) of each family member. Include only blood relatives and spouse. Do not include adoptive, foster or step- parents or grandparents. Circle "A" if the relative is alive and "D" if the relative is deceased.
- For each relative, circle whether or not they have had cancer. (Circle Yes or No). If you are not certain, circle "?" and fill in whatever information you can. **The shaded areas should only be completed for those relatives who have had cancer.**
- For those who have had cancer, fill in what type of cancer they have had -- "Type of Cancer," and about how old they were when they were told they had cancer "Age at Diagnosis." When possible, name the hospital where the cancer was treated and, if deceased, the place "City and State" of death.

* **If you are not certain of some dates of birth or dates of death, please estimate the year and circle those that are estimates.**

		First & Last Name	Date of Birth MM/DD/YY	Alive(A) Deceased(D) (circle)	Date of Death MM/DD/YY	Has had Cancer (circle)	Type of Cancer	Age at Diagnosis	Hospital Cancer was Treated	Place "City & State" of Death
1	Yourself	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
2	Your Mother	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
3	Mother's Mother	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
4	Mother's Father	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
5	Your Father	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
6	Father's Mother	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
7	Father's Father	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
8	Spouse	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
9	_____	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____
10	_____	_____	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____

SECTION B -- FAMILY HISTORY OF CANCER

Part 2 -- Your Brothers and Sisters

- Fill in the full names, "Date of Birth" and "Date of Death" (where applicable) of your brothers and sisters. Include only blood relatives. Do not include adoptive, foster or step-brothers or sisters. Circle "B" for brother and "S" for sister. Include their "Date of Birth" and circle "A" if the relative is alive and "D" if the relative is deceased.

- For each relative, circle whether or not they have had cancer. (Circle Yes or No). If you are not certain, circle "?" and fill in whatever information you can. **The shaded areas should only be completed for those relatives who have had cancer.**

- For those who have had cancer, fill in what type of cancer they have had -- "Type of Cancer," and about how old they were when they were told they had cancer "Age at Diagnosis." When possible, name the hospital where the cancer was treated and, if deceased, the place "City and State" of death.

* **If you are not certain of some dates of birth or dates of death, please estimate the year and circle those that are estimates.**

❑ **Check here if you have no brothers or sisters.**

	First & Last Name	Brother or Sister	Date of Birth MM/DD/YY	Alive(A) Deceased(D) (circle)	Date of Death MM/DD/YY	Has had Cancer (circle)	Type of Cancer	Age at Diagnosis	Hospital Cancer was Treated	Place "City & State" of Death	office use only HM HF
11	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
12	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
13	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
14	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
15	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
16	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____

SECTION B -- FAMILY HISTORY OF CANCER

Part 3 -- Your Children

- Fill in the names, "Date of Birth" and "Date of Death" (where applicable) of your children. Include only blood relatives. Do not include adoptive, foster or step- children. Circle "S" for son and "D" for daughter. Circle "A" if the relative is alive and "D" if the relative is deceased.
- For each relative, circle whether or not they have had cancer. (Circle Yes or No). If you are not certain, circle "?" and fill in whatever information you can. **The shaded areas should only be completed for those relatives who have had cancer.**
- For those who have had cancer, fill in what type of cancer they have had -- "Type of Cancer," and about how old they were when they were told they had cancer "Age at Diagnosis." When possible, name the hospital where the cancer was treated and, if deceased, the place "City and State" of death.

* **If you are not certain of some dates of birth or dates of death, please estimate the year and circle those that are estimates.**

❑ **Check here if you have no biological children.**

	First & Last Name	Son or Daughter	Date of Birth MM/DD/YY	Alive(A) Deceased(D) (circle)	Date of Death MM/DD/YY	Has had Cancer (circle)	Type of Cancer	Age at Diagnosis	Hospital Cancer was Treated	Place "City & State" of Death	office use only F#
17	_____	S D	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
18	_____	S D	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
19	_____	S D	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
20	_____	S D	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
21	_____	S D	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
22	_____	S D	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____

SECTION B -- FAMILY HISTORY OF CANCER

Part 4 -- Your Mother's Brothers and Sisters

- Fill in the names, "Date of Birth" and "Date of Death" (where applicable) of your mother's brothers and sisters. Include only blood relatives. Do not include adoptive, foster or step- brothers or sisters. Circle "B" for brother and "S" for sister. Include their "Date of Birth" and circle "A" if the relative is alive and "D" if the relative is deceased.

