

LTFU

Long-Term Follow-Up Sibling Survey

St. Jude Children's Research Hospital
Ann & Robert H. Lurie Children's Hospital of Chicago
Children's Healthcare of Atlanta/Emory University
Children's Hospital at Stanford
Children's Hospital Colorado
Children's Hospital of Orange County
Children's Hospital of Philadelphia
Children's Hospital of Los Angeles
Children's Hospital of Pittsburgh
Children's Hospitals & Clinics of Minnesota,
Minneapolis and St. Paul
Children's Medical Center of Dallas
Children's National Medical Center
City of Hope National Medical Center
Cook Children's Hematology-Oncology Center
Dana-Farber Cancer Institute/
Children's Hospital Boston
Mattel Children's Hospital at UCLA
Mayo Clinic
Memorial Sloan-Kettering Cancer Center
Miller Children's Hospital
Nationwide Children's Hospital
Riley Hospital for Children - Indiana University
Roswell Park Cancer Institute
Seattle Children's Hospital
St. Louis Children's Hospital
Texas Children's Hospital
Toronto Hospital for Sick Children
UAB/The Children's Hospital of Alabama
University of California at San Francisco
University of Chicago Comer Children's Hospital
University of Michigan - Mott Children's Hospital
University of Minnesota
U.T.M.D. Anderson Cancer Center

Our mailing address is:

Long-Term Follow-Up Study
St. Jude Children's Research Hospital
Department of Epidemiology
Mail Stop 735
262 Danny Thomas Place
Memphis, TN 38105-3678

St. Jude toll-free phone number:
1-800-775-2167

St. Jude e-mail: LTFU@stjude.org

ltfu.stjude.org



Thank you for participating in the Long-Term Follow-Up study as a brother or sister of an individual treated for childhood cancer, leukemia, tumor or a similar illness. Your participation helps to provide us with valuable information in the fight against these serious illnesses of childhood and adolescence.

You can be assured that we will respect your privacy at all times. Your child's name or other identifiers will not be used in any report of our findings, or released to any person or agency, except study investigators.

Your generosity in participating is greatly appreciated.

Sincerely,

The LTFU study staff

The questions in this booklet relate to:

Person completing this questionnaire is:

Your relationship:

Parent Other: _____

Today's date:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
m	m		d	d		y	y	y	y

Please! Do not mark below this line

Survey #023

9665023472

LTFU Consent Form

This form is an informed consent statement that requires your signature if you wish to participate in the study. Please review the following three pages and sign and date at the yellow arrows.

! Watch for this symbol - it indicates that you need to do something at this point in the consent.

INFORMED CONSENT STATEMENT

Note: When we say "you" throughout this document, we mean "you or your child."

LONG-TERM FOLLOW-UP STUDY

We would like to invite you to take part in the Long-Term Follow-Up Study (LTFU) being conducted by St. Jude Children's Research Hospital. This consent form gives you information about the research study. If you agree to take part, you can complete the consent process via the LTFU website or sign this consent document and return it in the self-addressed, stamped envelope you received. The second consent document is a copy for you to keep or you can print a copy from the website.

Before you learn about the study, it is important that you know the following:

- Whether or not you take part in this study is entirely up to you.
- If you decide not to be in the study, or to withdraw from the study at any time, it will not affect your relationship with St. Jude or with the original treating institution.
- This study is being sponsored (receiving financial support to offset a portion of the costs of the study) by the National Cancer Institute.
- The principal investigator (researcher) of this study is Dr. Leslie Robison, who can be reached at 800-775-2167.
- Your study information will be shared with researchers at St. Jude Children's Research Hospital, the LTFU Biopathology Center (Columbus, OH), LTFU Laboratory (Cincinnati, OH), LTFU Statistical Center (Seattle, WA), LTFU Radiation Physics Center (Houston, TX) and LTFU collaborating researchers.

Why is this study being done?

The purpose of this study is to learn about the health of persons who were treated for cancer, leukemia, tumors, or other similar illnesses as children, compared to their siblings (brothers and sisters). We are interested in studying the risk (chance) of second cancers, long-term side effects of chemotherapy and radiation therapy, and your family history of cancer. The information we collect will be used to make recommendations for the treatment and follow-up of future children who are diagnosed with cancer or a similar illness.

How many patients will take part in the study?

About 30,000 people from around the United States and Canada, who were treated as children for cancer or a similar illness, will take part in this study. Additionally, about 8,000 siblings will participate as a study comparison group.

What is involved in this study?

You will complete a set of questions about your health. Answering all of the questions will take about 45 minutes. You may leave blank any questions you are uncomfortable answering. The questionnaire can be completed over the internet at our website or by completing the questionnaire and returning it in the stamped, self-addressed envelope you received. You may also complete it over the phone with a trained interviewer.

The collected information will be entered into a computer for comparison with people who were treated as children for cancer or a similar illness. All of the information collected in this study will be kept private and participants will not be identified in any study reports.

Based on questionnaire answers, you may be contacted in the future to complete additional questionnaires.

This is a long-term study of childhood survivors of cancer or similar illnesses. In the future, you will receive a shorter questionnaire in the mail every other year until the study is finished.

What are the consequences of withdrawing from this study?

You can stop taking part in this study at any time. Whether or not you take part in this study will not affect your relationship with St. Jude or the original treating institution.

Please! Do not mark below this line

What are the risks of the study?

Very rarely, personal information from your records could be given out by accident. To prevent this from happening, electronic data is stored on password protected computers, only study team members work with the data, and study results are reported on the whole group, never identifying one individual in reports. You may become upset by some survey questions and do not have to answer any question that makes you uncomfortable.

What are the benefits of the study?

You may or may not receive a direct benefit from taking part in this study. The information we collect may help us make recommendations for the treatment and follow-up of future children who are diagnosed with cancer or a similar illness.

What other options are there?

Your participation in this study is voluntary. You may choose not to take part in this study.

What about new information?

