HUNTSMAN CANCER INSTITUTE

AT THE UNIVERSITY OF UTAH

High Risk Breast Cancer Clinic
Men'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 and used only by study staff. Your name will not be used in any reports.

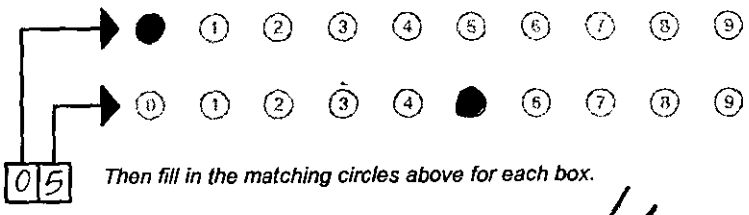
You can return this questionnaire in the pre-addressed, postage-paid envelope provided. Most people find it takes about 25 minutes to complete. If you have any questions about the questionnaire, please call the clinic staff at (801) 585-3525 or toll free at 1-(800) 936-6343.

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?



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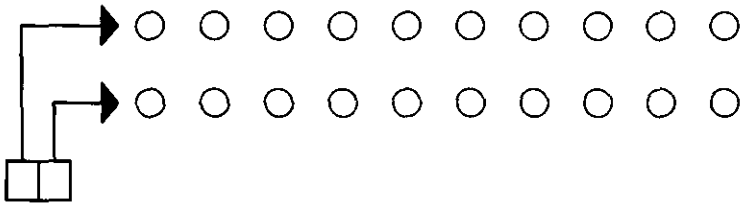
Background Information

1. How old are you?



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

7. **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.

8. **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	◯	◯	◯

9. **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	_____	_____	_____	_____	_____	_____	_____

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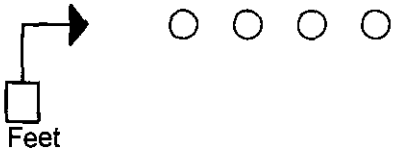
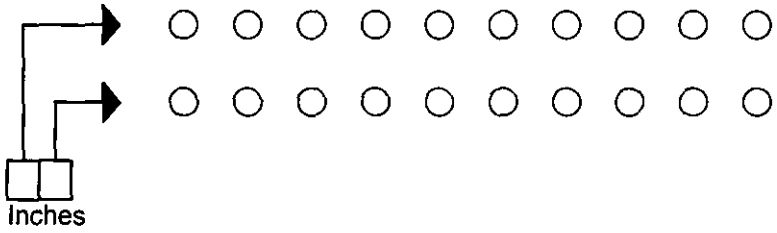
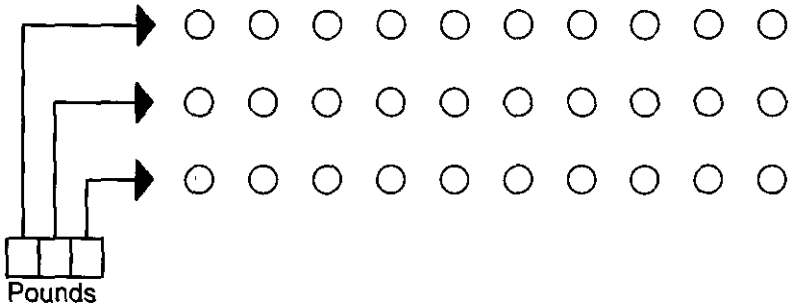
Height and Weight

10. How tall are you?

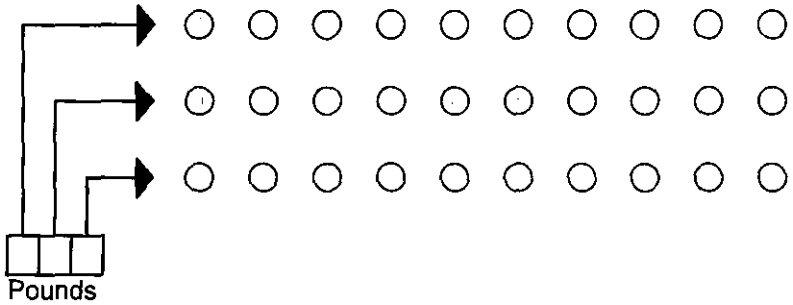




11. What is your current weight?



12. 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

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

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

14. 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.