- For each relative, circle whether or not they have had cancer. (Circle Yes or No). If you are not certain, circle "?" and fill in whatever information you can. **The shaded areas should only be completed for those relatives who have had cancer.**

- For those who have had cancer, fill in what type of cancer they have had -- "Type of Cancer," and about how old they were when they were told they had cancer "Age at Diagnosis." When possible, name the hospital where the cancer was treated and, if deceased, the place "City and State" of death.

* **If you are not certain of some dates of birth or dates of death, please estimate the year and circle those that are estimates.**

❑ **Check here if your mother had no brothers or sisters.**

	First & Last Name	Brother or Sister	Date of Birth MM/DD/YY	Alive(A) Deceased(D) (circle)	Date of Death MM/DD/YY	Has had Cancer (circle)	Type of Cancer	Age at Diagnosis	Hospital Cancer was Treated	Place "City & State" of Death	office use only HM HF
23	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
24	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
25	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
26	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
27	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____
28	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	____

SECTION B -- FAMILY HISTORY OF CANCER

Part 5 -- Your Father's Brothers and Sisters

- Fill in the names, "Date of Birth" and "Date of Death" (where applicable) of your father's brothers and sisters. Include only blood relatives. Do not include adoptive, foster or step- brothers or sisters. Circle "B" for brother and "S" for sister. Include their "Date of Birth" and circle "A" if the relative is alive and "D" if the relative is deceased.

- For each relative, circle whether or not they have had cancer. (Circle Yes or No). If you are not certain, circle "?" and fill in whatever information you can. **The shaded areas should only be completed for those relatives who have had cancer.**

- For those who have had cancer, fill in what type of cancer they have had -- "Type of Cancer," and about how old they were when they were told they had cancer "Age at Diagnosis." When possible, name the hospital where the cancer was treated and, if deceased, the place "City and State" of death.

* **If you are not certain of some dates of birth or dates of death, please estimate the year and circle those that are estimates.**

❑ **Check here if your father had no brothers or sisters.**

	First & Last Name	Brother or Sister	Date of Birth MM/DD/YY	Alive(A) Deceased(D) (circle)	Date of Death MM/DD/YY	Has had Cancer (circle)	Type of Cancer	Age at Diagnosis	Hospital Cancer was Treated	Place "City & State" of Death	office use only HM HF
29	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	___
30	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	___
31	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	___
32	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	___
33	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	___
34	_____	B S	__/__/__	A D	__/__/__	Yes No ?	_____	____	_____	_____	___

SECTION B -- FAMILY HISTORY OF CANCER

Part 6 -- Additional Family Members

- Please use this page to add any additional blood relations, such as first cousins, grandchildren, nieces or nephews who you think should be included in your family history.
- Fill in the name, "Date of Birth" and "Date of Death" (where applicable) of each relative. Include only blood relatives. Do not include adoptive, foster or step- relatives. Circle 'M' for male and 'F' for female. Circle "A" if the relative is alive and "D" if the relative is deceased.
- For each relative, circle whether or not they have had cancer. (Circle Yes or No). If you are not certain, circle "?" and fill in whatever information you can. **The shaded areas should only be completed for those relatives who have had cancer.**
- For those who have had cancer, fill in what type of cancer they have had -- "Type of Cancer," and about how old they were when they were told they had cancer "Age at Diagnosis." When possible, name the hospital where the cancer was treated and, if deceased, the place "City and State" of death.

