

BAYLOR/TEXAS MEDICAL CENTER, HOUSTON CHILDREN'S HOSPITAL, DENVER CHILDREN'S HOSPITAL OF COLUMBUS CHILDREN'S HOSPITAL OF LOS ANGELES CHILDREN'S HOSPITAL & MEDICAL CENTER, SEATTLE CHILDREN'S HOSPITAL OF PHILADELPHIA CHILDREN'S HOSPITAL OF PITTSBURGH CHILDREN'S MEDICAL HOSPITAL, CHICAGO CHILDREN'S NATIONAL MEDICAL CTR, WASHINGTON DC DANA FARRER CANCER INSTITUTE BOSTON EMORY UNIV SCHOOL OF MEDICINE, ATLANTA WACO CLINIC, RICHMOND MD ANDERSON CANCER CENTER, HOUSTON UNIVERSITY OF MICHIGAN, ANN ARBOR UNIVERSITY OF MICHIGAN CHILDREN'S MEDICAL CENTER, DETROIT UNIVERSITY OF MICHIGAN CHILDREN'S HOSPITAL, CHICAGO ST. LUDE CHILDREN'S RESEARCH HOSPITAL, MEMPHIS ST. LOUIS CHILDREN'S HOSPITAL STANFORD UNIV. SCHOOL OF MEDICINE, PALO ALTO UCLA MEDICAL CENTER, LOS ANGELES UCSF SCHOOL OF MEDICINE, SAN FRANCISCO UNIVERSITY OF ALABAMA, BIRMINGHAM UNIVERSITY OF MINNESOTA, MINNEAPOLIS UT-SOUTHWESTERN MEDICAL CENTER, DALLAS ROSWELL PARK, BUFFALO HOSPITAL FOR SICK CHILDREN, TORONTO

## Long-Term Follow-Up Study

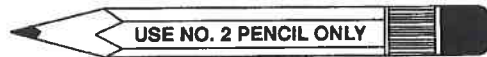
Person completing this questionnaire is \_\_\_\_\_  
 (Please print your full name)

If married, what is your maiden name \_\_\_\_\_

Today's date \_\_\_\_\_  
 (month/day/year)

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 the No. 2 pencil enclosed (Please do not use pen).
2. Completely darken your answers, that is, fill in the full circle.



Written responses must stay within the boxes provided.

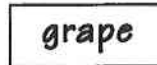
CORRECT



INCORRECT



CORRECT



INCORRECT



3. Make no stray marks of any kind. Other than your responses, please keep the form as clean as possible. Erase cleanly any answer you wish to change. Do not use "white-out".



PLEASE DO NOT MARK IN THIS AREA

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**A.1 What is your date of birth?**

Write the numbers in the boxes. →

Then fill in the matching circles. →

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	1 9 <input type="text"/>

Month

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

Day

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

Year

0
1
2
3
4
5
6
7
8
9

**A.2 What is your sex?**

Male

Female

**A.3 What is your social security number?**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

Do not have a social security number

**A.4 To which one of the following groups do you belong?**

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

**A.4a Are you Hispanic?**

No

Yes

**A.5 Are you a twin?**

No → **Go to Question A.6**

Yes ↓

- A.5a If yes, which type of twin are you?**
- Identical
  - Fraternal (non-identical) same sex
  - Fraternal (non-identical) opposite sex
  - Not sure what type, same sex

**A.6 Were you adopted?**

No

Yes

**A.7 How many full brothers and sisters (living or dead) do/did you have? Include only those brothers and sisters who have the same birth (biological) mother and father as you.**

<input type="text"/>	<input type="text"/>
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

**A.8 Please describe your current residence.**

- Single family dwelling - unattached (house)
- Single family dwelling - attached (townhouse or condominium)
- Apartment
- Dormitory
- Other

**A.9 Concerning your current residence, do you:**

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

**A.10 What is your current height without shoes?**

feet, and  inches

<input type="text"/>	<input type="text"/>
3	0
4	1
5	2
6	3
7	4
	5
	6
	7
	8
	9

**A.11 What is your current weight without shoes?**

pounds

<input type="text"/>	<input type="text"/>	<input type="text"/>
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

# Medical Care

The next questions are about health care received during the 2 year period between January 1, 1994 and December 31, 1995.

**B.1** Between January 1, 1994 and December 31, 1995 (2 year period), which of the following health care providers (excluding dentists) did you see or talk to for medical care? (Mark all that apply)

- None **→ Go to Question B.7, page 4**
- Physician (including Osteopath)
- Nurse
- Chiropractor
- Physical Therapist
- Other *specify*

**B.2** Where did you receive your 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
- Other *specify*

**B.3** During this 2 year period, how many times did you see a physician?

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

**B.4** During this 2 year period, how often did you telephone a doctor's office, regarding an illness or a medical condition you may have had?

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

**B.5** During this 2 year period, how many times were you admitted to any hospital?

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

**B.6** During this 2 year period (January 1, 1994 to December 31, 1995), did you have any operations or surgeries?

- No
- Yes



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**B.7** On these 2 pages, we would like to know about medicines/drugs you have taken during the 2 year period between January 1, 1994 and December 31, 1995. We are interested in medicine/drugs which you have taken consistently for more than one month, or for a total of 30 days in one year. Please list only those drugs prescribed by your doctor and filled by a pharmacist. Include pills, syrups, injections, patches, creams.

Please do NOT list medicine/drugs that you buy off the shelf at the drug store (over the counter drugs).

Not sure   
 Yes   
 No

1. **ANTIBIOTICS** such as amoxicillin, bactrim, erythromycin, penicillin or others .....

*If yes, specify the name of the drug(s).*

2. **BIRTH CONTROL PILLS** such as Demulen, Lo-ovral, Loestrin, Norinyl, Norplant, Ortho-Novum, Ovral, Triphasil or others .....

*If yes, specify the name of the drug(s).*

3. **ESTROGENS OR PROGESTERONES (FEMALE HORMONES)** such as Estrace, Estraderm patch, Premarin, Provera, Medroxyprogesterone or others .....

