HUNTSMAN CANCER INSTITUTE

AT THE UNIVERSITY OF UTAH

High Risk Breast Cancer Clinic
Women's Health and Medical Questionnaire

This questionnaire asks for general medical and health information about you. Your participation is very important. The information you give, when combined with that of others, will help researchers at the Huntsman Cancer Institute get a better picture of high risk families. You are free to skip any question.

Information you provide in this questionnaire will be treated confidentially and will not be released without your written permission to anyone but the clinical staff and researchers associated with the Huntsman Cancer Institute. Confidential information like your name and address will be stored in secured files accessible only to study staff. Your name will not be used in any reports.

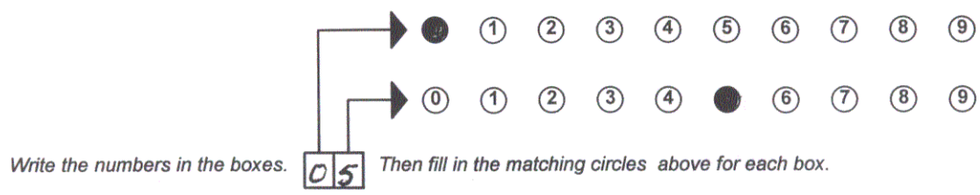
You can return this questionnaire in the pre-addressed, postage-paid envelope provided. Most people find it takes about 45 minutes to complete. If you have any questions about the questionnaire, please call the clinic staff at (801) 585-3525 or toll free at 1-(800) 936-6343.

DIRECTIONS

- Use a pencil.
- Darken the circle completely next to the answer you choose.
- Erase cleanly any marks on this form.
- Do not make any stray marks on this form.
- For questions where you write in a number, write the number in the box provided. Then mark the corresponding circle to the right.

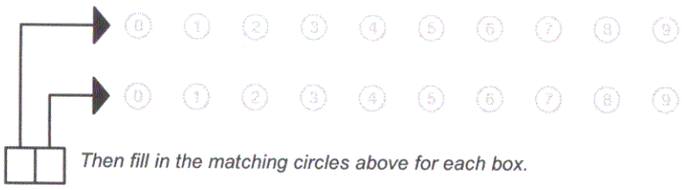
EXAMPLE

Including yourself, what is the total number of persons CURRENTLY living in your household?



Background Information

1. How old are you?



Write the numbers in the boxes. *Then fill in the matching circles above for each box.*

2. What is your date of birth?

__/__/__

3. What was the HIGHEST level of education you completed? *(Mark only one.)*

- ○ Less than 8 years
- ○ 8 to 11 years (without graduation)
- ○ High school graduation
- ○ Vocational or technical school
- ○ Some college or university
- ○ Bachelor's degree
- ○ Graduate degree

4. Are you currently: *(Mark only one.)*

- ○ Married or living as married
- ○ Widowed
- ○ Divorced
- ○ Separated
- ○ Never married

5. Please mark the religion which you currently practice:

- ○ Protestant
- ○ Catholic
- ○ Buddhist
- ○ Ashkenazi Jewish
- ○ Sephardic Jewish
- ○ Other Jewish
- ○ Hindu
- ○ Eastern Orthodox
- ○ Muslim
- ○ LDS or Mormon
- ○ Seventh Day Adventist
- ○ None
- ○ Other *Please specify* _____

Go to next page.

6. **What is your ethnic or racial background?** *(Mark all that apply.)*

- White
- Black or African American
- Asian
- Pacific Islander
- Native American
- Other *Please specify* _____
- Dont' know

6.1 **Are you Latino or Hispanic (ancestry is Mexican, Cuban, Puerto Rican, Central American, or South American)?**

No Yes

These next few questions ask about the general background of your parents and grandparents. For these questions, please think about full-blooded relatives only.

7. **In which COUNTRY were you, your parents and your grandparents born?**

	USA	Another Country *Please specify*	Don't know
You			
Your mother			
Your father			
Your mother's mother			
Your mother's father			
Your father's mother			
Your father's father			

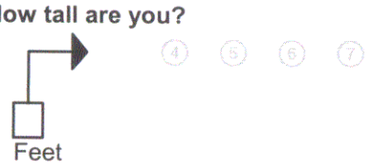
8. **Please mark the RELIGION into which you, your parents, and your grandparents were born:**

	You	Your mother	Your father	Your mother's mother	Your mother's father	Your father's mother	Your father's father
Protestant							
Catholic							
Buddhist							
Ashkenazi Jewish							
Sephardic Jewish							
Other Jewish							
Hindu							
Eastern Orthodox							
Muslim							
LDS or Mormon							
Seventh Day Adventist							
None							
Other							
Please specify	_____	_____	_____	_____	_____	_____	_____

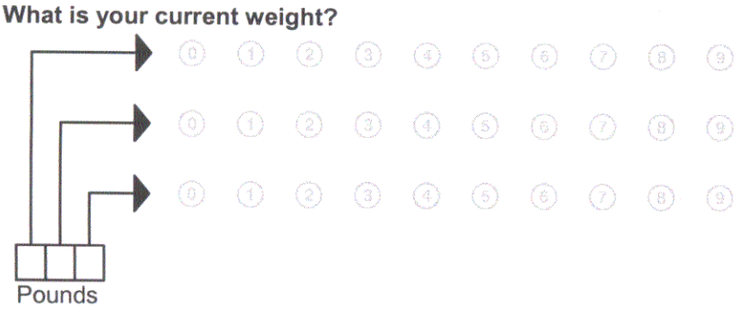
Go to next page.

Height and Weight

9. How tall are you?



10. What is your current weight?



10.1 What was your weight two years ago?

Many of the following questions ask for detailed medical and reproductive history information. Some questions ask you to give ages when certain things happened. If you are not sure about the exact age, please give your best guess.