* **If you are not certain of some dates of birth or dates of death, please estimate the year and circle those that are estimates.**

	First & Last Name	Relationship	Male or Female (circle 1)	Date of Birth MM/DD/YY	Alive(A) Deceased(D) (circle)	Date of Death MM/DD/YY	Has had Cancer (circle)	Type of Cancer	Age at Diagnosis	Hospital Cancer was Treated	Place "City & State" of Death	office use only REL #
35			M F	__/__/__	A D	__/__/__	Yes No ?					
36			M F	__/__/__	A D	__/__/__	Yes No ?					
37			M F	__/__/__	A D	__/__/__	Yes No ?					
38			M F	__/__/__	A D	__/__/__	Yes No ?					
39			M F	__/__/__	A D	__/__/__	Yes No ?					
40			M F	__/__/__	A D	__/__/__	Yes No ?					

Section C -- Exposures

1. Have you ever had any of the following types of x-ray examinations that included the chest area?

	Yes	No	Don't Know	# of x-rays	Age when first x-rayed	Age x-rays stopped
• X-rays for heart catheterization	1	2	8	____	____	____
• X-rays for scoliosis	1	2	8	____	____	____
• Other intensive x-rays to the chest area *Specify* _____	1	2	8	____	____	____

2. Have you ever had any of the following types of x-ray examinations that included the lower abdomen or pelvis?

	Yes	No	Don't Know	# of x-rays	Age when first x-rayed	Age x-rays stopped
• Barium examination of the lower bowel	1	2	8	____	____	____
• CT scan or x-rays of the spine or pelvis	1	2	8	____	____	____
• Other intensive x-rays of the lower abdomen or pelvis *Specify* _____	1	2	8	____	____	____

For questions 3 and 4, the term **treated** *refers to treatment with radiation for a medical condition.*

3. Have you ever been **treated** by radiation that included the chest area for any of the following conditions?

	Yes	No	Don't Know	# of treatments	Age at 1st treatment	Age treatments stopped
• Cancer	1	2	8	____	____	____
• Acne	1	2	8	____	____	____
• Mastitis	1	2	8	____	____	____
• Enlarged thymus gland	1	2	8	____	____	____
• Hemangioma	1	2	8	____	____	____
• Tuberculosis	1	2	8	____	____	____
• Other *Specify* _____	1	2	8	____	____	____

4. Have you ever been **treated** by radiation that included the lower abdomen or pelvis for any of the following conditions?

	Yes	No	Don't Know	# of treatments	Age at 1st treatment	Age treatments stopped
• Cancer	1	2	8	____	____	____
• Bleeding from the uterus (womb)	1	2	8	____	____	____
• Growth on the uterus (womb)	1	2	8	____	____	____
• Other *Specify* _____	1	2	8	____	____	____

5. Have you ever used products which contain talc (e.g. dusting power with talc)?

1☐ Yes
2☐ No
8☐ Don't know

6. Have you ever consumed any alcoholic beverages, such as beer, wine, or spirits at least once per week for 6 months or longer?

1☐ Yes -----> *Continue*
2☐ No -----> *Please go to #Q11*

7. At what age did you **first** start consuming alcohol at least once per week for 6 months or longer?

_____ years old

8. For how many years in total have you consumed alcohol at least once per week?

_____ years _____ months (if less than 1 year)

9. When you consume(d) alcohol at least once per week, how many drinks do (did) you usually have in a week?

beer (12 oz can or bottle) _____

wine or wine coolers (1 medium glass) _____

liquor (1 shot) _____

10. Are you currently consuming alcohol at least once per week?

1☐ Yes
2☐ No

a. **If no,** at what age did you **stop** consuming alcohol at least once per week?

_____ years old

11. Have you smoked a cigarette, even a puff in the past 30 days?

1☐ Yes **GO TO PART 2**
2☐ No **(CONTINUE)**

12. Have you smoked at least one cigarette per day for 3 months or longer?

1☐ Yes **GO TO PART 1 BELOW**
2☐ No **SKIP TO SECTION D**

PART 1 – FOR FORMER CIGARETTE SMOKERS ONLY

13. About how old were you when you first started smoking at least one cigarette per day for 3 months or longer? (____) years old

14. When you were smoking at least one cigarette per day, how many cigarettes did you smoke on a typical day? (____) cigarettes
not packs per day