*If yes, specify the name of the drug(s).*

4. **TESTOSTERONES (MALE HORMONES)** such as Delatesteral, Testosterone cypionate, enanthate or others .....

*If yes, specify the name of the drug(s).*

5. **THYROID MEDICATIONS** such as L-thyroxin, Levothyroid, Levothyroxin, Synthroid or others ..

*If yes, specify the name of the drug(s).*

6. **OTHER MEDICINES TO REPLACE BODY HORMONES** such as prednisone, DDAVP (Desmopressin), hydrocortisone, growth hormones or others .....

*If yes, specify the name of the drug(s).*

7. **MEDICATION FOR DIABETES** such as Insulin, Diabinese, Glucotrol, Micronase, Orinase, Tolinase or others .....

*If yes, specify the name of the drug(s).*

8. **MUSCLE RELAXANTS** such as Baclofen, Flexeril, Valium, Chlorzoxazone (Paraflex) or others .

*If yes, specify the name of the drug(s).*

9. **PRESCRIBED PAIN MEDICINES** such as Tylenol with Codeine (Tylenol #3), Ansaed, Disalcid, Feldene, Fiorecet or others .....

*If yes, specify the name of the drug(s).*

10. **PRESCRIBED NUTRITIONAL SUPPLEMENTS** such as Ferrous Sulfate (Iron), Magnesium, Potassium, Bicitra (Sodium Bicarbonate), Phosphorus (NutraPhos), Vitamin D (Rocalcetro) or others .....

*If yes, specify the name of the drug(s).*

Not sure  
 Yes  
 No

11. ANTI-EPILEPTIC (ANTI-SEIZURE) DRUGS such as Dilantin, Phenobarbital, Depakane, Tegretol (Carbamazepine), Klonipen, Primidone (Mysoline), Zarontin or others .....

If yes, specify the name of the drug(s):

12. DRUGS FOR HIGH BLOOD PRESSURE OR FOR YOUR HEART such as Atenolol (Tenoretic), Captopril, Digoxin (Lanoxin), Lasix (Furosemide), Inderal, Methyl-Dopa, Dyazide (Triamterene), Procardia, Vasotec or others .....

If yes, specify the name of the drug(s):

13. PRESCRIBED ANTACIDS (for excess stomach acid or ulcers) such as Tagamet (Cimetidine), Zantac (Ranitidine), Pepsid (Famotidine) or others .....

If yes, specify the name of the drug(s):

14. CHEMOTHERAPY/IMMUNE SUPPRESSANTS such as Cytosan, Immuran, Prednisone, Ifosfamide or others .....

If yes, specify the name of the drug(s):

15. ANTIDEPRESSANTS OR OTHER PRESCRIBED DRUGS FOR DEPRESSION OR OTHER MOOD DISORDERS such as Elavil, Prozac, Paxil, Zoloft, Navane, Ritalin or others .....

If yes, specify the name of the drug(s):

16. OTHER PRESCRIBED DRUGS .....

If yes, specify the name of the drug(s) and reason(s) for use:

**B.8 At the present time, do you have any of the following?**

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

specify



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# Medical Conditions

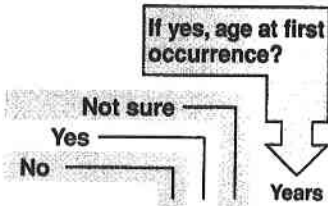
The next series of questions relate to medical conditions that have ever occurred in your lifetime.

Please indicate, by filling in the circle (either "No", "Yes", or "Not sure") if a doctor or other health care professional has told you that you have any of the following conditions. In addition, please give your approximate age when you were first told about this condition. (If more than one occurrence, please give age at first time.)

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

Some questions require a number as well as an answer. Write your answer in the boxes provided and fill in the corresponding circles.

**Example**

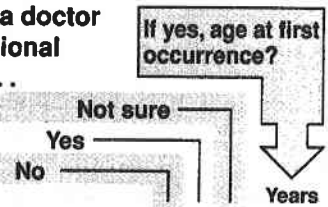


G.1 Hay fever? .....

G.2 Recurrent sinus infections or sinus surgery? .....

## HEARING/VISION/SPEECH

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



C.1 Hearing loss requiring a hearing aid? .

C.2 Deafness in one or both ears not completely corrected by hearing aid? .

C.3 Complete deafness in either ear? .....

C.4 Tinnitus or ringing in the ears? .....

C.5 Persistent dizziness or vertigo? .....

C.6 Problems hearing sounds, words, or language in crowds? .....

C.7 Any other hearing problems? .....

*If yes, describe this problem.*

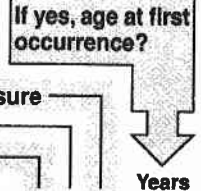
C.8 Legally blind in one or both eyes?.....

C.9 Cataracts? .....

C.10 Glaucoma (excess pressure in the eyeball)? .....

C.11 Problems with double vision?.....

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



C.12 A detached retina or any other condition of the retina?.....

*If yes, describe this problem.*

C.13 Any other trouble seeing with one or both eyes even when wearing glasses? .....

C.14 Very dry eyes requiring eye drops or ointment? .....

C.15 Any other eye problems?.....

*If yes, describe this problem.*

C.16 Stammering or stuttering? .....

C.17 Any other speech defects? .....

*If yes, describe this defect.*

C.18 Abnormal sense of taste? .....

C.19 Loss of taste or smell which has lasted for 3 months or more? .....

## URINARY SYSTEM

D.1 Kidney stones?.....

D.2 REPEATED kidney infections?.....

D.3 REPEATED bladder infections? .....

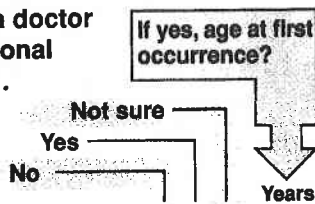
D.4 Dialysis? .....

D.5 Any other kind of kidney or urinary tract disorder? .....