Your Health History

11. In general, would you say your health is:

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

12. When did you LAST have a complete physical exam?

- ○ Never
- ○ Within the past year (0 to 12 months ago)
- ○ One to two years ago (13 to 24 months ago)
- ○ Two to five years ago (25 to 60 months ago)
- ○ More than five years ago (61 months or more)

Go to next page.

13. **Have you been hospitalized overnight at any time during the PAST TWO YEARS?**

○ No ○ Yes

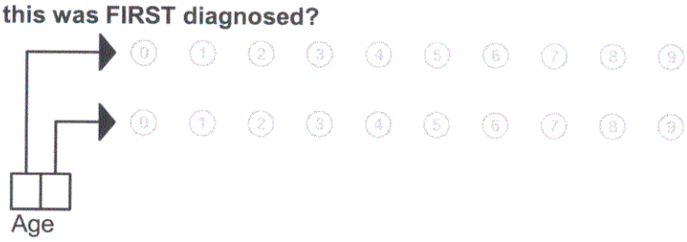
14. **Has a doctor ever told you that you had cancer, leukemia or a malignant tumor?**

○ No ○ Yes

14.1 What was the FIRST type of cancer?

_____ ○ Don't know

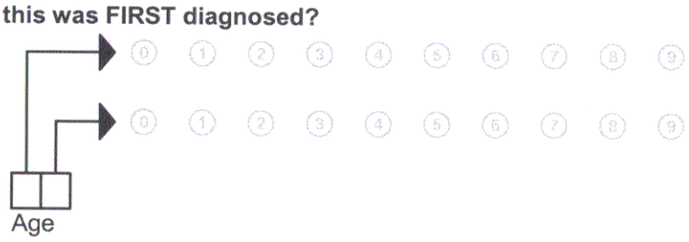
14.2 How old were you when this was FIRST diagnosed?



14.3 What was the SECOND type of cancer?

_____ ○ Don't know

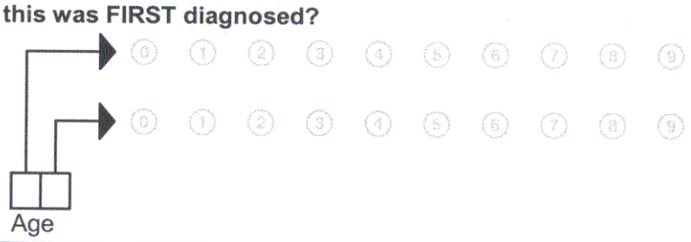
14.4 How old were you when this was FIRST diagnosed?



14.5 What was the THIRD type of cancer?

_____ ○ Don't know

14.6 How old were you when this was FIRST diagnosed?



15. **Has a doctor ever told you that you had BENIGN BREAST DISEASE, such as a non-cancerous cyst or breast lump?**

○ No ○ Yes

15.1 How old were you when this was FIRST diagnosed?

Go to next page.

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

○ No ○ Yes

16.1 How old were you when this was FIRST done?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

17. **Have you ever had a breast biopsy (i.e., some breast tissue removed by surgery) or lumpectomy that was diagnosed as cancer?**

○ No ○ Yes

17.1 How old were you when this was FIRST done?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

18. **Have you ever had a breast completely removed?**

○ No

○ Yes, right breast → **18.1 How old were you when this was done?**

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

18.2 Why was this breast removed?

- ○ to treat cancer
- ○ to prevent the development of cancer
- ○ other *Please specify* _____

○ Yes, left breast → **18.3 How old were you when this was done?**

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

18.4 Why was this breast removed?

- ○ to treat cancer
- ○ to prevent the development of cancer
- ○ other *Please specify* _____

19. Do you have any breast implants?

- ○ No
- ○ Yes, right breast
- ○ Yes, left breast
- ○ Yes, both breasts

20. Has a doctor ever told you that you had a cyst in one or both ovaries?

- ○ No
- ○ Yes

20.1 How old were you when this was FIRST diagnosed?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

21. Have you ever had an ovary completely removed? *If your ovaries were removed at different times, please give your age at the time of each operation.*

- ○ No
- ○ Yes, one ovary (or first ovary)

21.1 How old were you when this was done?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age removed

21.2 Why was this ovary removed?

- ○ to treat cancer
- ○ to prevent the development of cancer
- ○ other *Please specify* _____

- ○ Yes, both ovaries (or second ovary)

21.3 How old were you when this was done?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age removed

21.4 Why was this ovary removed?

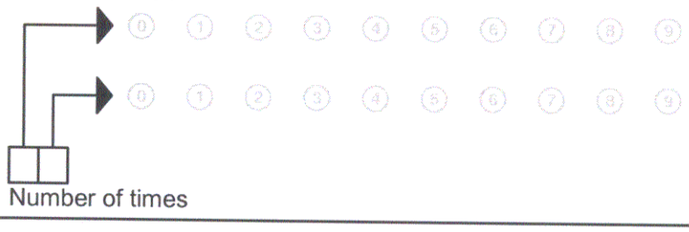
- ○ to treat cancer
- ○ to prevent the development of cancer
- ○ other *Please specify* _____

Go to next page.

22. **Have you ever had a D & C, that is, a "scraping" or "cleaning out" of your uterus or womb?**

○ No ○ Yes

22.1 How many times have you had a D & C?



Breast Examination

23. **Have you ever had a clinical breast exam, which is when a doctor, a medical assistant, or a nurse practitioner examines the breast(s) for lumps?**

○ No ○ Yes

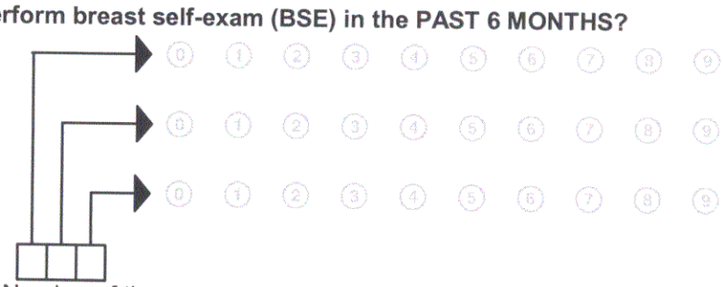
23.1 When was your LAST clinical breast exam?