15. About how old were you when you last quit smoking? (____) years old

16. For how many years did you smoke, at least one cigarette a day? (____) years

SKIP TO SECTION D IF YOU COMPLETED PART 1 ABOVE

PART 2 – FOR CURRENT CIGARETTE SMOKERS ONLY

17. About how old were you when you first started smoking at least one cigarette a day for 3 months or longer? (____) years old

18. For how many years have you smoked at least one cigarette a day? (____) years

19. Since you started smoking at least one cigarette per day, about how many cigarettes do you smoke on a typical day?

(____) cigarettes
not packs per day

20. During the past 7 days, how many cigarettes did you smoke on a typical day?

(____) cigarettes
not packs per day

21. Do you smoke your first cigarette during the first half hour (30 minutes) after you wake up?

1☐ Yes
2☐ No

Section D -- Physical Activity

Following are questions about your physical activity at various times in your life. For questions 1 and 2, for each of the **ages below that apply**, please estimate the average amount of **time each week** and the average number of **months each year** that you spent in **strenuous exercise and moderate exercise.**

1. STRENUOUS EXERCISE
How often did you participate in **STRENUOUS** exercise activites or sports (e.g., swimming laps, aerobics, calisthenics, running, jogging, basketball, cycling on hills, racquetball)? **Regardless of age, please complete (Past 3 years).**

	Average **hours** per week									Average **months** per year			
	None	1/2	1	1-1/2	2	3	4-6	7-10	11+	1-3	4-6	7-9	10-12
Between ages 12 and 17	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 18 and 24	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 25 and 34	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 35 and 44	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 45 and 54	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 55 and now	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Past 3 years	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑

2. MODERATE EXERCISE
How often did you participate in **MODERATE** exercise activities or sports (e.g., brisk walking, golf, volleyball, cycling on level streets, recreational tennis, or softball)? **Regardless of age, please complete (Past 3 years).**

	Average **hours** per week									Average **months** per year			
	None	1/2	1	1-1/2	2	3	4-6	7-10	11+	1-3	4-6	7-9	10-12
Between ages 12 and 17	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 18 and 24	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 25 and 34	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 35 and 44	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 45 and 54	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Between ages 55 and now	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑
Past 3 years	1❑	2❑	3❑	4❑	5❑	6❑	7❑	8❑	9❑	1❑	2❑	3❑	4❑

3. On the average, during the **last** year, how many **times a week** did you take part in **VIGOROUS** physical activity (strenuous sports or work) long enough to work up a sweat?

1❑ Never
2❑ 1 time
3❑ 2 times
4❑ 3 times
5❑ 4 times
6❑ 5 times
7❑ 6 times
8❑ 7 times

Section E -- Personal Medical History

1. What is your weight now? _____ lbs.

2. What was your weight two years ago? ___ lbs.

3. What is your height now? _____ ft. _____ in.

4. Has a doctor ever told you that you had a disease such as **cancer, leukemia or a malignant tumor?**

   1☐ Yes
   2☐ No
   8☐ Don't know

   If yes, what was the type(s) of cancer?

   1._____
   2._____

   How old were you when this was **first** diagnosed?

   _____ years
   _____ years

FOR MALES ONLY; FEMALES SKIP TO Q.7, PAGE 16

5. Has a doctor ever told you that you had prostatic hyperplasia (BPH or enlarged prostate)?

   1☐ Yes
   2☐ No
   8☐ Don't know

   a. **If yes,** how old were you when this was first diagnosed?

   _____ years old

6. Has a doctor ever told you that you had gynecomastia (enlarged breast)?

   1☐ Yes
   2☐ No
   8☐ Don't know

   a. **If yes,** how old were you when this was first diagnosed?