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

○ No ○ Yes

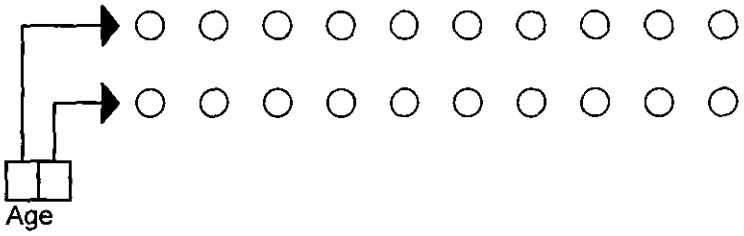
16. **Has a doctor ever told you that you had cancer, leukemia or a malignant tumor?**

○ No ○ Yes

16.1 What was the FIRST type of cancer?

_____ ○ Don't know

16.2 How old were you when this was FIRST diagnosed?

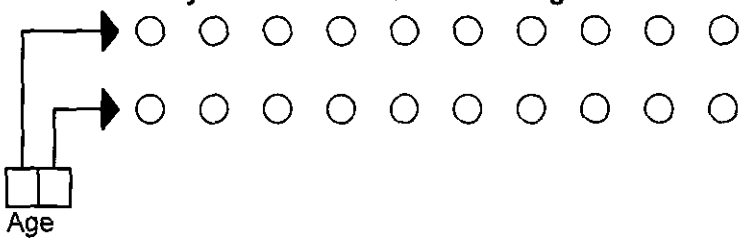


Age

16.3 What was the SECOND type of cancer?

_____ ○ Don't know

16.4 How old were you when this was FIRST diagnosed?

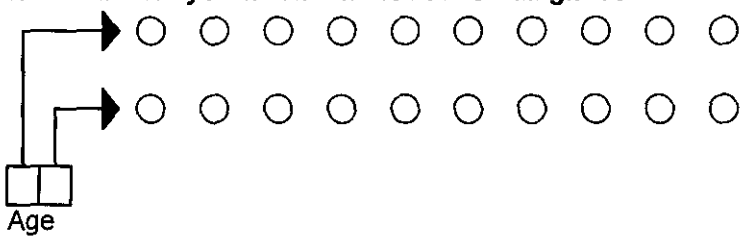


Age

16.5 What was the THIRD type of cancer?

_____ ○ Don't know

16.6 How old were you when this was FIRST diagnosed?



Age

Go to next page.

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.*

17. 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 catheterization	☐☐ 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

18. 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

19. *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

Go to next page.

20. **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
◯ Other *Please specify* _____	☐☐ Age	☐☐ Age	☐☐ ◯ Don't know

◯ None
◯ Don't know

21. **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* _____

22. **Have you or any other members of your family participated in any other research studies of familial cancer?**
◯ No ◯ Yes

23. **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.

23.1 **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

24. 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	○	○	○	○	○	○	○	○	○	○	○	○	○

Moderate Exercise

25. 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	○	○	○	○	○	○	○	○	○	○	○	○	○

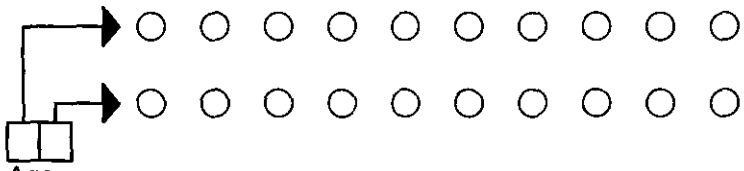
Go to next page.

Alcohol

26. 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

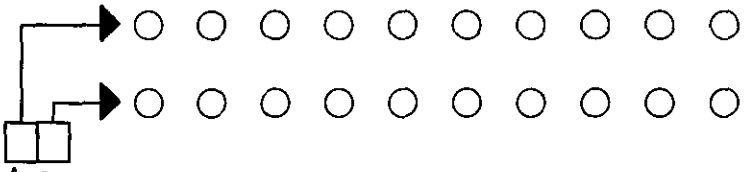
26.1 At what age did you FIRST start consuming alcohol AT LEAST ONCE PER WEEK FOR 6 MONTHS OR LONGER?