- ○ Within the past year (0 to 12 months ago)
- ○ One to two years ago (13 to 24 months ago)
- ○ Two to five years ago (25 to 60 months ago)
- ○ More than five years ago (61 months or more)

24. **Have you ever performed breast self-examination (BSE), which is when you examine your own breast(s) for lumps?**

○ No ○ Yes

24.1 How often did you perform breast self-exam (BSE) in the PAST 6 MONTHS?



25. **How confident are you that you could find a lump in your breast?**

- ○ Not at all confident
- ○ Somewhat confident
- ○ Moderately confident
- ○ Very confident

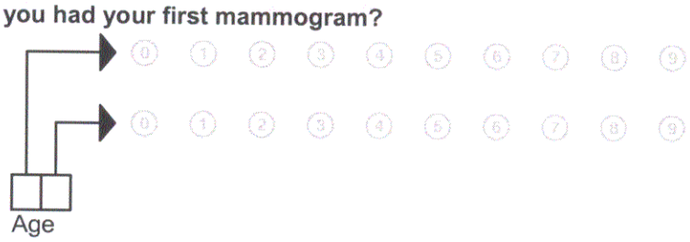
26. **Are you currently having any breast discharge?**

- ○ No
- ○ Yes, right breast
- ○ Yes, left breast
- ○ Yes, both breasts

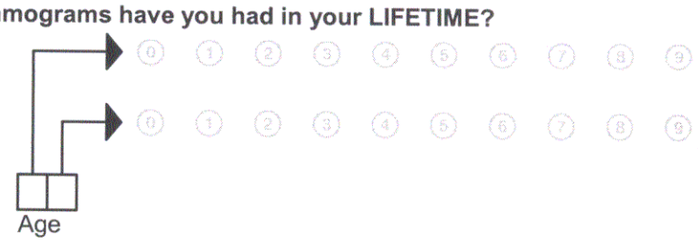
27. **Have you ever had a mammogram (x-ray examination of the breasts)?**

○ No ○ Yes

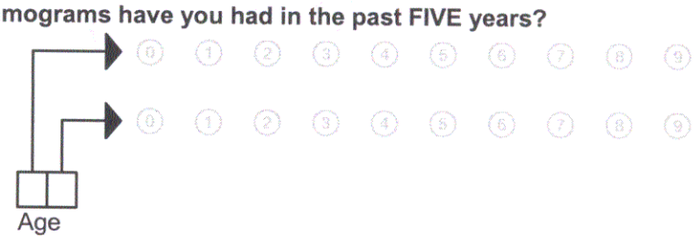
27.1 How old were you when you had your first mammogram?



27.2 In total, how many mammograms have you had in your LIFETIME?



27.3 In total, how many mammograms have you had in the past FIVE years?



27.4 When and where did you have your LAST TWO mammograms?

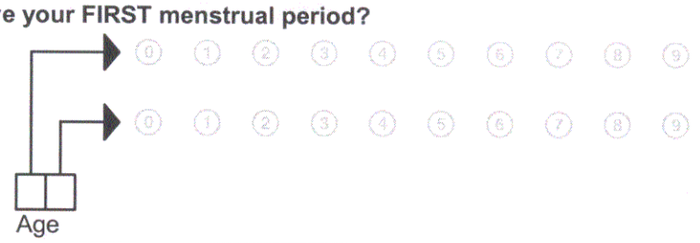
1. _____
   Date Clinic/Hospital
2. _____
   Date Clinic/Hospital

Reproductive History

28. **Have you ever had a menstrual period?**

○ No ○ Yes

28.1 At what age did you have your FIRST menstrual period?



Go to next page.

29. **Has a doctor ever told you that you had PRIMARY AMENORRHEA (failure of menstrual periods to start naturally)?**

○ No ○ Yes

29.1 How old were you when this was FIRST diagnosed?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

30. **Many women have their periods about once a month. Some women have their periods more often and others less often. How often are (or were) your menstrual periods? In other words, how many days are (or were) there from the first day of one menstrual period to the first day of the next period?**

○ Generally less than 25 days
○ Generally between 25 and 32 days
○ Generally more than 32 days
○ Variable length (sometimes long, sometimes short)

31. **Have you ever used hormonal contraceptives, in the form of birth control pills, implants or injections?**

○ No ○ Yes

31.1 How old were you when you FIRST started taking hormonal contraceptives?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

31.2 Are you currently taking hormonal contraceptives?

○ Yes ○ No

31.3 How old were you when you LAST took hormonal contraceptives?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

31.4 In total, for about how many years have you taken hormonal contraceptives?

○ Have taken continuously, that is, did not start and stop between start and last use
○ Less than a year

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

10

Pregnancy History

32. Have you ever been pregnant?

○ No ○ Yes

32.1 How many pregnancies have you had?

Number

32.2 How many live births have you had?

○ None

Number

32.3 How old were you when you had your FIRST live birth?

Age

32.4 How old were you when you had your LAST live birth?

Age

32.5 Did you ever breast feed a child for one month or more?

○ No ○ Yes

Please complete questions 33 to 37 for each pregnancy.

If you have never been pregnant, go to question 38.