   _____ years old

MALES SKIP TO SECTION G, Q8, PAGE 30

FOR FEMALES ONLY

7. Have you ever had any of the following medical conditions?
(CIRCLE YES=1, NO=2, DON'T KNOW=8)

	YES	*NO*	*DON'T KNOW*
Endometriosis	1	2	8
Fibrocystic disease	1	2	8
Rectal/colon polyps	1	2	8
Ulcerative colitis	1	2	8
Abnormal pap smear	1	2	8
Pelvic inflammatory disease	1	2	8

8. Has a doctor ever told you that you had benign breast disease, such as a non-cancerous cyst or breast lump?

1❑ Yes
2❑ No
8❑ Don't know

a. **If yes**, how old were you when this was first diagnosed?

_____ years old

9. Have you ever had a breast biopsy (i.e., breast tissue removed by a surgery) that was diagnosed as benign breast disease, such as a non-cancerous cyst or breast lump (does not include a fine needle biopsy)?

1❑ Yes
2❑ No
8❑ Don't know

a. **If yes,** at what age was this first done?

_____ years old

b. **If yes**, how many breast biopsies have you had?

_____ biopsies

10. Have you ever had a breast biopsy (i.e., breast tissue removed by a surgery) that was diagnosed as cancer?

1❑ Yes
2❑ No
8❑ Don't know

a. **If yes,** at what age was this first done?

_____ years old

b. **If yes**, how many breast biopsies have you had?

_____ biopsies

11. Please list any medicine you take on a regular basis. Please include prescription and non-prescription drugs as well as vitamins.

_____

_____

_____

12. Have you ever **considered** having your breasts surgically removed to prevent breast cancer? (This is called prophylactic mastectomy).

1❑ Yes
2❑ No

13. Have you ever had a breast completely removed?

❑ No
❑ Yes, the right breast -----> at what age was this? _____ years
❑ Yes, the left breast -----> at what age was this? _____ years

a. **If yes**, why did you have your breast(s) removed? ***(Check all that apply)***

❑ I had breast cancer
❑ To prevent my developing breast cancer
❑ Other _____

14. Have you ever had a lumpectomy?

❑ No
❑ Yes, the right breast -----> at what age was this? _____ years
❑ Yes, the left breast -----> at what age was this? _____ years

15. Has a doctor ever told you that you had cysts in one or both ovaries?

1❑ Yes
2❑ No
8❑ Don't know

a. **If yes**, how old were you when this was first diagnosed?

_____ years old

16. Have you ever **considered** having your ovaries surgically removed to prevent ovarian cancer? (This is called prophylactic oophorectomy).

1❑ Yes
2❑ No

17. Have you ever had a hysterectomy (surgical removal of the uterus)?

1❑ Yes
2❑ No
8❑ Don't know

a. **If yes**, how old were you?

_____ years old

18. Have you ever had an ovary completely removed? If your ovaries were removed at different times, please give your age at the most recent operation.

❑ No *SKIP TO SECTION F*
❑ Yes, one ovary -----> at what age was this? _____ years
❑ Yes, both ovaries -----> at what age was this? _____ years
❑ Don't know *SKIP TO SECTION F*

b. **If yes**, why did you have your ovaries removed? ***(Check all that apply)***

❑ I had ovarian cancer
❑ To prevent my developing ovarian cancer
❑ Other _____

Section F -- Reproductive History

1. Have you ever had a menstrual period?

   1❑ Yes
   2❑ No

   a. **If yes,** how old were you when your periods began? (____) years old

2. Has a doctor ever told you that you had **primary amenorrhea** (failure of menstrual periods to start naturally)?

   1❑ Yes ----> how old were you when this was **first** diagnosed? ____ years old
   2❑ No
   8❑ Don't know

3. Have you ever used hormonal contraceptives in the form of birth control pills, implants or injections for any reason other than menopause?

   1❑ Yes -----> *Continue*
   2❑ No -----> *Please go to #Q7*
   8❑ Don't know -----> *Please go to #Q7*

4. How old were you when you first started using hormonal contraceptives?

   _____ years old

5. Are you **currently** using hormonal contraceptives?

   1❑ Yes
   2❑ No

   a. **If no,** how old were you when you **last** used hormonal contraceptives?