You will be told of any new information learned during the course of the study, which might cause you to change your mind about staying in the study. You will receive a CCSS Newsletter every six months that contains a study update and other health information that may be helpful to yourself as well as people who were treated for cancer or similar illness. You have the right to learn about the results of the study. If you are interested in learning more about when and how to get the results of this research study, you may contact Dr. Leslie Robison at 901/595-3300 or Dr. Greg Armstrong, Project Director at St. Jude Children's Research Hospital, at 800/775-2167.

What about privacy?

To help us protect your privacy, we have obtained a Certificate of Confidentiality from the federal government. With this Certificate, the researchers cannot be forced to give out your personal information, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other process. The researchers will use the Certificate to block any demands for information that would identify you, except in the cases listed below.

The Certificate cannot be used to resist a demand for information from the United States Government, if that information is used to audit or check federally funded projects or to meet the needs of the U.S. Food and Drug Administration (FDA).

You should know that a Certificate of Confidentiality does not keep you or a member of your family from choosing to give out information about you or your part in this research. If an insurer, employer, or other person gets your written consent to receive research information, then the researchers cannot use the Certificate to keep that information private.

The Certificate of Confidentiality will not keep researchers or hospital staff from making reports required of them. These include reports about suspected child abuse, about diseases that spread from person to person, or about possible threat of harm to yourself or others.

Government agencies oversee research studies involving people. Your research records may be reviewed by the following:

- Food and Drug Administration (FDA)
- National Institutes of Health (NIH)
- Office of Human Research Protection (OHRP)
- St. Jude Children's Research Hospital Institutional Review Board, a committee that reviews the ethics and safety of research studies

By signing this consent form, you are allowing your research records to be reviewed by these persons.

Where can I get more information?

If you have questions regarding this study you may contact the St. Jude Principal Investigator for this study, Dr. Leslie Robison, at 901/595-3300 or Dr. Greg Armstrong, Project Director at St. Jude Children's Research Hospital, at 800/775-2167.

You can get more information about your rights as a research participant by calling the Chairman of the St. Jude Institutional Review Board at 901/595-4357 or the St. Jude Research Participant Advocate (Ombudsman) at 901/595-4644. If you live outside of the Memphis area, you may call 1-866-583-3472 (1-866-JUDE IRB). This is a toll-free call.

**SUMMARY OF RESEARCH AND PRIVACY RIGHTS
NON-THERAPEUTIC AND MINIMAL RISK RESEARCH**

IRB Approved Version: July 19, 2011

The following statement describes your/your child's rights as a research participant:

1. You may talk as much as you want with the researchers about the reasons for this study and about its risks.
2. This study may have risks that the researchers or other doctors do not know about now.
3. We may use your information to develop a new product or medical test to be sold. The sponsor, hospital, and researchers may benefit if this happens. There are no plans to pay you if your information is used for this purpose.
4. You will not be charged for being in this research study.
5. If you decide not to be in the study, or to withdraw from the study at any time, it will not affect your relationship with St. Jude.
6. The St. Jude Notice of Privacy Practices tells how your medical information may be used or given to someone outside the hospital. You have the right to read the Notice of Privacy Practices before you sign this form. You can find it at the bottom of every page on the St. Jude Internet website: www.stjude.org.
7. You have the right to see, copy, and ask for changes to your protected health information that will be used or given out. This consent form describes any limits to this right, such as research information that you will not see until the end of the study or that will only be used for research.
8. A description of this clinical trial will be available on <http://www.ClinicalTrials.gov>, as required by U.S. Law. This Website will not include information that can identify you. At most the Website will include a summary of the results. You can search this Website at any time.
9. Federal agencies such as the Food and Drug Administration (FDA), the Office of Human Research Protections (OHRP) or the National Institutes of Health (NIH), St. Jude Children's Research Hospital Institutional Review Board (IRB), as well as other regulatory agencies, committees, or persons involved in overseeing research studies, may review your research and medical record.
10. Information about you collected as part of this study may be given out as explained in this informed consent form.
11. After your records are given to or used by others, St. Jude Children's Research Hospital cannot promise that information will not be given out again. Also, the information given out may no longer be protected by federal privacy laws.
12. St. Jude uses reasonable safeguards and means to protect the security and confidentiality of e-mail/text messaging, fax information or mail sent to and received from you. However, St. Jude cannot guarantee the security and confidentiality of e-mail or text messaging or fax communications or mail. Despite the best efforts of St. Jude to protect private information, e-mails/text messaging or fax can be electronically taken by other users, changed, forwarded, or used without permission or detection. Possible risks include e-mail/text messaging, fax or mail senders can type the wrong address for an e-mail or mail or dial a wrong phone number. Backup copies of an e-mail/text messaging or fax may exist after the sender or receiver has deleted a copy.
13. Permission to use and give out your child's protected health information will end when your child turns 18 years of age (if applicable). At that time, researchers may get your child's consent if they wish to keep using or giving out your child's protected health information.
14. You may take back permission for your records to be used or given out at any time, for any reason, except the following:
 - When that information has already been given out or used based on your permission
 - When the information is needed to maintain the integrity of the study
15. To take back your permission, please fill out a form called a Revocation of Release of Authorization. You may ask for this form by calling the St. Jude Privacy Officer at 901-595-6141. You must mail the form or hand it to the:

HIPAA Privacy Officer
St. Jude Children's Research Hospital
262 Danny Thomas Place
Memphis, TN 38105
16. If you have more questions about this study, you can call the Principal Investigator of this study, Dr. Leslie Robison, at 901-595-3300.
17. You can get more details about your rights as a research participant by calling the chairman of the Institutional Review Board at 901-595-4357 or the Research Participant Advocate at 901-595-4644. If you are outside of the Memphis area, please call toll-free 1-866-583-3472 (1-866-JUDE IRB).

The staff will give you a copy of this statement.

RESEARCH PARTICIPANT STATEMENT

I have read (or have had read to me) the contents of this document and have been encouraged to ask questions. I have received answers to my questions. I give consent to take part in this research study and authorize the disclosure and use of my/my child's protected health information for the purposes of that research.