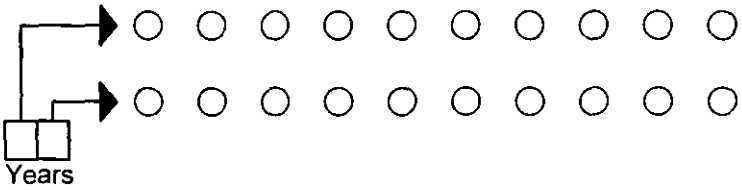
26.2 Are you currently consuming alcohol AT LEAST ONCE PER WEEK?

○ Yes ○ No

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



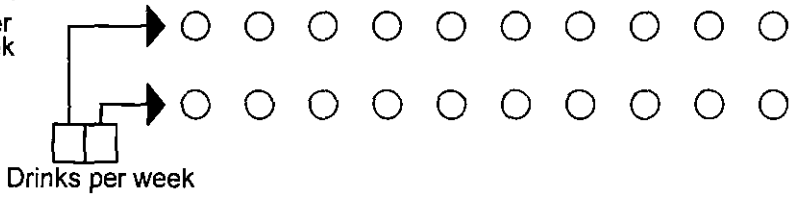
26.4 For how many years in total have you consumed alcohol AT LEAST ONCE PER WEEK?



26.5 When you consume(d) alcohol AT LEAST ONCE PER WEEK, how many drinks do (did) you usually have in a week?

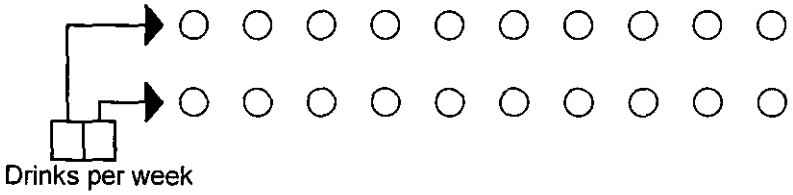
Beer (12 oz can or bottle)

○ Never consumed beer at least once per week



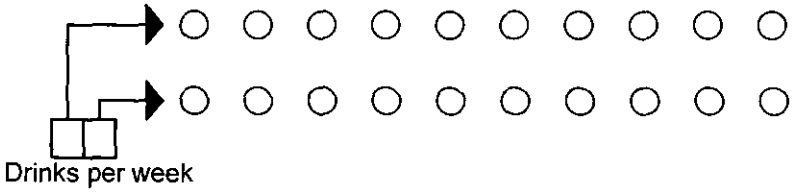
Wine or wine coolers (1 medium glass)

○ Never consumed wine at least once per week



Liquor (1 shot)

○ Never consumed liquor at least once per week



Go to next page.

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

○ No ○ Yes

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

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Age

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

○ Yes ○ No

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

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Age

27.4 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

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Years

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

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Number of cigarettes per day

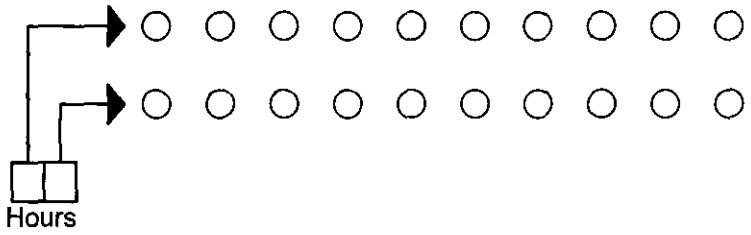
Go to next page.

