

LTFU

Long-Term Follow-Up



Thank you for participating in the Long-Term Follow-Up Study. Your participation in this research continues to provide us with valuable information in the fight against childhood cancer and similar illnesses.

It has been a few years since we sent you our last general survey and we would now like to update your information. By completing this survey, you will bring us up-to-date on your health. The length of time to complete this survey varies, but generally takes 30-60 minutes. You can mail the completed survey to us using the enclosed envelope.

You can also complete this survey online at: www.stjude.org/LTFUsurveyS

Your personalized login ID is your date of birth. Your password is:

If you prefer to complete the survey with a trained interviewer over the phone, then please contact us toll free at 1-800-775-2167 or via email at LTFU@stjude.org.

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

Your generosity in participating is greatly appreciated.

Sincerely,

The LTFU study staff

The questions in this survey relate to:

Today's date:

 / / 201

Person completing this survey is:

Your relationship:

Self Parent Other: _____

↓
If you are completing the survey on the participant's behalf, be aware that all survey questions are about

Please! Do not mark below this line

Edit

Survey #204

Code

8840644385

Participating Institutions

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

Our mailing address is:

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1-800-775-2167

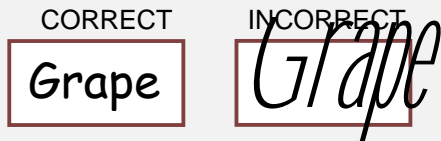
e-mail: LTFU@stjude.org

www.stjude.org/ltfu

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

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

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



MARKING EXAMPLES

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

Example 1

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

No Yes

Not sure		If yes, age at first use
Yes		
No		

Example 2

2. Have you ever taken. . .

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

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

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- b. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES, such as lovastatin, Zocor (simvastatin), Pravachol (pravastatin), Crestor, Lipitor, Zetia, Tricor, Vytorin, gemfibrozil-----

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

MEVACOR

<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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3	4
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Example 3

3. When was this condition diagnosed?

0	4
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Month (mm)

1	9	9	5
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Year (yyyy)

In the past we have asked you questions similar to those below. We would like to update this information.

A1. What is your current height without shoes?

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Feet Inches

A2. What is your current weight without shoes?

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Pounds

A3. Since this time last year, have you lost more than 10 pounds unintentionally (not due to dieting or exercise)?

- Yes
- No
- Not sure

A4. What is the highest grade or level of schooling you have now completed?

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

If Other, please describe.

A5. What is your current employment status? Include unpaid work in the family business or farm. *(Mark all that apply)*

- Working full-time (30 or more hours per week)
- Working part-time (less than 30 hours per week)
- Caring for home or family (not seeking paid work)
- Unemployed and looking for work
- Unable to work due to illness or disability
- Retired
- Student
- Other

If Other, please describe.

If you are not currently working full or part time. . .

➔ **Go to Question A7.**

A6. The following questions are about your present occupation. Please write your job title and brief details of what you do. If you have more than one job, please give the title of your main job.

A6a. Main job title:

A6b. Please briefly describe the primary tasks in your job:

A7. Over the last year, what was the total income of the household you live in?

- Less than \$20,000
- \$20,000 - \$39,999
- \$40,000 - \$59,999
- \$60,000 - \$79,999
- \$80,000 - \$99,999
- Over \$100,000
- Don't know

A8. During the past year, how many people in this household were supported on this income?

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

A9. Over the last year, what was your personal income?

- None
- Less than \$20,000
- \$20,000 - \$39,999
- \$40,000 - \$59,999
- \$60,000 - \$79,999
- \$80,000 - \$99,999
- Over \$100,000

A10. Do you currently have health insurance coverage?

- Canadian resident
- No
- Yes

MEDICAL CARE

B1. During the 2 year period between April 2015 and April 2017, which of the following healthcare providers (excluding dentists) did you see or talk to for medical care? This includes routine and sick care. (Mark all that apply)

- None → Go to Question B3.
- Primary care clinician in the community (e.g., family physician, general internist, pediatrician, nurse practitioner, physician's assistant)
- Clinician at a cancer center (e.g., oncologist, nurse practitioner or physician's assistant, other cancer specialist)
- Other Medical specialist (e.g., endocrinologist, cardiologist, surgeon)
- Psychiatrist
- Psychologist or counselor
- Physical or occupational therapist
- Other

If Other, please specify.

B2. During this 2 year period, how many times did you see a doctor?

