UNIVERSITY OF MINNESOTA

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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 CENTER, WASHINGTON DANA FARBER CANCER INSTITUTE, BOSTON HENRY FORD HOSPITAL, DETROIT MEMORIAL SLOAN-KETTERING CANCER CENTER, NEW YORK MINNEAPOLIS CHILDREN'S MEDICAL CENTER MOTT CHILDREN'S HOSPITAL, ANN ARBOR RILEY CHILDREN'S HOSPITAL, INDIANAPOLIS ST. JUDE CHILDREN'S RESEARCH HOSPITAL, MEMPHIS ST. LOUIS CHILDREN'S HOSPITAL STANFORD UNIV. SCHOOL OF MEDICINE, PALO ALTO UNIVERSITY OF ALABAMA, BIRMINGHAM UNIVERSITY OF MINNESOTA, MINNEAPOLIS UT-SOUTHWESTERN MEDICAL CENTER, DALLAS FOR SICK CHILDREN, TORONTO

Long-Term Follow-Up Study

of Individuals Treated for Cancer, Leukemia, Tumor or Similar Illness

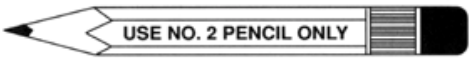
Person completing this questionnaire is _____
(Please print your full name)

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.

CORRECT	INCORRECT
Ⓐ Ⓑ Ⓒ ●	⊗ ✓ ◉ ◒

Written responses must stay within the boxes provided.

CORRECT	INCORRECT
grape	grape

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

00785

A.1 What is your date of birth?

Write the numbers in the boxes. →
Then fill in the matching circles. →

Month | Day | Year (1 9 _ _)

A.2 What is your sex?
- ○ Male
- ○ Female

A.3 What is your social security number?

___ – ___ – ____

- ○ 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 *specify*

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.

A.8 Please describe your current residence.
- ○ Single family dwelling - unattached (house)
- ○ Single family dwelling - attached (townhouse or condominium)
- ○ Apartment
- ○ Dormitory
- ○ Other *specify*

A.9 Concerning your current residence, do you:
- ○ Own your residence
- ○ Rent
- ○ Live with parents
- ○ Other *specify*

A.10 What is your current height without shoes? ___ feet, and ___ inches

A.11 What is your current weight without shoes? ___ pounds

Medical Care

The next questions are about health care received during the 2 year period between July 1, 1992 and June 30, 1994.

B.1 Between July 1, 1992 and June 30, 1994 (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.8, 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 → **Go to Question B.5**
- ○ 1 - 2 times
- ○ 3 - 4 times
- ○ 5 - 6 times
- ○ 7 - 10 times
- ○ 11 - 20 times
- ○ More than 20 times

B.4 As you know, you were asked to participate in this study because you were once diagnosed with a cancer, leukemia, tumor, or similar illness. How many of the above visits to the physician were related to this previous illness?

- ○ 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 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.6 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.7 During this 2 year period (July 1, 1992 to June 30, 1994), did you have any operations or surgeries?

- ○ No
- ○ Yes

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00785

B.8 On these 2 pages, we would like to know about medicines/drugs you have taken during the 2 year period between July 1, 1992 and June 30, 1994. 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).

	No	Yes	Not sure
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, Diabinase, 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), Ansaid, 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 (Rocalcetrol) or others	○	○	○
If yes, specify the name of the drug(s).			

	No	Yes	Not sure
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 Cytoxan, 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.9 At the present time, do you have any of the following?

	No	Yes
Persistent hair loss	○	○
Scarring or disfigurement of the head or neck region (including the face)	○	○
Scarring or disfigurement of the chest or abdomen region	○	○
Scarring or disfigurement of the arms or legs (including an abnormally short arm or leg)	○	○
Walk with a limp	○	○
Loss of an arm, leg, finger or toe	○	○
Loss of an eye	○	○
Other	○	○

specify

DO NOT WRITE IN THIS AREA

00785

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

	Not sure	Yes	No	If yes, age at first occurrence? (Years)
G.1 Hay fever?		●	○	
G.2 Recurrent sinus infections or sinus surgery?		○	●	6

HEARING/VISION/SPEECH

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

	Not sure	Yes	No	If yes, age at first occurrence? (Years)
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...

	Not sure	Yes	No	If yes, age at first occurrence? (Years)
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...

	Not sure	No	Yes	If yes, age at first occurrence? (Years)

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... (Not sure / Yes / No; If yes, age at first occurrence? Years)

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, (Arrythmia) requiring medication or follow-up by a doctor? ..... ○ ○ ○ ☐
F.4 Congestive heart failure or cardio-myopathy (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? ..... ○ ○ ○ ☐

00785

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?