*If yes, describe this disorder.*

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

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



**HORMONAL SYSTEMS**

- E.1 An overactive thyroid gland (hyperthyroid)?
- E.2 An underactive thyroid gland (hypothyroid)?
- E.3 Thyroid nodules?
- E.4 Other thyroid enlargements?
- E.5 Diabetes - that is controlled with diet?
- E.6 Diabetes - controlled with pills or tablets?
- E.7 Diabetes - controlled with insulin shots?
- E.8 Deficiency of growth hormone?
- E.9 Have you ever received injections of growth hormone (Protropin or Humatrope)?
- E.10 Osteoporosis, brittle, weak or fragile bones?
- E.11 Did you need medication to go into puberty?
- E.12 Any other hormonal problems?

*If yes, describe this problem.*

- E.13 Has a doctor ever told you that you might have trouble having children?
- E.14 Have you ever had medical tests (such as a blood test, an ultrasound, or sperm count) to see whether or not you might have trouble having children?

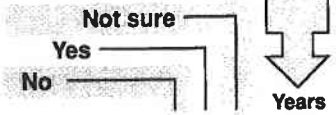
**Females - → Go to Question E.16**

- E.15 MALES - Have you ever been told you had a low sperm count?

**Males - → Go to Question F.1**

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

If yes, age at first occurrence?



- E.16 FEMALES - Have you ever had a menstrual period?      
If no, → Go to Question F.1
- E.17 FEMALES - Are you currently having menstrual periods?      
If no, at what age was your last menstrual period?
- E.18 Have you ever taken female hormones, including birth control pills (oral contraceptives) to have your period?

**HEART AND CIRCULATORY SYSTEM**

- F.1 Rheumatic heart disease?
- F.2 Hardening of the arteries or arteriosclerosis?
- F.3 Irregular heartbeat or palpitations, (Arrhythmia) requiring medication or follow-up by a doctor?
- F.4 Congestive heart failure or cardiomyopathy (weak heart muscle)?
- F.5 A myocardial infarction (heart attack)?
- F.6 Coronary heart disease?
- F.7 Hypertension (high blood pressure) NOT requiring medication?
- F.8 Hypertension (high blood pressure) requiring medication?
- F.9 A stroke or a cerebrovascular accident?
- F.10 Angina pectoris (chest pains due to lack of oxygen to heart requiring medication such as nitroglycerine)?
- F.11 Pericarditis or fluid around the heart?
- F.12 Pericardial constriction (scarring or tightness of the sac around the heart)?
- F.13 Stiff or leaking heart valves?
- F.14 Heart catheterization ("heart cath")?
- F.15 Biopsy of the heart muscle?



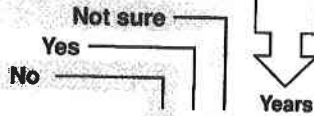
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DO NOT WRITE IN THIS AREA

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

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

If yes, age at first occurrence?



- F.16 Blood clot in head, lung, arm, leg, or pelvis?
- F.17 Does exercise cause severe chest pain, shortness of breath, or irregular heart beat?
- F.18 Have you seen a cardiologist (heart specialist)?
- F.19 Has anyone in your immediate family (biological mother, father, brothers, sisters) had a heart attack before the age of 55?
- F.20 Any other heart or circulatory problems?

If yes, describe this problem.

Males - → Go to Question G.1

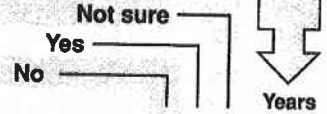
F.21 FEMALES - Heart failure during pregnancy or after delivery?

**RESPIRATORY SYSTEM**

- G.1 Bronchitis?
- G.2 Hay fever?
- G.3 Recurrent sinus infections?
- G.4 Tonsillitis or enlargement of the tonsils or adenoids?
- G.5 Pleurisy (inflammation of the lining of the lungs)?
- G.6 Asthma?
- G.7 Abnormal chest wall?
- G.8 Chronic cough or shortness of breath for greater than one month?
- G.9 Have you ever had a need for extra oxygen?      
If yes, are you currently using extra oxygen?
- G.10 Pneumonia, 3 or more times in the past 2 years?
- G.11 Emphysema?

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

If yes, age at first occurrence?



- G.12 Lung fibrosis or "scarring" of the lung?
- G.13 Any other breathing or lung problems?

If yes, describe this problem.

**DIGESTIVE SYSTEM**

- H.1 Gallstones?
- H.2 Any other gallbladder trouble?

If yes, describe this trouble.

- H.3 Cirrhosis of the liver?
- H.4 Hepatitis?
- H.5 Jaundice?
- H.6 Any other liver trouble?

If yes, describe this trouble.

- H.7 An ulcer?
- H.8 Any disease of the esophagus?

If yes, describe this disease.

- H.9 FREQUENT indigestion?
- H.10 FREQUENT heartburn?      
If yes, do you take medication for it more than once a month?
- H.11 Any other stomach trouble?

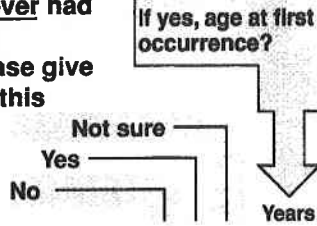
If yes, describe this trouble.

- H.12 Intestinal polyps?
- H.13 Diverticular disease?
- H.14 Colitis?
- H.15 FREQUENT constipation?
- H.16 Chronic diarrhea?
- H.17 Rectal or anal fistula?
- H.18 Rectal or anal stricture (narrowing or scarring)?



It is very important that you mark an answer for each of the following questions, even if you have never had that surgery.

Please indicate if you have ever had any of the following surgical procedures done. If yes, please give your approximate age when this surgery was performed.