28. **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

29. **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

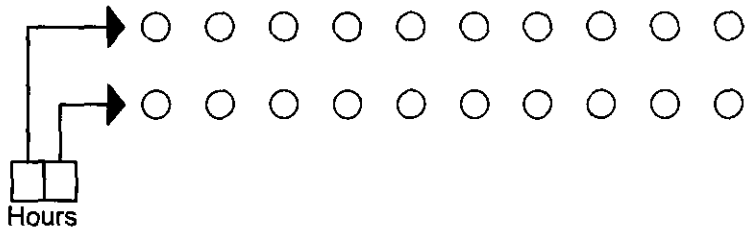


Hours

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

30. **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

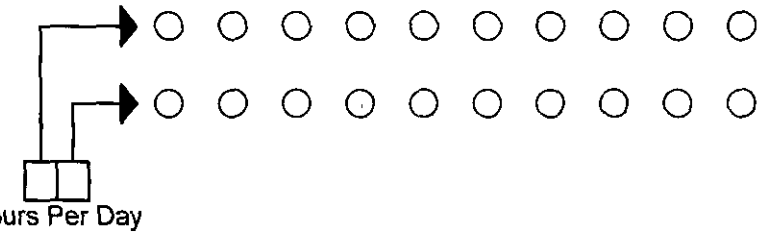


Hours

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

31. **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?**

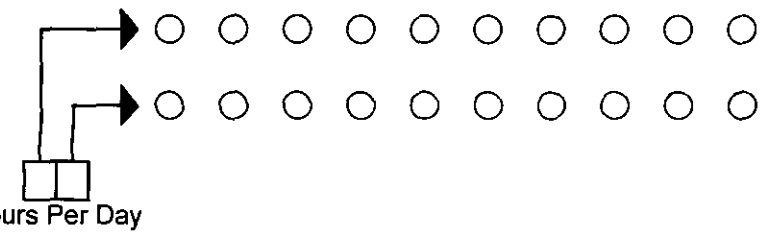
◯ None



Hours Per Day

32. **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



Hours Per Day

Go to next page.

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

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

33.1 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:* _____

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

- ◯ Not employed
- ◯ Currently employed

34.1 Job title and duties:

34.2 What industry is this job in?

34.3 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.

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

○ Same as current job ○ Different job

○ Not employed

35.1 Job title and duties:

35.2 What industry is this job in?

35.3 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

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

○ No ○ Yes

36.1 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.

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

○ No ○ Yes

37.1 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
- ○ Gallbladder disease
- ○ Surgery to remove your gallbladder
- ○ Cirrhosis of the liver
- ○ Other liver disease *Please specify:* _____
- ○ Other *Please specify:* _____

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

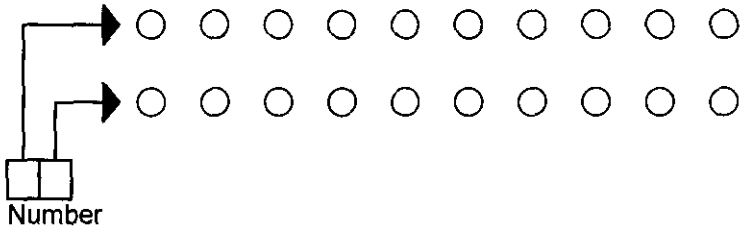
○ No ○ Yes

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

1. _____

2. _____

38.2 In total, how many tests have you had?



Number

38.3 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)

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

○ No ○ Yes

Go to next page.

39. **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

39.1 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)

40. **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

40.1 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:* _____

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

○ No ○ Yes

41.1 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.

42. **Did a doctor ever say you had arthritis or another immunologic disorder?**

○ No ○ Yes

42.1 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:* _____

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

○ No ○ Yes

43.1 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.

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

○ No ○ Yes

44.1 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:* _____

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

○ No ○ Yes

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

○ No ○ Yes

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

○ No ○ Yes

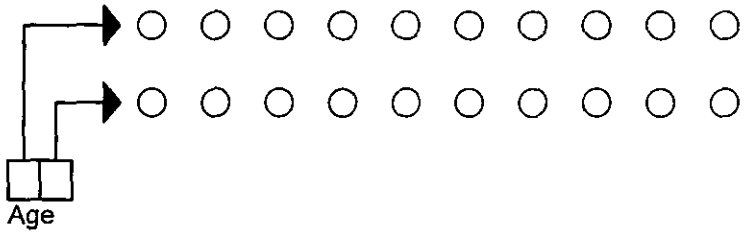
48. **Did a doctor ever say you had scoliosis?**

○ No ○ Yes

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

○ No ○ Yes

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



49.2 Did you ever take pills for high blood pressure?

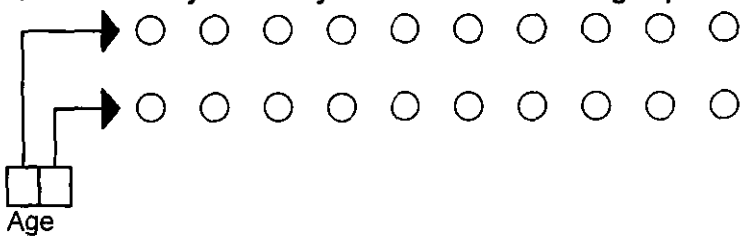
○ No ○ Yes

Go to next page.