Research Participant/Research Participant's Parent/Guardian

Date



Please! Do not mark below this line

HIPAA Authorization Form

If you sign this form, you are giving St. Jude Children's Research Hospital permission to use or disclose (give out) medical information. It will allow St. Jude to get copies of certain parts of your (your child's) medical record that we may need to review, such as treatment history for your (your child's) childhood illness or records for later illnesses.

LONG-TERM FOLLOW-UP STUDY HIPAA¹ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR RESEARCH

- Purpose.** As a research participant and at my request, I give Greg Armstrong, M.D., M.S.C.E., and the researcher's staff permission to use and disclose my (my child's) health information for a research project called Long-Term Follow-Up (LTFU) Study.
- Individual Health Information to be Used or Disclosed.** My (My child's) health information that may be used or disclosed for this research may include my (my child's) medical records.
- Who May Disclose My (My Child's) Health Information?** During this study, the researcher and the researcher's staff may get my (my child's) health information from hospitals, clinics, and health care providers who have treated me.
- Who May Receive My (My Child's) Health Information?** The health information disclosed by researchers and information given by me during the research study may be received and used by Greg Armstrong, M.D., M.S.C.E., the researcher's staff, LTFU collaborators, the LTFU Biopathology Center (Columbus, OH), the LTFU Biorepository (Cincinnati, OH), the LTFU Radiation Physics Center (Houston, TX), and the LTFU Statistical Center (Seattle, WA).
- Right to Refuse to Sign this Authorization.** I do not have to sign this form. If I decide not to sign the form, I may not be allowed to take part in this study. However, my decision not to sign this form will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.
- Right to Revoke.** I can change my mind and revoke (take back) this authorization (permission) at any time by sending a written notice of my decision to Dr. Greg Armstrong, St. Jude Children's Research Hospital, Department of Epidemiology and Cancer Control, 262 Danny Thomas Place, Memphis, TN 38105. If I take back my permission, the researcher may use and disclose only the protected health information already collected for the research study. No further health information about me will be collected by the researcher or disclosed to the researcher for this study.
- Possible Re-disclosure.** After my (my child's) health information is given out under this authorization form, there is a chance that it might be re-disclosed outside this study and no longer covered by this form. However, I understand that the research team and the St. Jude Institutional Review Board (IRB) are very careful to protect my (my child's) privacy and limit the use of information that can identify me (my child). (The IRB is the committee that reviews studies to be sure that the rights and safety of those taking part in the study are protected). In addition, the LTFU study maintains a Certificate of Confidentiality from the National Institute of Health to protect the identity of research subjects.

For those taking part in the research study who are not legal adults, this authorization form will expire when they become legal adults (unless the person taking part in the study has appointed a legal guardian to provided authorization). A new form will be required when the child becomes a legal adult. For a legal adult taking part in this study, this authorization (permission) expires at the end of the study.

I am the research participant, or I am legally authorized to act on behalf of the person taking part in the study.

I have read this information and have received a copy of the form.



Printed name of research participant

Date of birth

Signature of research participant or legal guardian

Date



Printed name of legal guardian

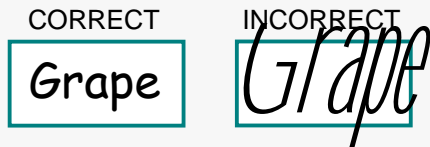
Describe how the person signing has authority to act on behalf of the research participant

¹ HIPAA is the Health Insurance Portability and Accountability Act of 1996, a federal law related to privacy of health information.

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging.
2. When marking boxes, make an x inside the box (see examples below).
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided:



MARKING EXAMPLES

Below are some examples of how to fill out this questionnaire. Please look these over before you begin.

Example 1

1. During the past month, did your child participate in any physical activities or exercises such as running, calisthenics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

No Yes

	Not sure		If yes, age at first use
	Yes		
No	Yes	Not sure	↓ years
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□ □
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3 4

Example 2

2. Has your child ever taken. . .

- a. BIRTH CONTROL PILLS such as Demulen, Lo-Ovral, Loestrin, Norinyl, Norplant, Ortho-Novum, Ovral, Triphasil-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

- b. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES, such as Zocor, Pravachol, Lipitor, Colestid (colestipol), Tricor, Lescol, Lopid (gemfibrozil), Mevacor, niacin, or Lorelco-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

mevacor

Example 3

3. When was this condition diagnosed?

04

1995

Month (mm)

Year (yyyy)

A1. What is your child's date of birth?

		/			/				
m	m		d	d		y	y	y	y

A2. What is his/her sex?

- Male
- Female

A3. To the nearest inch, what is his/her current height without shoes?

	feet, and			inches
--	-----------	--	--	--------

A4. To the nearest pound, what is his/her current weight without shoes?

			pounds
--	--	--	--------

A5. To which one of the following groups does he/she belong?

- White
- Black
- American Indian or Alaskan Native
- Asian
- Pacific Islander
- Other

Specify

A5a. Is he/she Hispanic?

- No
- Yes

A6. Is he/she a twin or born of a multiple birth?

- No → Go to Question A7.
- Yes ↓

A6a. If yes, which type of multiple is he/she?

- Identical twin
- Fraternal (non-identical) twin, same sex
- Fraternal (non-identical) twin, opposite sex
- Not sure what type of twin, same sex
- More than twin

Specify

A7. Was this child adopted?

- No
- Yes

A8. Concerning your child's current residence, does he/she:

- Own a residence
- Rent
- Live with parents
- Other

Specify

A9. On average, how many times per week does your child use the internet?

- Never
- 1-10 times
- 11 or more times

Medical Care

The next questions are about health care received by your child during the 2 year period between **May 2012 and May 2014**.