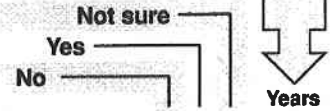


### SURGICAL PROCEDURES

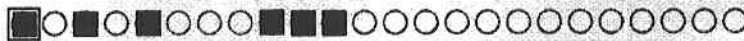
- I.1 Amputation of an arm, leg, hand, foot, finger or toe?      
*If yes, specify.*
- I.2 Scoliosis surgery (insertion of rods or other methods to straighten the spine)?
- I.3 Other surgery of spinal cord or spine?      
*If yes, specify.*
- I.4 Leg lengthening or shortening procedures?
- I.5 Joint replacement?      
*If yes, specify.*
- I.6 Other bone surgery?      
*If yes, specify.*
- I.7 Coronary artery bypass surgery?
- I.8 Pericardiectomy (stripping of the sac around the heart)?
- I.9 Angioplasty (enlarging a heart vessel using a balloon)?
- I.10 Other heart surgery?      
*If yes, specify.*
- I.11 Surgery for intestinal obstruction (blocked intestines)?

Please indicate if you have ever had any of the following surgical procedures done.

If yes, age at first occurrence?



- I.12 Colostomy or ileostomy (stool going into a bag)?
- I.13 Takedown (reconnection) of the colostomy or ileostomy?
- I.14 Surgery to remove a blood clot in an artery or vein?      
*If yes, specify which vein or part of body:*
- I.15 Removal of the thyroid gland in the neck?
- I.16 Removal of the spleen?
- I.17 Ventriculoperitoneal shunt (tube from the brain to the abdomen (under the skin) which removes excess spinal fluid)?
- I.18 Breast surgery for removal or biopsy of a suspicious lump?
- I.19 A bronchoscopy?
- I.20 Other lung surgery?      
*If yes, specify.*
- I.21 A liver biopsy?
- I.22 Reconstructive surgery (surgery to repair damage due to accident or medical therapy or other surgery)?
- I.23 Heart transplant?
- I.24 Lung transplant?
- I.25 Kidney transplant?
- I.26 Bone marrow transplant?
- I.27 Other organ transplant?      
*If yes, specify transplant.*
- I.28 Cataract surgery?
- I.29 Sinus surgery?
- I.30 Surgery on the jaw?
- I.31 Any other surgery?      
*If yes, specify surgery.*

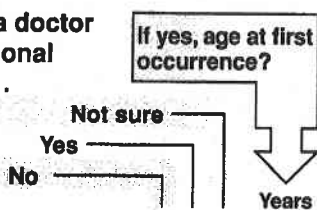


DO NOT WRITE IN THIS AREA

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

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



**BRAIN AND NERVOUS SYSTEM**

- J.1 Cerebral palsy? .....
- J.2 Paralysis of any kind? .....

*If yes, describe this problem.*

- J.3 Mental retardation? .....
- J.4 Epilepsy? .....
- J.5 Repeated seizures, convulsions, or blackouts? .....

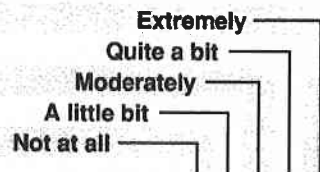
*If yes, describe this problem.*

- J.6 Migraine? .....
- J.7 Other frequent headaches? .....
- J.8 Problems with balance, equilibrium, or ability to reach for or manipulate objects? .....
- J.9 Tremors or problems with movements?.....
- J.10 Weakness or inability to move arm(s)? .....
- J.11 Weakness or inability to move leg(s)? .....
- J.12 Decreased sense of touch or feeling in hands, fingers, arms or legs?.....
- J.13 Prolonged pain or abnormal sensation in arms, legs, or back? .....
- J.14 Problems chewing or swallowing solids or liquids? .....
- J.15 Any other brain or nervous system problems?.....

*If yes, describe this problem.*

The next set of questions (J.16 to J.35) relate to the past 7 days.

Below is a list of problems people sometimes have. Please read each one carefully, and mark the circle to the right that best describes how much that problem has distressed or bothered you during the past 7 days including today. Mark only one circle for each problem and do not skip any items. If you change your mind, erase the first mark carefully.



- J.16 Nervousness or shaking inside .....
- J.17 Faintness or dizziness .....
- J.18 Pains in heart or chest .....
- J.19 Thoughts of ending your life.....
- J.20 Suddenly scared for no reason .....
- J.21 Feeling lonely .....
- J.22 Feeling blue.....
- J.23 Feeling no interest in things .....
- J.24 Feeling fearful.....
- J.25 Your feelings being easily hurt .....
- J.26 Nausea or upset stomach .....
- J.27 Trouble getting your breath.....
- J.28 Hot or cold spells.....
- J.29 Numbness or tingling in parts of your body .....
- J.30 Feeling hopeless about the future ....
- J.31 Feeling weak in parts of your body....
- J.32 Feeling tense or keyed up .....
- J.33 Spells of terror or panic .....
- J.34 Feeling so restless you couldn't sit still .....
- J.35 Feelings of worthlessness .....

**J.36** In this question, we are only interested in whether you have had certain medical conditions in the last 12 months. Please indicate whether you have had any of the following conditions, even if you have mentioned them before.

During the past 12 months, have you had:

	NO	YES		NO	YES		NO	YES
Diabetes? .....	<input type="radio"/>	<input type="radio"/>	Cirrhosis of the liver? .....	<input type="radio"/>	<input type="radio"/>	Bronchitis? .....	<input type="radio"/>	<input type="radio"/>
Epilepsy? .....	<input type="radio"/>	<input type="radio"/>	Hepatitis? .....	<input type="radio"/>	<input type="radio"/>	Hay fever? .....	<input type="radio"/>	<input type="radio"/>
Repeated seizures, convulsions, or blackouts? .....	<input type="radio"/>	<input type="radio"/>	Yellow jaundice? .....	<input type="radio"/>	<input type="radio"/>	Tonsilitis or enlargement of the tonsils or adenoids? .....	<input type="radio"/>	<input type="radio"/>
Repeated kidney infections? .....	<input type="radio"/>	<input type="radio"/>	An ulcer? .....	<input type="radio"/>	<input type="radio"/>	Emphysema? .....	<input type="radio"/>	<input type="radio"/>
Migraine? .....	<input type="radio"/>	<input type="radio"/>	FREQUENT indigestion? .....	<input type="radio"/>	<input type="radio"/>	Pleurisy? .....	<input type="radio"/>	<input type="radio"/>
FREQUENT headaches? .....	<input type="radio"/>	<input type="radio"/>	Diverticulitis? .....	<input type="radio"/>	<input type="radio"/>			
Gallstones? .....	<input type="radio"/>	<input type="radio"/>	Colitis? .....	<input type="radio"/>	<input type="radio"/>			
			FREQUENT constipation? .....	<input type="radio"/>	<input type="radio"/>			

### CANCER, LEUKEMIA OR TUMORS

The following questions (K.1 to K.8) relate to whether you have ever been diagnosed with cancer, leukemia, tumor, or other similar illness.