50. **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

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

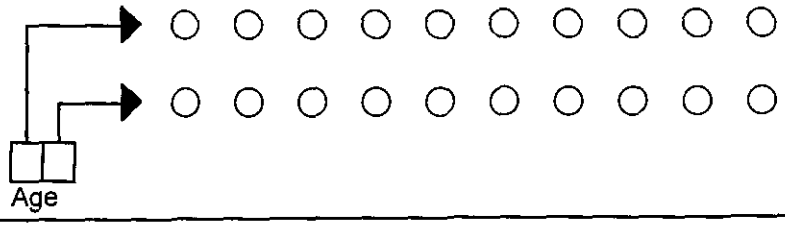


Age

50.2 **Are you currently taking aspirin?**

○ Yes ○ No

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

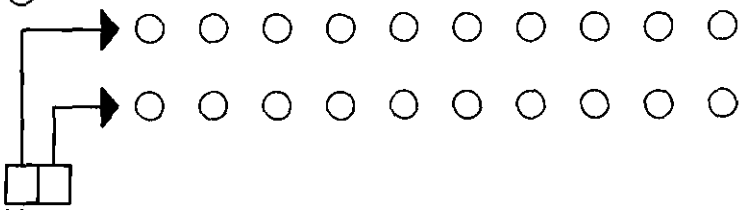


Age

50.4 **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



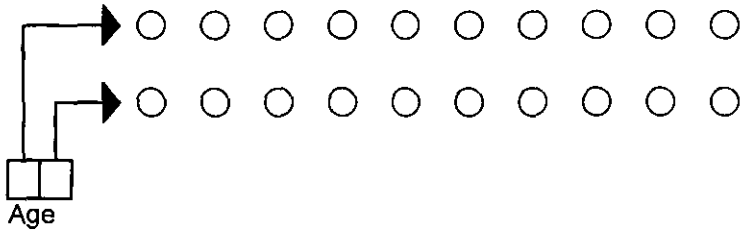
Years

Go to next page.

51. **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

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

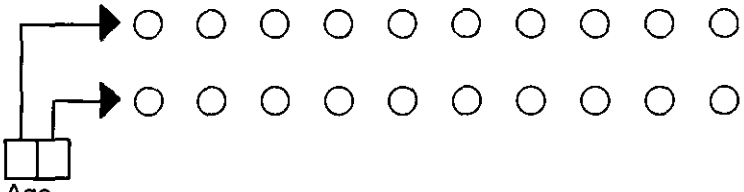


Age

51.2 Are you currently taking nonsteroidal anti-inflammatory drugs?

○ Yes ○ No

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

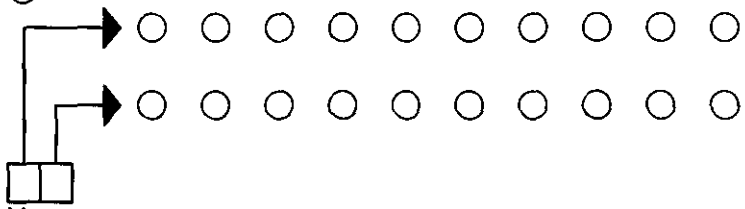


Age

51.4 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



Years

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

○ No ○ Yes *(List Below)*

Go to next page.

53. Are you allergic to any medications?

○ No ○ Yes *(List Below)*

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

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

55. 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	RESEARCH CLINIC	DATE RECEIVED	DATE REVIEWED
	○ HRBCC ○ FCCC	○ Jan … ○ Dec; DAY; YEAR	○ Jan … ○ Dec; DAY; YEAR
	FOLLOW-UP ○ Phone ○ Mail ○ Clinic ○ Other: Specify		