   _____ years old

6. In total, for about how many years have you used hormonal contraceptives?

   _____ years _____ months (if less than 1 yr)

7. Have you ever been pregnant?

   1❑ Yes -----> *Continue*
   2❑ No -----> *Please go to #Q13, Page 24*
   8❑ Don't know -----> *Please go to #Q13, Page 24*

	1st Pregnancy	2nd Pregnancy	3rd Pregnancy
8. What was the outcome of this pregnancy?	1❑ currently pregnant - **(SKIP TO Q. 13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion	1❑ currently pregnant - **(SKIP TO Q. 13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion	1❑ currently pregnant - **(SKIP TO Q.13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion
9. On what date did your pregnancy end?	____/____ month year	____/____ month year	____/____ month year
10. How long was this pregnancy?	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know
For live births/ stillbirths only: **11. What was the sex of *each* child delivered from this pregnancy?**	___ number of males ___ number of females	___ number of males ___ number of females	___ number of males ___ number of females
For live births only: **12. Did you breast feed this child?**	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know

	4th Pregnancy	5th Pregnancy	6th Pregnancy
8. What was the outcome of this pregnancy?	1❑ currently pregnant - **(SKIP TO Q. 13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion	1❑ currently pregnant - **(SKIP TO Q. 13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion	1❑ currently pregnant - **(SKIP TO Q.13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion
9. On what date did your pregnancy end?	____/____ month year	____/____ month year	____/____ month year
10. How long was this pregnancy?	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know
For live births/ stillbirths only: **11. What was the sex of *each* child delivered from this pregnancy?**	___ number of males ___ number of females	___ number of males ___ number of females	___ number of males ___ number of females
For live births only: **12. Did you breast feed this child?**	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know

	7th Pregnancy	8th Pregnancy	9th Pregnancy
8. What was the outcome of this pregnancy?	1❑ currently pregnant - **(SKIP TO Q. 13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion	1❑ currently pregnant - **(SKIP TO Q. 13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion	1❑ currently pregnant - **(SKIP TO Q.13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion
9. On what date did your pregnancy end?	____/____ month year	____/____ month year	____/____ month year
10. How long was this pregnancy?	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know
For live births/ stillbirths only: **11. What was the sex of *each* child delivered from this pregnancy?**	___ number of males ___ number of females	___ number of males ___ number of females	___ number of males ___ number of females
For live births only: **12. Did you breast feed this child?**	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know

	10th Pregnancy	11th Pregnancy	12th Pregnancy
8. What was the outcome of this pregnancy?	1❑ currently pregnant - **(SKIP TO Q. 13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion	1❑ currently pregnant - **(SKIP TO Q. 13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion	1❑ currently pregnant - **(SKIP TO Q.13, Pg. 24)** 2❑ single live birth 3❑ multiple birth 4❑ stillbirth 5❑ miscarriage/ spontaneous abortion 6❑ tubal pregnancy 7❑ induced abortion
9. On what date did your pregnancy end?	_____/_____ month year	_____/_____ month year	_____/_____ month year
10. How long was this pregnancy?	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know	1❑ 3 months or less 2❑ 4 to 6 months 3❑ 7 months or more 8❑ Don't know
For live births/ stillbirths only: **11. What was the sex of *each* child delivered from this pregnancy?**	___ number of males ___ number of females	___ number of males ___ number of females	___ number of males ___ number of females
For live births only: **12. Did you breast feed this child?**	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know	1❑ Yes 2❑ No *If yes:* 1❑ under 1 month 2❑ 1 to 5 months 3❑ 6 to 11 months 4❑ 12 to 24 months 5❑ over 24 months 8❑ Don't know

13. In your opinion, have you ever had any problems in getting pregnant?

1❑ Yes
2❑ No -----> *Please go to #Q14*
8❑ Don't Know *Please go to #Q14*

a. **If yes,** how long did it take you to get pregnant? (_____) years

❑ Never got pregnant

b. Have you ever consulted a doctor about difficulty in getting pregnant?

1❑ Yes
2❑ No

c. **If yes,** what was the diagnosis of the problem?