**K.1** Have you ever been diagnosed with cancer, leukemia, tumor or similar illness?

- No → Go to Question L.1, page 12  
 Yes

**K.2** Please write in the name of this disease.

**K.3** Where was this diagnosed?

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

**K.4** Date of Diagnosis:

Month	Year						
<table border="1" style="border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>			<table border="1" style="border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>				

**K.5** Have you had any additional cancers, leukemias, tumors, or similar illnesses after this diagnosis? (Include any relapse or recurrence of your original diagnosis.)

- No → Go to Question L.1, page 12  
 Yes

**K.6** Please write in the name of this disease.

**K.7** Where was this diagnosed?

Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

**K.8** Was this a:

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

Date of Recurrence or Diagnosis:

Month	Year						
<table border="1" style="border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>			<table border="1" style="border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>				



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## MARITAL STATUS

L.1 Have you ever been married or had a live-in relationship (lived as married)?

- No  
 Yes

→ Go to Question M.1, page 13

L.2 Which of these possibilities best describes your current marital status?

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

L.3 How many times have you been married or lived as married?

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨\*

The following are questions about your first marriage or your first live-in relationship.

L.4 In what year were you first married or what year did you begin living as married?

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

L.5 What type of relationship did you have?

- Formal marriage  
 Living together

L.6 Are you currently in this relationship?

- Yes  
 No

→ Go to Question M.1, page 13

L.7 In what year did you stop living together?

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

L.8 How did this relationship end?

- Divorce/annulment  
 Separation  
 Death of your partner

These questions are about your current or most recent marriage or live-in relationship.

L.9 In what year were you most recently married or what year did you begin living as married?

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

L.10 What type of relationship did you have?

- Formal marriage  
 Living together

L.11 Are you currently in this relationship?

- Yes  
 No

→ Go to Question M.1, page 13

L.12 In what year did you stop living together?

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

L.13 How did this relationship end?

- Divorce/annulment  
 Separation  
 Death of your partner

# OFFSPRING/PREGNANCY HISTORY

M.1 Have you ever been sexually active (had sexual intercourse)?

- No → Go to Question N.1, page 14  
 Yes

M.2 Are you currently sexually active?

- No  
 Yes

M.3 Which forms of birth control have you/your partners used? (Mark all that apply)

	Currently use	
	Used before, but NOT currently	
	Never used	
None .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Birth control pills .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Condoms .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Foam .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Sponge .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Diaphragm .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
IUD .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Rhythm .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Vasectomy .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Tubal ligation (tubes tied) .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Other .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
If other, please specify.		

M.4 Are you, or your partner, currently pregnant?

- No  
 Yes

Go to Question M.5, top of next column

M.5 Was there ever a period in your life when you and a partner tried for one year or more to become pregnant, without success?

- No → Go to Question M.9  
 Yes

M.6 Did you and/or a partner see a doctor because of this?

- No → Go to Question M.9  
 Yes

M.7 Did the doctor find a reason why you or a partner was unable to get pregnant?

- No → Go to Question M.9  
 Yes

If yes, specify.

M.8 Did you ever take medication to help you or a partner try to get pregnant?

- No → Go to Question M.9  
 Yes

If yes, specify.

M.9 Have you and a partner ever become pregnant?

- No → Go to Question N.1, page 14  
 Yes

M.10 Including live births, stillbirths, miscarriages, and abortions, how many times have you become pregnant or had a woman become pregnant by you?

Times

Go to Question M.11

M.11 Please fill in the following information for each of your pregnancies, or each time a woman has become pregnant by you, regardless of the outcome.

Outcome	Your age (years) at beginning of pregnancy	Weeks pregnancy lasted
Medical abortion	36 and over	41 or more weeks
Miscarriage	31 - 35	38 - 40 weeks
Stillbirth	26 - 30	33 - 37 weeks
Live birth	21 - 25	25 - 32 weeks
	15 - 20	12 - 24 weeks
	Under 15	Less than 12 weeks

Pregnancy 1 .....	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
Pregnancy 2 .....	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
Pregnancy 3 .....	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
Pregnancy 4 .....	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
Pregnancy 5 .....	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>

(Please attach a separate sheet of paper, if more than 5 pregnancies.)

# HEALTH HABITS

## Smoking

**N.1** Have you smoked at least 100 cigarettes in your entire life?

No → Go to Question N.2

Yes

**N.1a** About how old were you when you first started smoking cigarettes fairly regularly?

Years old:

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

**N.1b** On average, how many cigarettes a day do/did you smoke?

Cigarettes a day:

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

**N.1c** How many years, in total, have you smoked?

Total years smoked:

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

**N.1d** Do you smoke cigarettes now?

No → Go to Question N.1f

Yes

(Go to N.1e in next column)

**N.1e** During the past two years, did you make a serious attempt to stop smoking cigarettes?

No → Go to Question N.2

Yes

**N.1f** If you have smoked at least 100 cigarettes in your life, but you no longer smoke, how old were you when you last smoked?

Years old:

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

**N.2** Have you ever used any of the tobacco products listed below? (Mark all that apply)

Yes, regularly use   
 Yes, occasionally use   
 Yes, no longer use   
 Never used

Chewing tobacco? .....

Snuff tobacco? .....

Pipes? .....

Cigars? .....

If yes, to any of the above, how long?

11+ years   
 5 - 10 years   
 3 - 4 years   
 1 - 2 years   
 Less than 1 year

Chewing tobacco? .....

Snuff tobacco? .....

Pipes? .....

Cigars? .....