	1st Pregnancy	2nd Pregnancy	3rd Pregnancy	4th Pregnancy	5th Pregnancy
33. On what date did your pregnancy end?	___/___ month year	___/___ month year	___/___ month year	___/___ month year	___/___ month year
34. What was the outcome of this pregnancy?	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion
35. How long was this pregnancy?	O 3 months or under O 4 to 6 months O 7 or more months	O 3 months or under O 4 to 6 months O 7 or more months	O 3 months or under O 4 to 6 months O 7 or more months	O 3 months or under O 4 to 6 months O 7 or more months	O 3 months or under O 4 to 6 months O 7 or more months
36. What was the sex of EACH child delivered from this pregnancy?	*Mark all that apply.* O male O male O male O female O female O female	*Mark all that apply.* O male O male O male O female O female O female	*Mark all that apply.* O male O male O male O female O female O female	*Mark all that apply.* O male O male O male O female O female O female	*Mark all that apply.* O male O male O male O female O female O female
For live births only: 37. Did you breast feed this child?	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months

	6th Pregnancy	7th Pregnancy	8th Pregnancy	9th Pregnancy	10th Pregnancy
33. On what date did your pregnancy end?	____/____ month year	____/____ month year	____/____ month year	____/____ month year	____/____ month year
34. What was the outcome of this pregnancy?	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion	O Currently pregnant O Single live birth O Multiple birth O Still birth O Miscarriage O Tubal pregnancy O Induced abortion
35. How long was this pregnancy?	O 3 months or under O 4 to 6 months O 7 or more months	O 3 months or under O 4 to 6 months O 7 or more months	O 3 months or under O 4 to 6 months O 7 or more months	O 3 months or under O 4 to 6 months O 7 or more months	O 3 months or under O 4 to 6 months O 7 or more months
36. What was the sex of EACH child delivered from this pregnancy?	*Mark all that apply.* O male O male O male O female O female O female	*Mark all that apply.* O male O male O male O female O female O female	*Mark all that apply.* O male O male O male O female O female O female	*Mark all that apply.* O male O male O male O female O female O female	*Mark all that apply.* O male O male O male O female O female O female
For live births only: 37. Did you breast feed this child?	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months	O No O Yes ↓ O Under 1 month O 1 to 5 months O 6 to 11 months O 12 to 24 months O Over 24 months

38. **Did you ever try for one straight year or more to become pregnant and, during that time, not become pregnant?**

○ No ○ Yes

38.1 **Did you or your partner ever visit a doctor, clinic, or hospital because you had trouble getting pregnant?**

○ No ○ Yes

38.2 **What was the reason you had a problem getting pregnant?** *(mark all that apply.)*

- ○ A problem with your ovaries or hormones
- ○ A problem with your fallopian tubes
- ○ A problem with your uterus or cervix
- ○ Your partner had fertility problems
- ○ No problem was found
- ○ Other *Please specify* _____
- ○ Don't know

39. **Looking to the future, do you intend to have a (another) child or children sometime?**

- ○ No
- ○ Yes
- ○ Undecided

40. **Have you or your husband (if married) had an operation or medical treatment that makes you unable to have another child?**

- ○ No
- ○ Yes

Menopause and Hormone Use

41. How long ago was your LAST period?

- ○ Less than 1 month
- ○ 1 to 6 months
- ○ 7 months to less than 1 year
- ○ 1 year or more
- ○ Never had a menstrual period (*Go to question 43*)

42. Have your menstrual periods STOPPED permanently for ONE YEAR OR MORE? (Please do not include times when you were pregnant or breast feeding, or times when your periods stopped because you were seriously ill or exercising strenuously.)

○ No ○ Yes

42.1 How old were you when you had your LAST period?

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

Age

42.2 Why did your periods stop?

- ○ Natural menopause (periods stopped by themselves)
- ○ Surgery or other medical treatment

42.3 What surgery or other medical treatment did you receive that made your periods stop? *(Mark all that apply)*

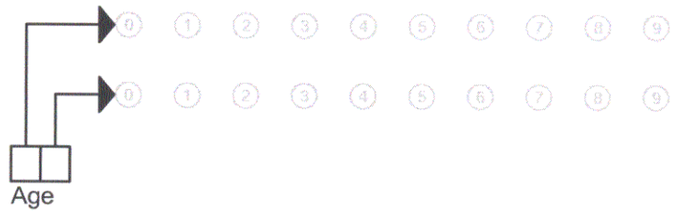
- ○ Hysterectomy (uterus or womb removal)
- ○ Both ovaries removed
- ○ Radiation or chemotherapy
- ○ Other *Please specify:* _____

Go to next page.

43. **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 contraceptives (birth control pills).**

○ No ○ Yes

43.1 **How old were you when you FIRST took estrogen, progestin, or other female hormones?**



43.2 **Were you still having periods when you FIRST took estrogen, progestin or other female hormones?**

○ No ○ Yes

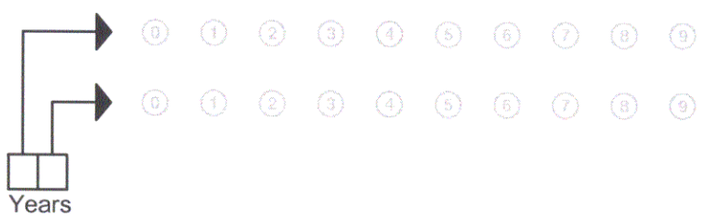
43.3 **Are you currently taking estrogen, progestin, or other female hormones?**

○ Yes ○ No

43.4 **How old were you when you LAST took estrogen, progestin, or other female hormones?**

43.5 **In total, for about how many years have you taken estrogen, progestin, or other female hormones?**

○ Have taken continuously, that is, did not start and stop between start and last use
○ Less than a year



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

- ○ No
- ○ Yes

44.1 **Was the drug prescribed for infertility as part of GIFT (gamete intra-fallopian transfer) or IVF (in vitro fertilization) treatment?**