B1. Between May 2012 and May 2014, which of the following health care providers (excluding dentists) did your child see or talk to for medical care? (Mark all that apply)

- None → Go to Question B6.
- Physician (including Osteopath)
- Nurse
- Chiropractor
- Physical Therapist
- Psychologist or psychiatrist
- Other

Specify

B2. Where did your child receive his/her health care? (Mark all that apply)

- Doctor's office
- Oncology (cancer) center or clinic
- Other type of clinic
- Hospital
- Emergency Room or Urgent Care Center
- Long-term follow-up clinic
- Other

Specify

B3. During this 2 year period, how many times did your child see a physician?

- 0 times
- 1 - 2 times
- 3 - 4 times
- 5 - 6 times
- 7 - 10 times
- 11 - 20 times
- More than 20 times

B4. During this 2 year period, how often did you telephone a doctor's office regarding an illness or a medical condition your child may have had?

- 0 times
- 1 - 2 times
- 3 - 4 times
- 5 - 6 times
- 7 - 10 times
- 11 - 20 times
- More than 20 times

B5. During this 2 year period, how many times was he/she admitted to any hospital?

--	--

B6. At the present time, does your child have any of the following?

	No	Yes
Persistent hair loss.	<input type="checkbox"/>	<input type="checkbox"/>
Scarring or disfigurement of the head or neck region (including the face).	<input type="checkbox"/>	<input type="checkbox"/>
Scarring or disfigurement of the chest or abdominal region.	<input type="checkbox"/>	<input type="checkbox"/>
Scarring or disfigurement of the arms or legs (including an abnormally short arm or leg).	<input type="checkbox"/>	<input type="checkbox"/>
Walk with a limp.	<input type="checkbox"/>	<input type="checkbox"/>
Loss of an arm or a leg	<input type="checkbox"/>	<input type="checkbox"/>
Loss of an eye	<input type="checkbox"/>	<input type="checkbox"/>
Other.	<input type="checkbox"/>	<input type="checkbox"/>

Specify

B7. Please indicate all medicines/drugs your child took *regularly* during the two-year period between **May 2012 and May 2014.**

- We are only asking about medicines/drugs which he/she took consistently for more than one month, or for 30 days or more in a year.

- Please list only drugs prescribed by a doctor and filled by a pharmacist. Include pills, syrups, injections, patches, or creams.

- Please do NOT include medicines/drugs that were bought without a prescription (over-the-counter drugs).

If yes, age at first use

If yes, is he/she currently taking any of these?

1. BIRTH CONTROL PILLS such as Demulen, Lo-Ovral, Loestrin, Norinyl, Norplant, Ortho-Novum, Ovral, Triphasil -----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

Not sure			years		Yes	
No	Yes			No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. ESTROGENS OR PROGESTERONES (FEMALE HORMONES) such as Estrace, Estraderm, Premarin, Provera, Medroxyprogesterone, Vivelle-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	----------------------	----------------------	--------------------------	--------------------------

3. TESTOSTERONES (MALE HORMONES) such as Androgel, Delatesteral, Testosterone cypionate, Testosterone enanthate-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	----------------------	----------------------	--------------------------	--------------------------

4. PILLS OR INSULIN FOR DIABETES such as Glucophage (metformin), Glucotrol (glipizide), Glynase (glyburide), Prandin, Amaryl, Avandia, Actos, or insulin injections (such as Humulin, Novolin, Lantus)-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	----------------------	----------------------	--------------------------	--------------------------

5. MEDICATIONS FOR HIGH BLOOD PRESSURE OR HYPERTENSION such as hydrochlorothiazide (HCTZ), Dyazide (triamterene/HCTZ), Tenormin (atenolol), Lopressor (metoprolol), Zestril or Prinivil (lisinopril), Vasotec (enalapril), Cozaar, Hyzaar, Diovan, or others-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	----------------------	----------------------	--------------------------	--------------------------

B7. (Cont.) Please indicate all medicines/drugs your child took *regularly* during the two-year period between **May 2012 and May 2014.**

- We are only asking about medicines/drugs which he/she took consistently for more than one month, or for 30 days or more in a year.

- Please list only drugs prescribed by a doctor and filled by a pharmacist. Include pills, syrups, injections, patches, or creams.

- Please do NOT include medicines/drugs that were bought without a prescription (over-the-counter drugs).

6. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES such as Lovastatin, Zocor (simvastatin), Pravachol (pravastatin), Crestor, Lipitor, Zetia, Tricor, Vytorin, gemfibrozil-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

7. MEDICATIONS FOR HEART CONDITIONS, INCLUDING ANGINA, CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE, OR IRREGULAR HEART BEAT-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

8. THYROID MEDICATIONS such as Synthroid (levothyroxine or L-thyroxine), Levothroid, or others-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

9. MEDICATIONS FOR DEPRESSION such as Prozac (fluoxetine), Serzone, Celexa, Zoloft, Wellbutrin, Effexor, Desyrel (trazodone), or Vivactil-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

10. OTHER PRESCRIBED DRUGS-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name **and** specify the reason the drug was prescribed.

	Not sure			If yes, age at first use		If yes, is he/she currently taking any of these?	
	No	Yes		years		No	Yes
6. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. MEDICATIONS FOR HEART CONDITIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. THYROID MEDICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. MEDICATIONS FOR DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. OTHER PRESCRIBED DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical Conditions

The next series of questions relate to medical conditions that have ever occurred in your child's lifetime.

Please indicate, by marking the box (either "No", "Yes", or "Not sure"), if a doctor or other health care professional has told you that your child has or has had any of the following conditions. In addition, please give your child's approximate age when the condition first occurred. (If more than one occurrence, please give age at first occurrence.)

Because we need definite responses, it is very important to mark an answer for each question, even if your child has never had that condition. Please do not leave any questions blank (unmarked).

HEARING/VISION/SPEECH

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence years
C1. Hearing loss requiring a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C2. Deafness in both ears not completely corrected by hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C3. Deafness in only one ear not completely corrected by hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C4. Tinnitus or ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C5. Persistent dizziness or vertigo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C6. Hearing loss, not requiring a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C7. Any other hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe this problem.