Not sure / Yes / No — Years

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?

Not sure / Yes / No — Years

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.

If yes, age at first occurrence?

Not sure | Yes | No

Years

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?

Not sure | Yes | No

Years

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 since your therapy stopped? ..... ○○○ ☐☐

I.20 Other lung surgery? ..... ○○○ ☐☐

If yes, specify.

I.21 A liver biopsy since your therapy stopped? ..... ○○○ ☐☐

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

00785

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. . .

If yes, age at first occurrence?

Not sure | Yes | No | Years

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.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
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 Do you currently have pain as a result of your cancer, leukemia, tumor or similar illness, or its treatment?

○ No pain
○ Small amount of pain
○ Medium amount of pain
○ A lot of pain
○ Very bad excruciating pain

If you have pain, where is it? (name all areas)

J.37 Do you currently have anxieties/fears as a result of your cancer, leukemia, tumor or similar illness, or its treatment?

○ No anxiety/fears
○ Small amount of anxiety/fears
○ Medium amount of anxiety/fears
○ A lot of anxiety/fears
○ Very many, extreme anxiety/fears

J.38 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?	○	○	Cirrhosis of the liver?	○	○	Bronchitis?	○	○
Epilepsy?	○	○	Hepatitis?	○	○	Hay fever?	○	○
Repeated seizures, convulsions, or blackouts?	○	○	Yellow jaundice?	○	○	Tonsilitis or enlargement of the tonsils or adenoids?	○	○
Repeated kidney infections?	○	○	An ulcer?	○	○	Emphysema?	○	○
Migraine?	○	○	FREQUENT indigestion?	○	○	Pleurisy?	○	○
FREQUENT headaches?	○	○	Diverticulitis?	○	○			
Gallstones?	○	○	Colitis?	○	○			
			FREQUENT constipation?	○	○			

CANCER, LEUKEMIA OR TUMORS

As you know, you were diagnosed with a cancer, leukemia, tumor, or other similar illness. The following questions (K.1 to K.8) relate to the diagnosis of another cancer, leukemia, tumor, or other similar illness, or a recurrence (relapse) of your original diagnosis, which has occurred since the first one.

K.1 At any time following this original diagnosis, were you diagnosed with another cancer, leukemia, tumor or similar illness? (Include any relapse or recurrence of your original diagnosis).

○ 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 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
	1 9

K.5 Have you had any additional cancers, leukemias, tumors, or similar illnesses after this second one?

○ 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
	1 9

00785

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MARITAL STATUS

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

- ○ No → **Go to Question M.1, page 13**
- ○ Yes

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 _ _

L.5 What type of relationship did you have?

- ○ Formal marriage
- ○ Living together

L.6 Are you currently in this relationship?

- ○ Yes → **Go to Question M.1, page 13**
- ○ No

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

Year: 1 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 _ _

L.10 What type of relationship did you have?

- ○ Formal marriage
- ○ Living together

L.11 Are you currently in this relationship?

- ○ Yes → **Go to Question M.1, page 13**
- ○ No

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

Year: 1 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	○	○	○
Birth control pills	○	○	○
Condoms	○	○	○
Foam	○	○	○
Sponge	○	○	○
Diaphragm	○	○	○
IUD	○	○	○
Rhythm	○	○	○
Vasectomy	○	○	○
Tubal ligation (tubes tied)	○	○	○
Other	○	○	○

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: Live birth	Stillbirth	Miscarriage	Medical abortion	Your age (years) at beginning of pregnancy: Under 15	15 - 20	21 - 25	26 - 30	31 - 35	36 and over	Weeks pregnancy lasted: Less than 12 weeks	12 - 24 weeks	25 - 32 weeks	33 - 37 weeks	38 - 40 weeks	41 or more weeks
Pregnancy 1	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pregnancy 2	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pregnancy 3	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pregnancy 4	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pregnancy 5	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

(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 1 2 3 4 5 6 7 8 9

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

Cigarettes a day: 0 1 2 3 4 5 6 7 8 9

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

Total years smoked: 0 1 2 3 4 5 6 7 8 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 1 2 3 4 5 6 7 8 9

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

	Never used	Yes, no longer use	Yes, occasionally use	Yes, regularly use
Chewing tobacco?	○	○	○	○
Snuff tobacco?	○	○	○	○
Pipes?	○	○	○	○
Cigars?	○	○	○	○

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

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

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

Years old:

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.)