## Alcohol

**N.3** In your entire life, have you ever had at least 2 drinks of any kind of alcoholic beverage?

No → Go to Question N.9, page 15

Yes

(Go to N.4 on next page)



DO NOT WRITE IN THIS AREA

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**N.4 How old were you when you started drinking?**

Years old:

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

**N.5 When you drink, do you most often drink alone or with others?**

- Alone
- With others

**N.6 During the past 2 years, on the average, how many times per month did you drink the following: (If less than one per month, enter 0.)**

	Wine (4 oz. glass):	Beer (12 oz. can):	Mixed drink (1 shot):																																																																																												
Glasses a month	<table border="1"><tr><td>0</td><td>0</td><td>0</td></tr><tr><td>1</td><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td><td>2</td></tr><tr><td>3</td><td>3</td><td>3</td></tr><tr><td>4</td><td>4</td><td>4</td></tr><tr><td>5</td><td>5</td><td>5</td></tr><tr><td>6</td><td>6</td><td>6</td></tr><tr><td>7</td><td>7</td><td>7</td></tr><tr><td>8</td><td>8</td><td>8</td></tr><tr><td>9</td><td>9</td><td>9</td></tr></table>	0	0	0	1	1	1	2	2	2	3	3	3	4	4	4	5	5	5	6	6	6	7	7	7	8	8	8	9	9	9	Cans a month	<table border="1"><tr><td>0</td><td>0</td><td>0</td></tr><tr><td>1</td><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td><td>2</td></tr><tr><td>3</td><td>3</td><td>3</td></tr><tr><td>4</td><td>4</td><td>4</td></tr><tr><td>5</td><td>5</td><td>5</td></tr><tr><td>6</td><td>6</td><td>6</td></tr><tr><td>7</td><td>7</td><td>7</td></tr><tr><td>8</td><td>8</td><td>8</td></tr><tr><td>9</td><td>9</td><td>9</td></tr></table>	0	0	0	1	1	1	2	2	2	3	3	3	4	4	4	5	5	5	6	6	6	7	7	7	8	8	8	9	9	9	Drinks a month	<table border="1"><tr><td>0</td><td>0</td><td>0</td></tr><tr><td>1</td><td>1</td><td>1</td></tr><tr><td>2</td><td>2</td><td>2</td></tr><tr><td>3</td><td>3</td><td>3</td></tr><tr><td>4</td><td>4</td><td>4</td></tr><tr><td>5</td><td>5</td><td>5</td></tr><tr><td>6</td><td>6</td><td>6</td></tr><tr><td>7</td><td>7</td><td>7</td></tr><tr><td>8</td><td>8</td><td>8</td></tr><tr><td>9</td><td>9</td><td>9</td></tr></table>	0	0	0	1	1	1	2	2	2	3	3	3	4	4	4	5	5	5	6	6	6	7	7	7	8	8	8	9	9	9
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**N.7 On the days that you drink, on average, how many drinks do you have?**

- No drinks in the past 2 years
- One drink/day
- Two drinks/day
- Three drinks/day
- Four drinks/day
- Five drinks/day
- Six or more drinks/day

**N.8 Have you had at least one drink of beer, wine, or liquor during the past year?**

- No
- Yes

**Physical Activity**

**N.9 On how many of the past 7 days did you exercise or do sports for at least 20 minutes that made you 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

**N.10 Because of any impairment or health problems, do you need the help of other persons with personal care needs, such as eating, bathing, dressing, or getting around your home?**

- No
- Yes

**N.11 Because of any impairment or health problems, do you 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

**N.12 Does any impairment or health problem keep you from holding a job or attending school?**

- No
- Yes

**N.13 Do you currently have a driver's license?**

- No
- Yes

**N.14 Over the last 2 years, how long (if at all) has your health limited you in each of the following activities? (Mark one circle on each line)**

Not limited at all  
 Limited for 3 months or less  
 Limited for more than 3 months

- a. The kinds or amounts of vigorous activities you can do, like lifting heavy objects, running or participating in strenuous sports .....
- b. The kinds or amounts of moderate activities you can do, like moving a table, carrying groceries or bowling ....
- c. Walking uphill or climbing a few flights of stairs .....
- d. Bending, lifting or stooping .....
- e. Walking one block .....
- f. Eating, dressing, bathing, or using the toilet .....

**Health Practices**

**N.15 Would you say that your health is:**

- Excellent
- Very good
- Good
- Fair
- Poor

**N.16** 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 you had a general physical examination when you were not sick?

- Less than 1 year ago
- 1 - 2 years ago
- 3 - 4 years ago
- 5 or more years ago
- Never

**N.17** How long has it been since you last went to a dentist?

- Less than 1 year ago
- 1 - 2 years ago
- 3 - 4 years ago
- 5 or more years ago
- Never

Females - → Go to Question N.19

**N.18 MALES-** How often do you perform monthly testicular self-examination?

- Regularly (once a month)
- Occasionally
- Rarely or never

Males - → Go to Question O.1

**N.19 FEMALES-** How often do you perform monthly breast self-examination?

- Regularly (once a month)
- Occasionally
- Rarely or never

**N.20 FEMALES-** When was the last time you had a Pap smear (test for cancer of the cervix)?

- Less than 1 year ago
- 1 - 2 years ago
- 3 - 4 years ago
- 5 or more years ago
- Never

**N.21 FEMALES-** When was the last time you had a breast examination by a doctor or a health care professional?

- Less than 1 year ago
- 1 - 2 years ago
- 3 - 4 years ago
- 5 or more years ago
- Never

**N.22 FEMALES-** Have you ever had a mammogram?

- No
- Yes → Age at first mammogram

### SCHOOL HISTORY

**O.1** What is the highest grade or level of schooling that you have completed?

- 1 - 8 years (grade school)
- 9 - 12 years (high school), but did not graduate
- Completed high school
- Training after high school, other than college
- Some college
- College graduate
- Post graduate level

**O.2** If you have completed high school, did you receive a regular high school diploma or did you receive a high school equivalency certificate, also called a GED?