C8. Legally blind in only one eye?

If yes, does he/she have any sight in this eye?
 No Yes

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence years
C9. Legally blind in both eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<i>If yes, does he/she have any sight?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes					
C10. Cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C11. Glaucoma (excess pressure in the eyeball)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C12. Problems with double vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C13. A detached retina or any other condition of the retina?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe this problem.

C14. Crossed or turned eyes (strabismus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C15. Lazy eye (amblyopia)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C16. Any other trouble seeing with one or both eyes even when wearing glasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C17. Very dry eyes requiring eye drops or ointment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C18. Any other eye problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe this problem.

Please! Do not mark below this line

Remember, it is very important that you mark an answer for each of the following questions, even if your child has never had that condition.

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence years
C19. Stammering or stuttering? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C20. Any other speech defects? . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe this defect.

C21. Abnormal sense of taste? . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
C22. Loss of taste or smell lasting for 3 months or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

URINARY SYSTEM

D1. Kidney stones?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D2. REPEATED (more than 3 in any 12 month period) kidney or bladder infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D3. Dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D4. Blood in his/her urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D5. Urinary incontinence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D6. Any other kind of kidney, bladder or urinary tract disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe this disorder.

HORMONAL SYSTEMS

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence years
E1. An overactive thyroid gland (hyperthyroid)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E2. An underactive thyroid gland (hypothyroid)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E3. Thyroid nodules?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E4. Swollen or enlarged thyroid gland?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E5. Diabetes that can be controlled with diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E6. Diabetes controlled with pills or tablets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E7. Diabetes controlled with insulin shots?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E8. Deficiency of growth hormone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E9. Has your child received injections of growth hormone (such as Nutropin, Genotropin, Humatrope, Norditropin, Saizen)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E10. Osteoporosis or osteopenia (thin, brittle, or fragile bones)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E11. Has your child ever broken a bone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe all occurrences.

E12. Any other hormonal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
---	--------------------------	--------------------------	--------------------------	--------------------------	----------------------

If yes, describe this problem.

Remember, it is very important that you mark an answer for each of the following questions, even if your child has never had that condition.

HEART AND CIRCULATORY SYSTEM

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence years
F1. Congestive heart failure or cardiomyopathy (weak heart muscle)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F2. A myocardial infarction (heart attack)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F3. Irregular heartbeat or palpitations, (Arrhythmia) requiring medication or follow-up by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F4. Coronary heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe this problem.

F5. Hypertension (high blood pressure) requiring medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
If yes, does he/she currently take hypertension medication? <input type="checkbox"/> No <input type="checkbox"/> Yes					
F6. Angina pectoris (chest pains due to lack of oxygen to the heart requiring medication such as nitroglycerin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F7. Pericarditis or fluid around the heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F8. Pericardial constriction (scarring or tightness of the sac around the heart)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F9. Stiff or leaking heart valves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F10. Blood clot in head, lung, arm, leg, or pelvis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F11. Does exercise cause severe chest pain, shortness of breath, or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence years
F12. High cholesterol (or triglyceride) requiring prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
If yes, does he/she currently take medication for this? <input type="checkbox"/> No <input type="checkbox"/> Yes					
F13. Any other heart or circulatory problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe this problem.

F14. Has anyone in your child's immediate family (biological mother, father, brothers, sisters) had a heart attack before the age of 55?

No Yes

RESPIRATORY SYSTEM

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

G1. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G2. Chronic cough or shortness of breath for more than one month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G3. Has your child had a need for extra oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G4. Pneumonia, 3 or more times in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G5. Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G6. Lung fibrosis or "scarring" of the lung?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G7. Problems with breathing while at rest that lasted for more than 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Please! Do not mark below this line

It is very important that you mark an answer for each of the following questions, even if your child has never had that condition.

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

				Not sure	If yes, age at first occurrence years
	Yes, but the condition is no longer present				
	Yes, and the condition is still present				
	No				

G8. Any other breathing or lung problems?

If yes, describe this problem.

DIGESTIVE SYSTEM

H1. Hepatitis?

If yes, what type(s)? (Mark all that apply)

Hepatitis A

Hepatitis B

Hepatitis C

Don't know

Other

H2. Cirrhosis of the liver?

H3. Any other liver trouble?

If yes, describe.

H4. Intestinal (colon) polyps?

H5. Fatty liver?

H6. Esophageal strictures (narrowing of the esophagus)?

H7. Rectal or anal fistula?

H8. Rectal or anal stricture (narrowing or scarring)?

H9. Any other stomach or digestive trouble?

SURGICAL PROCEDURES

Please indicate if your child has ever had any of the following surgical procedures done.

				Not sure	If yes, age at first occurrence years
	No	Yes			

11. Amputation of an arm, leg, hand, foot?

If yes, specify (example: left hand, right foot).

12. Scoliosis surgery (insertion of rods or other methods to straighten the spine)?

13. Other surgery of spinal cord or spine?

If yes, specify.

14. Leg lengthening or shortening procedures?

15. Joint replacement?

If yes, specify.

16. Other bone surgery?

If yes, specify.

17. Coronary artery bypass surgery?

18. Pericardiectomy (stripping of the sac around the heart)?

Please! Do not mark below this line

It is very important that you mark an answer for each of the following questions, even if your child has never had that condition.

Please indicate if your child has ever had any of the following surgical procedures done.

- | | No | Yes | Not sure | If yes, age at first occurrence
years |
|--|--------------------------|--------------------------|--------------------------|--|
| I9. Heart catheterization ("heart cath")? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I10. Angioplasty (enlarging a heart vessel using a balloon)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I11. Surgery for heart valve replacement? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I12. Surgery for pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I13. Other heart surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

If yes, specify.