- ○ No
- ○ Yes

44.2 **What is (are) the name(s) of the drug(s)?** *(Mark all that apply)*

- ○ Clomid
- ○ Pergonal
- ○ Serophene
- ○ hCG
- ○ Other *Please specify* _____
- ○ Don't know

44.3 **How old were you when you FIRST started this type of drug?**

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

Age

44.4 **In total, for how many MONTHS have you taken this type of drug?**

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

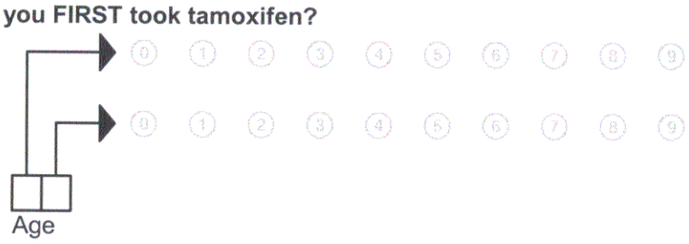
Months

Go to next page.

45. Have you ever taken tamoxifen?

○ No ○ Yes

45.1 How old were you when you FIRST took tamoxifen?



45.2 Are you currently taking tamoxifen?

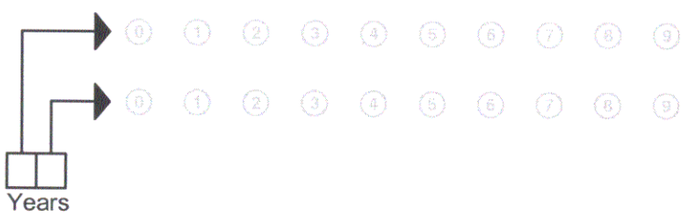
○ Yes ○ No

45.3 How old were you when you LAST took tamoxifen?

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

○ Have taken continuously, that is, did not start and stop between start and last use

○ Less than a year



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Radiation Exposure

These next few questions ask about x-ray examinations or treatment you might have had. Questions 46 and 47 ask about frequent or prolonged *examinations*. Questions 48 and 49 ask about *treatment*.

46. Have you ever had any of the following types of x-ray examinations that included the chest area? Please do not include mammograms. *(Mark all that apply.)*

	Age FIRST examination	Age LAST examination	Total number of examinations
○ X-rays for heart cathetererization	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ X-rays for scoliosis	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Other intensive X-rays of the chest area *Please specify* _____	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ None			
○ Don't know			

47. Have you ever had any of the following types of x-ray examinations that included the lower abdomen or pelvis? *(Mark all that apply.)*

	Age FIRST examination	Age LAST examination	Total number of examinations
○ Barium examination of the lower bowel	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ CT scan or x-rays of the lower spine or pelvis	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Other *Please specify* _____	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ None			
○ Don't know			

48. *Except for radiation for breast cancer,* have you ever been TREATED with radiation that included the chest area? *(Mark all that apply.)*

	Age FIRST treatment	Age LAST treatment	Total number of treatments
○ Cancer	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Enlarged thymus gland	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Acne	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Hemangioma	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Tuberculosis	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Mastitis	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Other *Please specify* _____	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ None			
○ Don't know			

49. Have you ever been TREATED with radiation that included the lower abdomen or pelvis? *(Mark all that apply.)*

	Age FIRST treatment	Age LAST treatment	Total number of treatments
○ Cancer	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Bleeding from the uterus or womb	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Growth on the uterus or womb	☐☐ Age	☐☐ Age	☐☐ ○ Don't know
○ Other *Please specify* _____	☐☐ Age	☐☐ Age	☐☐ ○ Don't know

○ None
○ Don't know

50. Are you, or have you ever been, a participant in a cancer prevention trial? *(Mark all that apply.)*

○ No
○ Yes, a dietary trial
○ Yes, other *Please specify* _____
○ Yes, a tamoxifen trial

50.1 What were you taking?
○ Tamoxifen
○ Placebo
○ Don't know

50.2 When did you START taking this medication?
___/___
Month/Year

50.3 When did you STOP taking this medication?
___/___
Month/Year

51. Have you or any other members of your family participated in any other research studies of familial cancer?
○ No ○ Yes

52. Are you a twin?
○ No ○ Yes

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

Non-identical twins are no more alike than ordinary brothers and sisters. Genetically 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.

52.1 Do you think you and your twin are genetically identical?
○ No ○ Yes

Go to next page.

Your Physical Activity

The following are questions about your physical activity at various times in your life. 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 you spent in strenuous exercise and moderate excerise.

Strenuous Exercise

53. How often did you participate in strenuous excerise activities or sports (e.g., swimming laps, aerobics, calisthenics, running, jogging, basketball, cycling on hills, racquetball)?

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

Moderate Exercise

54. How often did you participate in moderate exercise activities or sports (e.g., brisk walking, golf, volleyball, cycling on level streets, recreation tennis, or softball)?

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

Alcohol

55. **Have you ever consumed any alcoholic beverages, such as beer, wine, or liquor at least once per week for 6 MONTHS OR LONGER?**

○ No ○ Yes

55.1 **At what age did you FIRST start consuming alcohol AT LEAST ONCE PER WEEK FOR 6 MONTHS OR LONGER?**

Age

55.2 **Are you currently consuming alcohol AT LEAST ONCE PER WEEK?**

○ Yes ○ No

55.3 **At what age did you STOP consuming alcohol AT LEAST ONCE PER WEEK?**

Age

55.4 **For how many years in total have you consumed alcohol AT LEAST ONCE PER WEEK?**

Years

55.5 **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)

○ Never consumed beer at least once per week

Drinks per week

Wine or wine coolers (1 medium glass)

○ Never consumed wine at least once per week

Drinks per week

Liquor (1 shot)

○ Never consumed liquor at least once per week

Drinks per week

Go to next page.