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)

	No	Yes	Not sure
Learning disabled or special education program?	○	○	○
If yes, were you in the program because of:			
- missed school	○	○	○
- low scores on tests	○	○	○
- problems learning or concentrating	○	○	○
- emotional or behavioral problems	○	○	○
Advanced placement or talented program?	○	○	○
Homebound education for at least one school year?	○	○	○

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)

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

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00785

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?

- ○ 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:

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

	Yes	No
Military (Army, Navy, etc.)	○	○
Police Department	○	○
Fire Department	○	○

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

	Yes	No
Civilian job	○	○
Military (Army, Navy, etc.)	○	○
Police Department	○	○
Fire Department	○	○

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
Retinoblastoma
Brain tumor
Hodgkins disease
Sarcoma
Germ cell tumor
Cancer - Any other type, or location unknown
Wilms tumor
Lymphoma
Teratoma
Seminoma
Neuroblastoma
Carcinoma
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

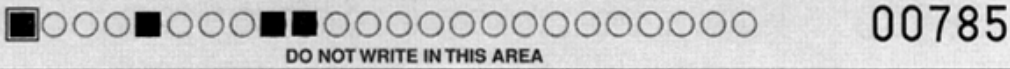
Any abnormality present at birth, such as:

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

Hereditary Conditions

Some of the more common conditions known to be hereditary:

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



DO NOT WRITE IN THIS AREA

Please complete this section on all members of your family. It is very important that you include everyone, even those family members who did not have conditions listed on the previous page.

- **If a family member has 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 person is alive or dead. If the person died of another cause (like an accident) and never had any of these illnesses, or if the person 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	● Male ○ Female	5/11/51	● Alive ○ Dead		None	
Sharon Marie Smith	○ Male ● Female	6/29/55	○ Alive ● Dead	11/5/90	Leukemia	29
Peter Quintin Smith	● Male ○ Female	2/15/62	● Alive ○ Dead		Aniridia Wilms Tumor	0 3
Unnamed (stillbirth)	○ Male ● Female	4/20/63	○ Alive ● 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.)
	○ Male ○ Female			

P.2 YOUR FULL BROTHERS AND SISTERS (those with the same mother and father as you)

- **Please write in the name of all of your brothers and sisters (living or dead) in this section, whether they have had one of these conditions or not.**

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.)
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			

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

Please go on to the next page

P.3 YOUR PARENTS

- **This section concerns your birth (biological) parents. Please use this section to record any cancers, birth defects and/or hereditary conditions which have occurred in your parents (if any).**

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.)
Mother		○ Alive ○ Dead			
Father		○ Alive ○ Dead			

YOUR HALF-BROTHERS AND HALF-SISTERS (IF ANY)

- **If you do not have half-brothers or half-sisters** → Go to Question P.6, page 21

- **This section concerns your half-brothers and half-sisters (if any). Please list all half-brothers and half-sisters and record cancers, birth defects and/or hereditary conditions which have occurred. Please follow the instructions given on the top of the previous page.**

P.4 OTHER CHILDREN OF YOUR MOTHER

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.)
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			

P.5 OTHER CHILDREN OF YOUR FATHER

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.)
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			

Attach an additional sheet if needed.

00785

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P.6 YOUR CHILDREN (IF ANY)

- **If you have not had any children** → Go to Question P.8, page 22
- **This section concerns <u>your</u> own (biological or natural) children (if any). Please list all of your children and record cancers, birth defects, and/or hereditary conditions which have occurred. Please follow the instructions given on the top of page 19.**

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.)
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			
	○ Male ○ Female		○ Alive ○ Dead			

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

P.7 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.)
		○ Alive ○ 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.)
		○ Alive ○ Dead			
Please list the names of the biological children of this parent.					

Attach an additional sheet if needed.

P.8 Do you have any more distant relatives, such as your grandparents, cousins, aunts, uncles, nieces or nephews who had cancer before they were 45 years old?

- ○ No → **Go to Question Q.1**
- ○ Yes

If yes, write in the name, relationship to you, the type of cancer and age when this relative had cancer.

Full Name	Relationship To You	Side of Family	Type Of Cancer	Age When Cancer Occurred
		○ Mother ○ Father		
		○ Mother ○ Father		
		○ Mother ○ Father		
		○ Mother ○ Father		
		○ Mother ○ Father		

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 23**
- ○ Yes

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00785

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.

	Not at all concerned	Not very concerned	Concerned	Somewhat concerned	Very concerned
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

Please go on to the next page

R.7 For our future planning, what type of information or help do you think should be available to survivors of childhood cancer, leukemia, tumor or similar illness?

Attach additional pages, if necessary.

R.8 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.8a Could you please give your new address or location:

Address _____

City _____

State **Zip Code**

- ○ Future address not known

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!

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