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|----------------------|
| I14. Surgery for intestinal obstruction (blocked intestines)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I15. Colostomy or ileostomy (stool going into a bag)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I16. Biopsy or removal of lump in thyroid gland? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I17. Removal of part or all of the thyroid gland? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I18. Removal of the spleen? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I19. Ventriculoperitoneal (VP) shunt (tube from the brain to the abdomen under the skin) that removes excess spinal fluid? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I20. Breast biopsy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I21. Breast-conserving or breast-sparing surgery (lumpectomy)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I22. Mastectomy or removal of a breast? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

If yes, was one or both breasts removed?

One Both

Please indicate if your child has ever had any of the following surgical procedures done.

- | | No | Yes | Not sure | If yes, age at first occurrence
years |
|------------------------------|--------------------------|--------------------------|--------------------------|--|
| I23. Any lung surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

If yes, specify.

- | | | | | |
|---------------------------------------|--------------------------|--------------------------|--------------------------|----------------------|
| I24. Periodontal (gum) surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I25. Heart transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I26. Lung transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I27. Kidney transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I28. Liver transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I29. Bone marrow transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I30. Other organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

If yes, specify transplant.

- | | | | | |
|------------------------------|--------------------------|--------------------------|--------------------------|----------------------|
| I31. Cataract surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
|------------------------------|--------------------------|--------------------------|--------------------------|----------------------|

Males → Go to Question I35.

- | | | | | |
|-------------------------------------|--------------------------|--------------------------|--------------------------|----------------------|
| I32. Removal of one ovary? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I33. Removal of both ovaries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I34. Removal of uterus? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

Females → Go to Question I37.

- | | | | | |
|------------------------------------|--------------------------|--------------------------|--------------------------|----------------------|
| I35. Removal of one testis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I36. Removal of both testes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| I37. Any other surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

If yes, specify surgery.

Just a reminder - it is very important that you mark an answer for each of the following questions, even if your child has never had that condition.

Have you ever been told by a doctor or other health care professional that your child has, or has had. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence years
J12. Weakness or inability to move leg(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J13. Paralysis of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J14. Has your child had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
If yes, as a result of the stroke . . .					
a. Did the symptoms last more than 24 hours? <input type="checkbox"/> No <input type="checkbox"/> Yes					
b. Did it affect:					
Speech.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Only one side of the body . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Both sides of the body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Did your child lose consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes					
d. Did he/she have weakness or inability to move arm(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
e. Did he/she have weakness or inability to move leg(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
f. Did he/she have paralysis of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe this problem.

J15. Any other brain or nervous system problems?

If yes, describe this problem.

SOCIAL FUNCTIONING

K1. About how many close friends does your child have?

- 0 → Go to Question K3.
 1
 2 or 3
 4 or more

K2. About how many times a week does your child do things with close friends?

- Less than 1
 1 or 2
 3 or more

K3. Compared to other children of his/her age, how well does your child . . .

	Worse	About Same	Better
a. Get along with his/her brothers and sisters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Get along with other children?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Behave with his/her parents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Play and work by himself/herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

K4. How well do the following statements describe your child's behavior?

	Often True	Sometimes True	Not True
a. Has sudden changes in mood or feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feels or complains that no one loves him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Is rather high strung, tense, or nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Cheats or tells lies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Is too fearful or anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Argues too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Has difficulty concentrating, cannot pay attention for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Is easily confused, seems to be in a fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Bullies, or is cruel or mean to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Is disobedient at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Is disobedient at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Does not seem to feel sorry after he/she misbehaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

K4. (Cont.) How well do the following statements describe your child's behavior?

	Often True	Sometimes True	Not True
m. Has trouble getting along with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Has trouble getting along with teachers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Is impulsive, or acts without thinking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Feels worthless or inferior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Is not liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Has a lot of difficulty getting his/her mind off certain thoughts, has obsessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Is restless or overly active, cannot sit still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Is stubborn, sullen, or irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Has a very strong temper and loses it easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Is unhappy, sad or depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. Is withdrawn, does not get involved with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If child is 12 years of age or older → **Go to Question K6.**

K5. FOR CHILDREN UNDER 12 YEARS OF AGE

	Often True	Sometimes True	Not True
a. Breaks things on purpose, deliberately destroys his/her own things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Clings to adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cries too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Demands a lot of attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Is too dependent on others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If child is under 12 years of age → **Go to Question K7.**

K6. FOR CHILDREN 12 YEARS OF AGE OR OLDER

	Often True	Sometimes True	Not True
a. Feels others are out to get him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Hangs around with kids who get into trouble.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Is secretive, keeps things to himself/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Worries too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

K7. How much bodily pain has your child had during the past 4 weeks?

- None → **Go to Question L1, next page.**
- Very mild
- Mild
- Moderate
- Severe
- Very severe

K8. During the past 4 weeks, how much did pain interfere with your child's normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

K9. For pain that your child has had during the past 4 weeks, where has this pain been located? (Mark all that apply)

- Head
- Neck
- Chest
- Hands/Arms
- Abdomen
- Back
- Pelvis
- Legs/Feet
- Other

Specify

Please! Do not mark below this line

CANCER, LEUKEMIA, OR TUMOR

The following questions (L1-L9) relate to whether your child has ever been diagnosed with cancer, leukemia, tumor or other similar illness.

L1. Has your child ever been diagnosed with cancer, leukemia, tumor, or similar illness?

No → **Go to Question M1.**

Yes ↓

L2. Please write the name of this disease.

L3. Did he/she have treatment for this disease?

No → **Skip L3a and go to Question L4.**

Yes → **L3a. What treatments did he/she receive? (Mark all that apply)**

- Chemotherapy
- Radiation therapy
- Surgery

L4. Where was this diagnosed?

Hospital:

Address:

City, State/Province, Zip Code:

Doctor's Name:

Date of Diagnosis:

Month

Year

L5. Has your child had any additional cancers, leukemias, tumors, or similar illnesses after this diagnosis? (Include any relapse or recurrence of his/her original diagnosis.)

No → **Go to Question M1.**

Yes ↓

L6. Please write the name of this disease.

L7. Did he/she have treatment for this disease?