Smoking

56. Have you ever smoked AT LEAST ONE CIGARETTE A DAY FOR THREE MONTHS OR LONGER?

○ No ○ Yes

56.1 At what age did you FIRST start smoking cigarettes regularly (AT LEAST ONE CIGARETTE PER DAY FOR THREE MONTHS OR LONGER)?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

56.2 Are you currently smoking AT LEAST ONCE CIGARETTE PER DAY?

○ Yes ○ No

56.3 At what age did you STOP smoking AT LEAST ONE CIGARETTE PER DAY?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Age

56.4 For how many years in total have you smoked AT LEAST ONE CIGARETTE PER DAY?

○ Have smoked continuously, that is, did not start and stop between start and last use
○ Have smoked for less than one year

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Years

56.6 When you smoke(d) AT LEAST ONE CIGARETTE PER DAY, how many cigarettes do (did) you usually smoke in a day?

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4 5 6 7 8 9

Number of cigarettes per day

Go to next page.

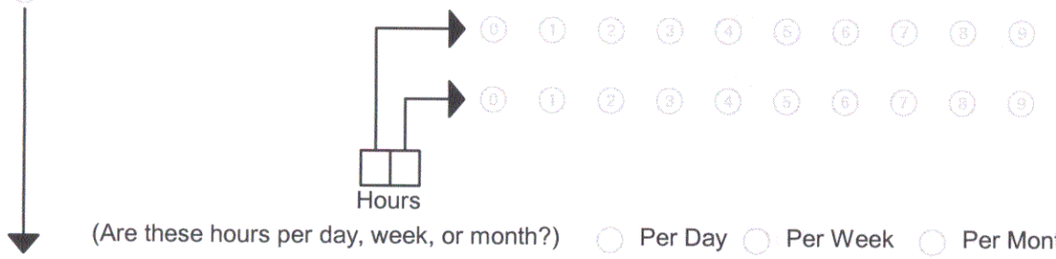
Other Tobacco Products and Secondary Smoking Information

57. Have you used any of these tobacco products on a regular basis for 6 MONTHS OR LONGER? *(Mark all that apply.)*

- ○ Pipe
- ○ Cigars
- ○ Chewing tobacco
- ○ Snuff
- ○ Never used any of these tobacco products for 6 months or longer

58. During the LAST 12 MONTHS, what was the approximate number of hours per day, week, or month you were exposed to other people's cigarette smoke IN YOUR HOME?

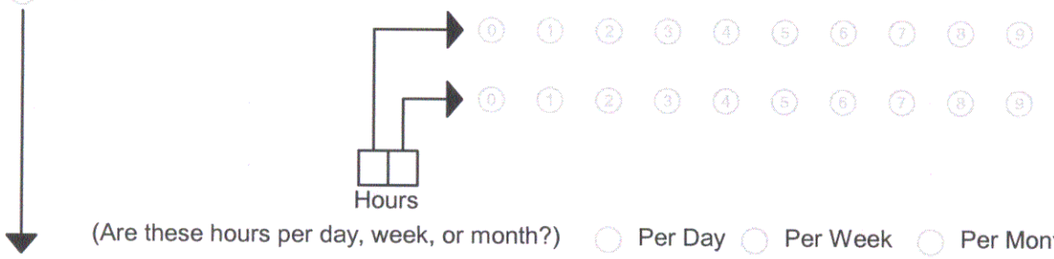
- ○ None



(Are these hours per day, week, or month?) ○ Per Day ○ Per Week ○ Per Month

59. During the LAST 12 MONTHS, what was the approximate number of hours per day, week or month, you were exposed to other people's cigarette smoke OUTSIDE YOUR HOME?

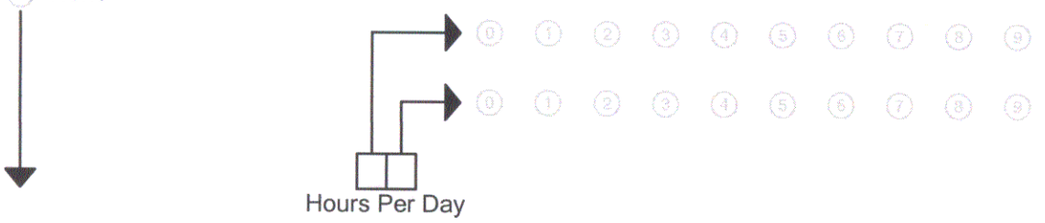
- ○ None



(Are these hours per day, week, or month?) ○ Per Day ○ Per Week ○ Per Month

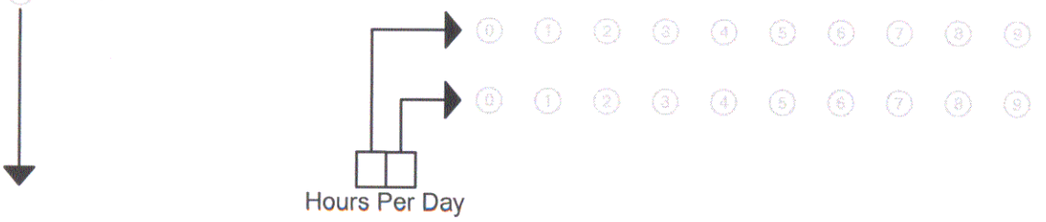
60. During the LAST 3 DAYS, what was the approximate number of hours per day you were exposed to other people's cigarette smoke IN YOUR HOME?

- ○ None



61. During the LAST 3 DAYS, what was the approximate number of hours per day you were exposed to other people's cigarette smoke OUTSIDE YOUR HOME?