- Standard diploma
- GED

**O.3** In elementary, junior, or high school were you ever in any of the following programs? (Mark all that apply)

	Not sure	
	Yes	
	No	
Learning disabled or special education program? .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
<b>If yes, were you in the program because of:</b>		
- missed school .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
- low scores on tests .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
- problems learning or concentrating ..		<input type="radio"/> <input type="radio"/> <input type="radio"/>
- emotional or behavioral problems ..		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Advanced placement or talented program? .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>
Homebound education for at least one school year? .....		<input type="radio"/> <input type="radio"/> <input type="radio"/>

**O.4** If you were in a learning disabled or special education program, what grades were you in at that time? (Mark all that apply)

- |                           |                            |
|---------------------------|----------------------------|
| <input type="radio"/> K   | <input type="radio"/> 7th  |
| <input type="radio"/> 1st | <input type="radio"/> 8th  |
| <input type="radio"/> 2nd | <input type="radio"/> 9th  |
| <input type="radio"/> 3rd | <input type="radio"/> 10th |
| <input type="radio"/> 4th | <input type="radio"/> 11th |
| <input type="radio"/> 5th | <input type="radio"/> 12th |
| <input type="radio"/> 6th |                            |



DO NOT WRITE IN THIS AREA

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## EMPLOYMENT HISTORY

**O.5 Have you ever had a job?**

- No → Go to Question O.10  
 Yes

**O.6 During the last 12 months, did you work at any time at a job or business, not counting work around the house? (Include unpaid work in the family business or farm.)**

- Yes → Go to Question O.8  
 No

**O.7 How long has it been since you last worked at a job or business?**

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

- Weeks  
 Months  
 Years

→ Go to Question O.10

**O.8 What kind of business or industry was this job in? (For example, TV and radio manufacturing, retail shoe store, farming.)**

*Describe business or industry.*

**O.9 During the last 12 months, approximately how many days of sick time did you take?**

Days:

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

**O.10 Have you ever applied for entry into the following services?**

	Yes <input type="checkbox"/>
	No <input type="checkbox"/>
Military (Army, Navy, etc.) .....	<input type="checkbox"/> <input type="checkbox"/>
Police Department .....	<input type="checkbox"/> <input type="checkbox"/>
Fire Department .....	<input type="checkbox"/> <input type="checkbox"/>

**O.11 Have you ever not gotten a job or into military service because of your previous medical history?**

	Yes <input type="checkbox"/>
	No <input type="checkbox"/>
Civilian job .....	<input type="checkbox"/> <input type="checkbox"/>
Military (Army, Navy, etc.) .....	<input type="checkbox"/> <input type="checkbox"/>
Police Department .....	<input type="checkbox"/> <input type="checkbox"/>
Fire Department .....	<input type="checkbox"/> <input type="checkbox"/>

## FAMILY HISTORY INFORMATION

Conditions or illnesses occurring in family members may be important clues in determining our genetic make-up. This section of the questionnaire deals with cancer, conditions present at birth, and hereditary conditions which may be present in you or in your family members. Please use the list below to complete the following section.

### Cancer

Any diagnosis of cancer or malignant tumor, such as:

Leukemia	Wilms tumor
Retinoblastoma	Lymphoma
Brain tumor	Teratoma
Hodgkins disease	Seminoma
Sarcoma	Neuroblastoma
Germ cell tumor	Carcinoma
Cancer - Any other type, or location unknown	
Skin cancer - please note if melanoma or non-melanoma. (Non-melanoma, also called basal cell or squamous cell carcinoma of the skin, is usually removed in the doctors office, with no further treatment needed.)	

### Conditions Present At Birth

Any abnormality present at birth, such as:

Blindness or difficulty seeing	Hole in the heart
Crossed eyes (Strabismus)	Other congenital heart defect
Eyes different colors	Mongolism (Down's syndrome, Trisomy 21)
Hare lip (Cleft lip)	Open spine (Spina bifida)
Hole in roof of mouth (Cleft palate)	Exposed brain (Anencephaly)
Absent, fused or extra fingers or toes	Large or multiple birth marks
Hip displacement	Water on the brain (Hydrocephalus)
Diverted urinary stream (Hypospadias)	Macrocephaly (Enlarged head)
Undescended testicle (Cryptorchism)	Microcephaly (Small head)
Deafness or impaired hearing	Hemihypertrophy (Enlargement of one arm or leg)
Shortened limbs	Deformed chest
Club foot	Other skeletal abnormality

### Hereditary Conditions

Some of the more common conditions known to be hereditary:

Achondroplasia	Multiple polyposis
Acrocephalosyndactyly	Myotonic dystrophy
Aniridia	Neurofibromatosis (type 1)
Apert's syndrome	Nevoid basal cell carcinoma syndrome
Ataxia-telangiectasia	Osteogenesis imperfecta
Beckwith-Wiedemann syndrome	Polycystic disease of the kidney
Bilateral acoustic neurofibromatosis (type 2)	Polyposis coli (Gardner's syndrome)
Bloom's syndrome	Tuberous sclerosis
Congenital megacolon (Hirschsprung's disease)	Turner's syndrome
Cystic fibrosis	von Hippel-Lindau syndrome
Fanconi's anemia	von Recklinghausen's disease
Klinefelter's syndrome	Wiskott-Aldrich syndrome
Marfan's syndrome	Xeroderma pigmentosum
Multiple exostoses	



DO NOT WRITE IN THIS AREA

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Please complete this section on yourself, all your own (biological or natural) children and parents of these children. It is very important that you include everyone, even those who did not have conditions listed on the previous page.

- If the following individuals have had a history of cancer, a birth defect and/or one of the hereditary conditions listed on the previous page, please write the type of cancer, birth defect, or hereditary condition into the spaces provided. Include all stillborn children (a stillbirth is a pregnancy more than 20 weeks). Fill out the medical history section whether this individual is alive or dead. If the individual has died of another cause (like an accident) and never had any of these illnesses, or if he/she is still living and does not have any of these, write NONE in the medical history section. Enter "0" for age at onset if present at birth or found in the first year of life.