No → **Skip L7a and go to Question L8.**

Yes → **L7a. What treatments did he/she receive? (Mark all that apply)**

- Chemotherapy
- Radiation therapy
- Surgery

L8. Where was this diagnosed?

Hospital:

Address:

City, State/Province, Zip Code:

Doctor's Name:

L9. Was this a:

- Recurrence of your child's original diagnosis
- New cancer, leukemia, tumor, or similar illness
- Don't know

Date of Recurrence or New Diagnosis:

Month

Year

Please use a separate sheet of paper for additional cancers

MARITAL STATUS

M1. What is your child's current living arrangement?
(Mark all that apply)

- Lives with spouse/partner
- Lives with parent(s)
- Lives with roommate(s)
- Lives with brother(s) and/or sister(s)
- Lives with other relative(s) (not including minor children)
- Lives alone
- Other

Specify

M2. Has your child ever been married or had a live-in relationship (lived as married)?

- No → Go to Question N1.
- Yes

M3. Which of these possibilities best describes his/her current marital status?

- Married
- Living with a partner as married
- Widowed
- Divorced
- Separated or no longer living as married

M4. How many times has he/she been married or lived as married?

- 1 6
- 2 7
- 3 8
- 4 9+
- 5

OFFSPRING/PREGNANCY HISTORY

N1. To your knowledge, has your child ever been sexually active (had sexual intercourse)?

- Don't know
- No → Go to Question O1.
- Yes ↴

N2. Is he/she currently sexually active?

- Don't know
- No
- Yes

N3. Is your daughter currently pregnant, or does your son currently have a woman pregnant by him?

- Don't know
- No
- Yes

N4. Was there ever a period in your child's life when he/she and a partner tried for one year or more to become pregnant, without success?

- Don't know
- No
- Yes

N5. Has your daughter ever become pregnant, or has your son ever had a woman become pregnant by him?

- Don't know
- No → Go to Question O1.
- Yes ↴

N6. Including live births, stillbirths, miscarriages, and abortions, how many times has your daughter become pregnant or has your son had a woman become pregnant by him?

times

N7. Please fill in the following information for each of your daughter's pregnancies, or each time a woman has become pregnant by your son, regardless of the outcome.

	<u>Pregnancy outcome</u>				Your child's age at start of pregnancy	Partner's age at start of pregnancy	Weeks pregnancy lasted
	Live birth	Stillbirth	Miscarriage	Medical abortion			
Pregnancy 1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please attach a separate sheet of paper if more than 5 pregnancies

HEALTH HABITS

Physical Activity

O1. On how many of the past 7 days did your child exercise or do sports for at least 20 minutes that made him/her sweat or breathe hard (e.g., dancing, jogging, basketball, etc.)?

- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days

O2. Because of any impairment or health problems, does your child need the help of other persons with personal care needs, such as eating, bathing, dressing, or getting around their home?

- No
- Yes

O3. Because of any impairment or health problems, does your child need the help of other persons in handling routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

- No
- Yes

O4. Does any impairment or health problem keep your child from holding a job or attending school?

- No
- Yes

O5. Does he/she currently have a driver's license?

- No
- Yes

O6. Over the last 2 years, how long (if at all) has your child's health limited him/her in each of the following activities?

(Mark one box for each item.)

	Limited for more than 3 months	Limited for 3 months or less	Not limited at all
a. The kinds or amounts of vigorous activities he/she can do, like lifting heavy objects, running or participating in strenuous sports.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The kinds or amounts of moderate activities he/she can do, like moving a table, carrying groceries or bowling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Walking uphill or climbing a few flights of stairs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bending, lifting, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Walking one block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Eating, dressing, bathing, or using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Practices

O7. In general, would you say your child's health is:

- Excellent
- Very good
- Good
- Fair
- Poor

O8. Would you rate your child as being:

- Completely disabled
- Severely disabled
- Moderately disabled
- Mildly disabled
- Not at all disabled

O9. Some people get a general physical examination from a doctor once in a while even though they are feeling well and have not been sick. When was the last time your child had a general physical examination when he/she was not sick?

- Never
- Less than 1 year ago
- 1-2 years ago
- More than 2 years but less than 5 years ago
- 5 or more years ago
- Don't know

O10. When was the last time your child had an echocardiogram (ultrasound of the heart to look at the heart muscle and heart valves)?

- Never
- Less than 1 year ago
- 1-2 years ago
- More than 2 years but less than 5 years ago
- 5 or more years ago
- Don't know

O11. When was the last time your child had a test to measure his/her bone strength or bone mineral density (such as a DEXA, quantitative CT scan, or ultrasound)?

- Never
- Less than 1 year ago
- 1-2 years ago
- More than 2 years but less than 5 years ago
- 5 or more years ago
- Don't know

O12. How long has it been since your child last went to a dentist?

- Never
- Less than 1 year ago
- 1-2 years ago
- More than 2 years but less than 5 years ago
- 5 or more years ago
- Don't know

GENETIC CONDITIONS

Please mark the appropriate box (either "No", "Yes", or "Not sure") for each of the listed conditions. Indicate "Yes" only if a physician has told you that your child was born with, or has the condition.

Because we need definite responses, and questions left blank are difficult to interpret, it is very important that you mark an answer for each of the following questions, even if your child has never had that condition. If you have never heard of these conditions, it is unlikely that your child has had them.

P1a. Have you ever been told by a doctor that your child has. . .

	No	Yes	Not sure
a. Ataxia telangiectasia.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Beckwith-Wiedemann syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Bilateral acoustic neurofibromatosis (Neurofibromatosis Type 2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bloom's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Klinefelter's syndrome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Fanconi's anemia.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Multiple exostoses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Familial adenomatous polyposis (FAP or Gardner syndrome).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Neurofibromatosis (Type 1).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Nevoid basal cell carcinoma syndrome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Turner's syndrome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Von Hippel-Lindau syndrome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Wiskott-Aldrich syndrome.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Xeroderma pigmentosum.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Any other genetic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe this disorder.