- ○ None



Occupational History

62. Do you currently have a job for pay including self-employment?

- ○ Employed full time
- ○ Employed part time
- ○ Currently not employed

62.1 What is the reason you are employed part-time or not employed?

- ○ Full or part-time homemaker
- ○ Student
- ○ Retired
- ○ Disabled
- ○ Currently looking for employment
- ○ Other *Please specify:* _____

63. What is your current job for pay including self-employment?

- ○ Not employed
- ○ Currently employed

63.1 Job title and duties:

63.2 What industry is this job in?

63.3 How long have you had this job?

- ○ One year or less
- ○ 2-5 years
- ○ 6-10 years
- ○ 11-20 years
- ○ More than 20 years

Go to next page.

64. **For the job where you were employed for the LONGEST time, what was your job?**

- ○ Same as current job
- ○ Different job
- ○ Not employed

64.1 Job title and duties:

64.2 What industry is this job in?

64.3 How long did you have this job?

- ○ One year or less
- ○ 2-5 years
- ○ 6-10 years
- ○ 11-20 years
- ○ More than 20 years

Your Medical History

65. **Has a doctor ever told you that you had heart problems, problems with your blood circulation, or blood clots?**

- ○ No
- ○ Yes

65.1 Please mark the conditions or procedures below that a doctor said you had. *(Mark all that apply.)*

- ○ Angina or heart attack
- ○ Aortic aneurysm
- ○ Atrial fibrillation (a type of irregular heart beat) or other rhythm problem
- ○ Heart failure or congestive heart failure
- ○ Peripheral vascular disease or claudication (poor blood flow to the legs or blocked or narrowed arteries to the legs). Do not include varicose veins or phlebitis.
- ○ Blood clots either in your legs (sometimes called deep vein thrombosis or DVT) or in your lungs (pulmonary embolus or PE)
- ○ Surgical or balloon opening, or surgical bypass of the blood vessels in the heart, neck, abdomen, or legs
- ○ Other *Please specify:* _____

Go to next page.

66. **Did a doctor ever say you had a digestive tract disorder, including any problems with your stomach, colon, pancreas, gallbladder, or liver?**

○ No ○ Yes

66.1 Please mark the conditions or procedures below that a doctor said you had. *(Mark all that apply.)*

- ○ Reflux disorder
- ○ Stomach or duodenal ulcer
- ○ Surgery to remove all or part of your stomach
- ○ Pancreatitis
- ○ Ulcerative colitis or Crohn's disease
- ○ Surgery to remove all or part of your colon
- ○ Gallbaldder disease
- ○ Surgery to remove your gallbladder
- ○ Cirrhosis of the liver
- ○ Other liver disease *Please specify:* _____
- ○ Other *Please specify:* _____

67. **Have you ever had a colonoscopy or sigmoidoscopy?**

○ No ○ Yes

67.1 When and where did you have your LAST TWO tests?

1. _____

2. _____

67.2 In total, how many tests have you had?

67.3 When was the LAST test?

- ○ Within the past year (0 to 12 months ago)
- ○ One to two years ago (13 to 24 months ago)
- ○ Two to five years ago (25 to 60 months ago)
- ○ More than five years ago (61 months or more)

67.4 Have you ever had any polyps of the colon, intestine, bowel, or rectum removed?

○ No ○ Yes

Go to next page.

68. **Have you ever had a test to see if there was blood in your bowel movement? This is sometimes called a hemoccult test.**

○ No ○ Yes

68.1 When was the LAST test?

- ○ Within the past year (0 to 12 months ago)
- ○ One to two years ago (13 to 24 months ago)
- ○ Two to five years ago (25 to 60 months ago)
- ○ More than five years ago (61 months or more)

69. **Did a doctor ever say that you had diabetes or another gland problem such as a thyroid gland problem (not including thyroid cancer)?**

○ No ○ Yes

69.1 Please mark the conditions or procedures below that a doctor said you had. *(Mark all that apply.)*

- ○ Insulin dependent diabetes
- ○ Other diabetes
- ○ Goiter
- ○ Overactive thyroid
- ○ Underactive thyroid
- ○ Nodule (lump) in thyroid
- ○ Thyroid surgery
- ○ Other *Please specify:* _____

70. **Did a doctor ever say that you had a urological disorder (kidney or bladder)?**

○ No ○ Yes

70.1 Please mark the conditions or procedures below that a doctor said you had. *(Mark all that apply.)*

- ○ Difficulty or discomfort urinating (passing water)
- ○ Blood in your urine
- ○ Bladder or kidney stones
- ○ Kidney failure requiring dialysis or transplant
- ○ Other kidney disease *Please specify:* _____
- ○ Bladder surgery
- ○ Other *Please specify:* _____

Go to next page.

71. **Did a doctor ever say you had arthritis or another immunoloigc disorder?**

○ No ○ Yes

71.1 **Please mark the conditions or procedures below that a doctor said you had.** *(Mark all that apply.)*

- ○ Rheumatoid arthritis (not including rheumatism)
- ○ Juvenile rheumatoid arthritis
- ○ Systemic Lupus Erythematosus (SLE)
- ○ Scleroderma
- ○ Ankylosing Spondylitis
- ○ Other arthritis
- ○ Hip or other joint replaced
- ○ Other surgery for arthritis
- ○ Other *Please specify:* _____

72. **Did a doctor ever say you had a neurological disorder?**

○ No ○ Yes

72.1 **Please mark the conditions or procedures below that a doctor said you had.** *(Mark all that apply.)*

- ○ Migraine headaches
- ○ Epilepsy or other seizure disorders
- ○ Multiple sclerosis
- ○ Depression requiring medication or shock therapy
- ○ Stroke
- ○ Mini-stroke or transient ischemic attack (TIA)
- ○ Parkinson's disease
- ○ Alzheimer's disease
- ○ Huntington's disease
- ○ Surgery related to any of these conditions
- ○ Other *Please specify:* _____

Go to next page.