DIAGNOSIS: _____

14. Have you ever taken a drug for infertility (to try to become pregnant), or because your periods stopped?

1❑ Yes -----> *Continue*
2❑ No -----> *Please go to #Q16*
8❑ Don't know -----> *Please go to #Q16*

15. What is (are) the name(s) of the drug(s)? **Note: GIFT = (gamete inter-fallopian transfer) and IVF = (in vitro fertilization)**

	Age started	# of years/ months taken	Was drug used for GIFT or IVF treatment
❑ Clomid	_____	_____yrs _____mths	❑ No ❑ Yes
❑ Pergonal	_____	_____yrs _____mths	❑ No ❑ Yes
❑ Serophene	_____	_____yrs _____mths	❑ No ❑ Yes
❑ hCG	_____	_____yrs _____mths	❑ No ❑ Yes
❑ Other	_____	_____yrs _____mths	❑ No ❑ Yes
Please specify	_____		
❑ Don't know			

16. How long ago was your last period?

1❑ Less than 1 month
2❑ 1 to 6 months
3❑ 7 months to less than 1 year
4❑ 1 year or more
5❑ Never had a period -----> *Please go to #Q20*

17. Have your menstrual periods stopped **for one year or more?** Please do not consider times when your periods stopped due to pregnancy, breast feeding, serious illness or strenuous exercise.

1❑ Yes -----> *Continue*
2❑ No -----> *Please go to #Q20*

18. How old were you when you had your last period before your periods stopped permanently for one year or more?

_____ years old

19. Why did your periods stop permanently?

1❑ Natural menopause -----> *Please go to #Q20*
2❑ Surgery or other medical treatment
❑ Other _____
8❑ Don't know

a. What surgery or other medical treatment did you receive that made your periods stop? ***(Please check as many as apply).***

❑ Hysterectomy (uterus or womb removed)
❑ Both ovaries removed
❑ Radiation or chemotherapy
❑ Other
*Please specify*_____
❑ Don't know

20. Have you ever taken estrogen, progestin, or other female hormones for menopause? The preparation may be pills, injections/shots, skin patches, vaginal creams, or vaginal suppositories. This question **does not** include oral contraceptive (birth control) pills.

1❑ Yes -----> *Continue*
2❑ No -----> *Please go to #Q25*
8❑ Don't Know -----> *Please go to #Q25*

21. How old were you when you first took estrogen, progestin, or other female hormones (not including birth control pills)?

_____ years old

22. Were you still having periods when you first took estrogen, progestin or other female hormones?

1❑ Yes 2❑ No

23. Are you currently taking estrogen, progestin, or other female hormones?

1❑ Yes
2❑ No
8❑ Don't Know

a. **If no,** how old were you when you **last** took estrogen, progestin, or other female hormones?

_____ years old

24. In total, for how many months have you taken or did you take estrogen, progestin, or other female hormones?

_____ months _____ years (if more than 12 months)

25. Have you ever taken tamoxifen?

1❑ Yes ------> *Continue*
2❑ No -----> *Please go to Section G*
8❑ Don't know -----> *Please go to Section G*

26. How old were you when you **first** took tamoxifen?

_____ years old

27. Are you currently taking tamoxifen?

1❑ Yes
2❑ No
8❑ Don't know

a. **If no,** how old were you when you **last** took tamoxifen?

_____ years old

28. In total, for how many years have you taken tamoxifen?

_____ years _____ months (if less than 1 yr)

Section G -- General Medical Care

1. Have you ever had a mammogram (an x-ray of the breasts)?

   1☐ Yes -----> *Continue*
   2☐ No -----> *Please go to #Q2*
   8☐ Don't Know -----> *Please go to #Q2*

   a. **If yes**, how old were you when you had your first mammogram?

   _____ years old

   b. **If yes**, how many mammograms have you had in the past 5 years?

   _____ mammograms

   c. **If yes**, how many mammograms have you had in the past year?

   _____ mammograms

   d. **If yes**, how many mammograms in total have you had in your lifetime?

   _____ mammograms

   e. When was the last time you had a mammogram? _____ (approximately)
   Mo/Yr

   Hospital/Clinic: _____
   City/State: _____

   f. Have you ever been told that a mammogram you had was abnormal?