P1b. If your child has a son or daughter (blood relative only), has he/she ever had any of the above conditons? (Mark all that apply)

My child's . . .

What conditions?

Son →

Daughter →

CONDITIONS PRESENT AT BIRTH

It is very important that you mark an answer for each of the following questions even if your child has never had the condition.

P2. Has your child ever had genetic counseling for cancer risk?

- No
 Yes

P3a. To the best of your knowledge, was your child born with...

	No	Yes	Not sure
a. Cleft lip or palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Club foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Large or multiple birthmarks (any 1 larger than a quarter, or 6 larger than a dime)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Deafness or impaired hearing at birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Blindness or difficulty seeing at birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Eyes different colors or missing an iris (the colored part of the eye)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Hydrocephalus (excessive water around or within the brain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Spina bifida or other neural tube defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Unusually small head (microcephaly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Unequal sized limbs (hemihypertrophy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Extra fingers, deformed chest, shortened limbs or any other skeletal abnormality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Hole in the heart or other congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If other, please specify.

m. Any congenital abnormality of the pancreas, liver, or digestive tract (stomach, intestines).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Any kidney, bladder, or genital abnormalities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Undescended testes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Any other birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If other, please specify.

P3b. If your child has a son or daughter (blood relative only), has he/she ever had any of the conditions in Question P3a? (Mark all that apply)

My child's . . . *What conditions?*

Son →

Daughter →

P4. If your child has a son or daughter (blood relative only), has he/she ever had cancer? (Mark all that apply)

My child's . . . *What types?*

Son →

Daughter →

SCHOOL HISTORY

Q1. What is the highest grade or level of schooling that your child has completed?

- 1 - 8 years (grade school)
- 9 - 12 years (high school), but did not graduate
- Completed high school/GED
- Training after high school, other than college
- Some college
- Other

Specify

Q2. If your child has completed high school, did he/she receive a regular high school diploma or did he/she receive a high school equivalency certificate, also called a GED?

- High school diploma
- GED

Q3. In elementary, junior, or high school was he/she ever in any of the following programs? (Mark all that apply)

	No	Yes	Not sure
Learning disabled or special education program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes</i> , was he/she in the program because of. . .			
a. Missed school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Low scores on tests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Problems learning or concentrating. . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Emotional or behavioral problems. . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advanced placement or talented program? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homebound education for at least one school year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q4. If your child was in a learning disabled or special education program, what grades was he/she in at that time? (Mark all that apply)

- K
- 1st
- 2nd
- 3rd
- 4th
- 5th
- 6th
- 7th
- 8th
- 9th
- 10th
- 11th
- 12th

EMPLOYMENT HISTORY

R1. Has your child ever had a job?

- No → Go to Question S1.
- Yes ↓

R2. What is his/her current employment status? Include unpaid work in the family business or farm. (Mark all that apply)

- Not currently working → Go to Question S1.
- Working full-time (30 or more hours per week)
- Working part-time (less than 30 hours per week)
- Caring for home or family (not seeking paid work)
- Unemployed and looking for work
- Unable to work due to illness or disability
- Student
- Other

Specify.

R3. The following questions are about your child's present occupation. Please write his/her job title and brief details of what he/she does. If he/she has more than one job, please give the title of your child's main job (please give only one):

R3a. Main job title:

R3b. Please briefly describe your child's primary job tasks:

INCOME

S1. Over the last year, what was the total income of the household your child lives in?

- Less than \$20,000
- \$20,000 - \$39,999
- \$40,000 - \$59,999
- \$60,000 - \$79,999
- \$80,000 - \$99,999
- Over \$100,000

S2. During the past year, how many people in this household were supported on this income?

- 1 6
- 2 7
- 3 8
- 4 9 or more
- 5

INSURANCE

T1. Have you ever had difficulty obtaining health insurance for your child because of his/her health history?

- No
- Yes

T2. Does your child currently have health insurance coverage?

- Canadian resident → Go to Question T4.
- No → Go to Question T4.
- Yes

T3. How is this insurance provided? *(Mark all that apply)*

- Through parent's place of employment
- Through parent's policy
- Through a policy you have purchased for your child
- Medicaid or other public assistance program
- Medicare
- Military dependant/Veteran's benefits (CHAMPUS)
- Other

Specify.

T3a. Does this health insurance plan have any exclusions or restrictions because of your child's health history?

- Don't know
- No
- Yes

Specify.

T3b. Is there an extra premium charge on your health insurance policy because of your child's health history?

- Don't know
- No
- Yes

T4. Have you ever had difficulty obtaining life insurance for your child because of his/her health history?

- No
- Yes
- Never tried to obtain life insurance

T5. Does your child currently have life insurance coverage?

- No
- Yes

OTHER ISSUES

Please rate how concerned you are about the following:

	Very concerned	Somewhat concerned	Concerned	Not very concerned	Not at all concerned
U1. Your child's future health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U2. Your child's ability to have children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U3. Your child developing a cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U4. Your ability to get health insurance for your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U5. Your ability to get life insurance for your child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U6. Any other issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify.

Continue on next page.

We have your child's current address and phone as:

Is this information correct, or are you planning on moving in the next 6 months?

Correct Not correct Moving

Do you have an email address we could use to contact you?

No Yes

Your Email Address

--

Please give us your child's correct address or location (if different from above) and cell phone number if applicable:

Address		
City	State	
Zip Code	Home Phone Number	Cell Phone Number

Please provide the name and address of someone who could give us your new address should you move. We will contact this person only if we are unable to reach you at your home address.

Name	
Address	Relationship to you
City	State
Zip Code	Phone Number

When you have completed this questionnaire please return it to us in the enclosed envelope.

Mail to:

LONG-TERM FOLLOW-UP STUDY
St. Jude Children's Research Hospital
Department of Epidemiology
Mail Stop 735
262 Danny Thomas Place
Memphis, TN 38105-3678

Thank you!