73. **Did a doctor ever say you had a pulmonary disorder including any lung or breathing problems?**

○ No ○ Yes

73.1 Please mark the conditions or procedures below that a doctor said you had. *(Mark all that apply.)*

- ○ Asthma
- ○ Chronic bronchitis
- ○ Emphysema
- ○ Other lung condition
- ○ Surgery for any of the above conditions
- ○ Other *Please specify:* _____

74. **Did a doctor ever say you had anemia?**

○ No ○ Yes

75. **Have you ever had a blood transfusion?**

○ No ○ Yes

76. **Did a doctor ever say you had osteoporosis?**

○ No ○ Yes

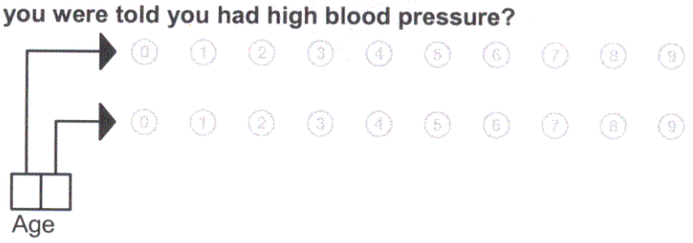
77. **Did a doctor ever say you had scoliosis?**

○ No ○ Yes

78. **Did a doctor ever say that you had hypertension or high blood pressure?**

○ No ○ Yes

78.1 How old were you when you were told you had high blood pressure?



78.2 Did you ever take pills for high blood pressure?

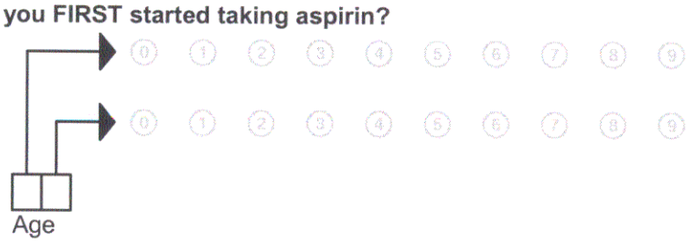
○ No ○ Yes

Go to next page.

79. **Did you ever take aspirin, excluding Tylenol, REGULARLY? By regularly, I mean at least 3 times a week for at least one month.**

○ No ○ Yes

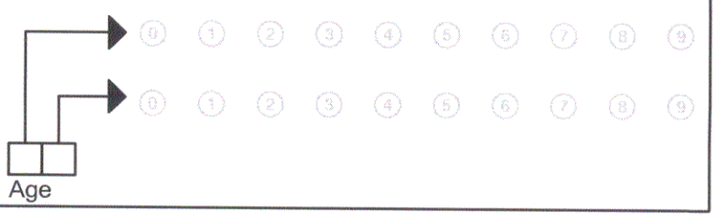
79.1 **How old were you when you FIRST started taking aspirin?**



79.2 **Are you currently taking aspirin?**

○ Yes ○ No

79.3 **How old were you when you LAST took aspirin?**



79.4 **In total, for about how many years have you taken aspirin?**

○ Have taken continuously, that is, did not start and stop between start and last use

○ Have taken for less than one year

Go to next page.

80. **Did you ever take other nonsteroidal anti-inflammatory drugs such as ibuprofen, Advil, Nuprin, Motrin, clinoril, Naprosyn, Aleve, or Feldene REGULARLY? By regularly, I mean at least 3 times a week for at least one month.**

○ No ○ Yes

80.1 **How old were you when you FIRST started taking nonsteroidal anti-inflammatory drugs?**

80.2 **Are you currently taking nonsteroidal anti-inflammatory drugs?**

○ Yes ○ No

80.3 **How old were you when you LAST took nonsteroidal anti-inflammatory drugs?**

80.4 **In total, for about how many years have you taken nonsteroidal anti-inflammatory drugs?**

○ Have taken continuously, that is, did not start and stop between start and last use
○ Have taken for less than one year

81. **Are you currently taking any medications? Please include those that you take occasionally.**

○ No ○ Yes *(List Below)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Go to next page.

82. **Are you allergic to any medications?**

○ No ○ Yes *(List Below)*

83. **Who completed this questionnaire?** *(Mark all that apply.)*

- ○ The person to whom the questions refer
- ○ Spouse
- ○ Daughter
- ○ Sister
- ○ Other *Please specify* _____

84. **Please feel free to add any additional information.**

Thank you for taking the time to fill out this questionnaire.
Your participation is very much appreciated.

PLEASE MAIL THIS QUESTIONNAIRE IN THE RETURN ENVELOPE PROVIDED.

FOR OFFICE USE ONLY

SUBJECT ID
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RESEARCH CLINIC
○ HRBCC
○ FCCC
FOLLOW-UP
○ Phone
○ Mail
○ Clinic
○ Other:
Specify

DATE RECEIVED	DAY	YEAR
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○ Feb		
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○ May	2 2	2 2 2 2
○ June	3 3	3 3 3 3
○ July	4 4	4 4 4 4
○ Aug	5 5	5 5 5 5
○ Sept	6 6	6 6 6 6
○ Oct	7 7	7 7 7 7
○ Nov	8 8	8 8 8 8
○ Dec	9 9	9 9 9 9

DATE REVIEWED	DAY	YEAR
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○ Mar	0 0	0 0 0 0
○ Apr	1 1	1 1 1 1
○ May	2 2	2 2 2 2
○ June	3 3	3 3 3 3
○ July	4 4	4 4 4 4
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○ Sept	6 6	6 6 6 6
○ Oct	7 7	7 7 7 7
○ Nov	8 8	8 8 8 8
○ Dec	9 9	9 9 9 9