**EXAMPLE OF FAMILY HISTORY**

Full Name (First, Middle, Last)	Sex	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Birth Defect, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
John Paul Smith	<input checked="" type="radio"/> Male <input type="radio"/> Female	5/11/51	<input checked="" type="radio"/> Alive <input type="radio"/> Dead		None	
Sharon Marie Smith	<input type="radio"/> Male <input checked="" type="radio"/> Female	6/29/55	<input type="radio"/> Alive <input checked="" type="radio"/> Dead	11/5/90	Leukemia	29
Peter Quintin Smith	<input checked="" type="radio"/> Male <input type="radio"/> Female	2/15/62	<input checked="" type="radio"/> Alive <input type="radio"/> Dead		Aniridia Wilms Tumor	0 3
Unnamed (stillbirth)	<input type="radio"/> Male <input checked="" type="radio"/> Female	4/20/63	<input type="radio"/> Alive <input checked="" type="radio"/> Dead	4/20/63	None	

**P.1 YOURSELF**

Full Name (First, Middle, Last)	Sex	Date of Birth (Mo/Day/Yr)	Medical History of Cancer, Birth Defect, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
	<input type="radio"/> Male <input type="radio"/> Female			

Please go on to the next page

**P.2 YOUR CHILDREN (IF ANY)**

• If you have not had any children → Go to Question Q.1, page 21

Full Name (First, Middle, Last)	Sex	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Birth Defect, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			
	<input type="radio"/> Male <input type="radio"/> Female		<input type="radio"/> Alive <input type="radio"/> Dead			

(If you need more space, please use a separate sheet of paper, and attach it to this page.)

**P.3 OTHER PARENT OF YOUR CHILDREN**

• This section concerns the birth (or biological) parents of your children listed above. Please write in the other parent (or parents) of your children.

Full Name (First, Middle, Last)	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Birth Defect, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
		<input type="radio"/> Alive <input type="radio"/> Dead			

If all of your children do not have the same other parent, please list the names of the biological children of this parent.

Full Name (First, Middle, Last)	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Birth Defect, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
		<input type="radio"/> Alive <input type="radio"/> Dead			

Please list the names of the biological children of this parent.

Attach an additional sheet if needed.

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# INSURANCE

**Q.1** Have you ever had difficulty in obtaining health insurance because of your health history?

- No
- Yes

**Q.2** Do you currently have health insurance coverage?

Canadian Resident **→ Go to Question Q.4**

No **→ Go to Question Q.4**

Yes  
↓

**Q.3** How is this health insurance provided? (Mark all that apply)

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

*specify*  
[ ]

**Q.3a** Does this health insurance plan have any exclusions or restrictions because of your health history?

- Don't know
- No
- Yes

*specify*  
[ ]

**Q.3b** Is there an extra premium charge on your health insurance policy because of your health history?

- Don't know
- No
- Yes

**Q.4** Have you ever had difficulty in obtaining life insurance because of your health history?

- No
- Yes
- Never tried to obtain life insurance

**Q.5** Do you currently have life insurance coverage?

- No **→ Go to Question Q.7, page 22**
- Yes

**Q.6** How is this life insurance provided? (Mark all that apply)

- Through your employer
- Through your spouse's or parent's policy
- Through a policy you have purchased yourself
- Other *specify*

[ ]

**Q.6a** Does this life insurance plan have any exclusions or restrictions?

- Don't know
- No
- Yes

*specify*  
[ ]

**Q.6b** Is there an extra premium charge on your life insurance policy because of your health history?

- Don't know
- No
- Yes

**Q.6c** What is the total dollar value of your life insurance policy(ies)?

- Under \$10,000
- \$10,000 - \$49,999
- \$50,000 - \$99,999
- \$100,000 or more
- Don't know

**RELIGION**

**Q.7 What is your religious preference?**

- None
- Catholic
- Lutheran
- Baptist
- Presbyterian
- Episcopalian
- Methodist
- Other Protestant
- Jewish
- Other

*Please specify*

**INCOME**

**Q.8 Over the last year, what is the total income of the household you live in?**

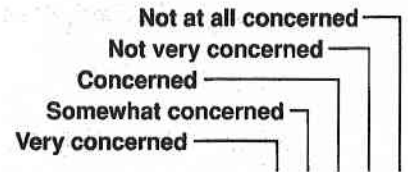
- Less than \$9,999
- \$10,000 - \$19,999
- \$20,000 - \$39,999
- \$40,000 - \$59,999
- Over \$60,000

**Q.9 Over the last year, what is your personal income?**

- None
- Less than \$9,999
- \$10,000 - \$19,999
- \$20,000 - \$39,999
- \$40,000 - \$59,999
- Over \$60,000

**OTHER ISSUES**

Please rate how concerned you are about the following issues.



- R.1 Your future health ..... ○○○○○
- R.2 Your ability to have children ..... ○○○○○
- R.3 Developing a cancer ..... ○○○○○
- R.4 Your ability to get health insurance .. ○○○○○
- R.5 Your ability to get life insurance ..... ○○○○○
- R.6 Any other issues ..... ○○○○○

*Please specify*



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**R.7 Are you planning on moving in the next six months, or do we have your correct address?**

- Address correct as shown on envelope
- Address correction
- Moving

**R.7a Could you please give your new address or location:**

Address	
_____	
City	
_____	
State	Zip Code
_____	_____

Future address not known

**R.8 What is your current telephone number?**

Area Code
(       )

**R.9 It would be helpful if you could provide us with the name and address of someone who could give us your new address should you move. We would contact this person only if we are unable to reach you at your home address:**

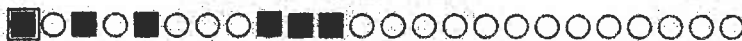
Name	
_____	
Address	
_____	
City	
_____	
State	Zip Code
_____	_____

**After completing this questionnaire, please return by using the enclosed envelope, and mail to:**

**Leslie L. Robison, Ph.D.  
University of Minnesota  
Suite 300  
1300 S. Second St.  
Minneapolis, MN 55454**

**Again, thank you for your help and your participation in this study!**

ID # _____
Consents Mailed _____
Resend Consents _____



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