   1☐ Yes
   2☐ No

2. During the past 6 months, about how often did you examine your own breasts for lumps or other changes?

   _____ times

3. When did a physician or a health care practitioner last examine your breasts?

   1☐ Within the past year
   2☐ Between one and three years ago
   3☐ More than three years ago
   4☐ Never

4. In your opinion, what are your chances of getting breast cancer someday?

1❑ Much more than the average woman
2❑ More than the average woman
3❑ Same as the average woman
4❑ Less than the average woman
5❑ Much less than the average woman

5. Have you ever had a Pap smear?

1❑ Yes -----> *Continue*
2❑ No -----> *Please go to #Q6*

a. **If yes,** when was the last time you had a Pap smear?

_____ (approximately)
Mo/Yr

6. Have you ever had any of the following tests to screen for ovarian cancer?

a. Pelvic exam (examination of the cervix and uterus by a physician or health care practitioner)

1❑ Yes
2❑ No
8❑ Don't Know

If yes, how many pelvic exams have you had in the past 5 years?_____exams

When was the last time you had this?_____ (approximately)
Mo/Yr

b. CA-125 (a blood test that is sometimes used to find ovarian cancer)

1❑ Yes
2❑ No
8❑ Don't know

If yes, how many CA-125 tests have you had in the past three years?

_____ tests

When was the last time you had this?_____(approximately)
Mo/Yr

c. Pelvic or transvaginal ultrasound

- In a pelvic ultrasound, a probe is moved over your abdomen to project sound waves and an image is displayed on a screen.

- A transvaginal ultrasound involves inserting a plastic sound probe into the vagina and an image of the ovaries is displayed on a screen.

1❑ Yes
2❑ No
8❑ Don't know

If yes, how many pelvic or transvaginal ultrasound exams have you had in the past five years?_____ (Don't include those done for pregnancy).

When was the last time you had this?_____(approximately)
Mo/Yr

7. In your opinion, what are your chances of getting ovarian cancer someday?

1❑ Much more than the average woman
2❑ More than the average woman
3❑ Same as the average woman
4❑ Less than the average woman
5❑ Much less than the average woman

FEMALES CONTINUE; MALES BEGIN AGAIN HERE

8. Have you ever had a test for blood in your stool (bowel movements)?

1❑ Yes
2❑ No
8❑ Don't know

9. Have you ever had a sigmoidoscopy or a colonoscopy? (Both exams involve using a thin, lighted tube to examine the colon and rectum).

1❑ Yes
2❑ No
8❑ Don't know

10. In your opinion, what are your chances of getting colon cancer someday?

1❑ Much more than the average person
2❑ More than the average person
3❑ Same as the average person
4❑ Less than the average person
5❑ Much less than the average person

11. Are you, or have you ever been a participant in a cancer prevention trial?

1❑ Yes
2❑ No

a. **If yes,** was it: *(check as many as apply)*

❑ Tamoxifen trial
❑ Dietary trial
❑ Other
Please specify _____
❑ Don't know

12. Have you or other members of your family participated in other research studies of familial cancer?

1❑ Yes
2❑ No
8❑ Don't know

a. **If yes,** please give the name of the study: _____

13. What type of health insurance do you currently have?

1☐ Uninsured
2☐ Blue Cross/Blue Shield
3☐ Other private insurance_____
4☐ HMO. . . specify _____
5☐ Medicare
6☐ Medicaid

14. Are you a twin?

1☐ Yes
2☐ No

a. **If yes, please read the following statement and answer the question:**

Non-identical twins are no more alike than ordinary brothers and sisters. Identical twins on the other hand look so much alike (that is, they have a strong resemblance to each other in height, coloring, features of the face, etc.) that people often mistake one for the other, especially during their childhood.

Do you think you and your twin are identical?

1☐ Yes
2☐ No
8☐ Don't Know

If you would like your doctor to be informed of our screening recommendations, please provide us with his/her name, address and telephone number below.

Name: _____

Address: _____

_____

_____

Phone: ( ) _____

Thank you

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