- None 7-10 times
- 1-2 times 11-20 times
- 3-4 times More than 20 times
- 5-6 times

B3. During the PAST 12 MONTHS, how many times have you gone to a HOSPITAL EMERGENCY ROOM about your own health (This includes emergency room visits that resulted in a hospital admission)?

times

B4. How often do you carefully check your whole body (including the skin on your back and back of your legs) for any sign of skin cancer?

- Once a month
- Every few months
- Every 6 months
- Every year
- Never

B5. In the PAST 12 MONTHS, has your regular healthcare provider carefully examined your whole body for any sign of skin cancer?

- No
- Yes
- Not sure

MEDICAL TESTS

C1. The following questions are about medical screening tests you may have received.

When was the last time you had . . .

	Never	Less than 1 year ago	1-2 years ago	More than 2 years but less than 5 years ago	5 or more years ago	I had one, but I don't recall when	I don't know if I ever had one
a. An echocardiogram (ultrasound of the heart to look at the heart muscle and heart valves) or a MUGA scan?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. An MRI of your heart (you were placed inside of a scanner, like a long tube)?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. An MRI of the head or brain?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. A test to measure your bone strength or bone mineral density (such as a DEXA scan)?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. A home blood stool test to determine whether your stool contains blood?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sigmoidoscopy or colonoscopy to view the colon for signs of cancer or other problems?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. An ultrasound of the thyroid gland?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. An ultrasound of the carotid arteries (blood vessels in the neck)?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. A skin exam for skin cancer by a healthcare provider?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For females							
j. A mammogram?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. A breast ultrasound?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. A breast MRI?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. A pap smear?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For males							
n. A PSA or blood test to detect prostate cancer?-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C2. Please indicate all medicines/drugs you took *regularly* during the two-year period between **April 2015 and April 2017.**

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

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

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

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

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

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

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

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

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

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

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

	If yes, age at first use			If yes, are you currently taking?	
	No	Yes	Not sure	No	Yes
1. BIRTH CONTROL PILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. ESTROGENS OR PROGESTERONES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. TESTOSTERONES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. PILLS OR INSULIN FOR DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C2. (Cont.) Please indicate all medicines/drugs you took *regularly* during the two-year period between **April 2015 and April 2017.**

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

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

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

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

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

	No	Yes	Not sure
5. MEDICATIONS FOR HIGH BLOOD PRESSURE OR HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. MEDICATIONS FOR HEART CONDITIONS, INCLUDING ANGINA, CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE, OR IRREGULAR HEART BEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. THYROID MEDICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, age at first use

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If yes, are you currently taking?

No	Yes
<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="checkbox"/>	<input type="checkbox"/>
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Please! Do not mark below this line

C2. (Cont.) Please indicate all medicines/drugs you took *regularly* during the two-year period between **April 2015 and April 2017.**

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

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

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

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

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

10. MEDICATIONS FOR ATTENTION OR MEMORY PROBLEMS such as Ritalin, Adderall, Concerta, Strattera, Aricept (donepezil), or Provigil (modafinil)-----

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

11. OTHER PRESCRIBED DRUGS-----

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

	No	Yes	Not sure	If yes, age at first use	If yes, are you currently taking?	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
9. MEDICATIONS FOR DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. MEDICATIONS FOR ATTENTION OR MEMORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. OTHER PRESCRIBED DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medical Conditions

The next series of questions relate to medical conditions that you have ever had. You may have previously told us about some of these conditions. We are asking again to make sure our records are current and to capture occurrences of new medical conditions.

Please indicate, by marking the box (either "No", "Yes", or "Not sure") if a doctor or other health care professional has told you that you have or have had any of the following conditions. If you answer "yes", please give your age when the condition first occurred.

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).**

HEARING/VISION/SPEECH

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

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence
D1. Hearing loss requiring a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D2. Deafness in both ears not completely corrected by hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D3. Deafness in only one ear not completely corrected by hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D4. Tinnitus or ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D5. Persistent dizziness or vertigo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D6. Hearing loss, not requiring a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D7. Any other hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe the other hearing problem(s). List the age at first occurrence for each problem separately.

D8. Legally blind in only one eye?

If yes, do you have any sight in this eye?
 No Yes

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

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence
D9. Legally blind in both eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
If yes, do you have any sight? <input type="checkbox"/> No <input type="checkbox"/> Yes					
D10. Cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D11. Glaucoma (excess pressure in the eyeball)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D12. Problems with double vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D13. A detached retina or any other condition of the retina?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe the other condition(s). List the age at first occurrence for each condition separately.

D14. Crossed or turned eyes (strabismus)?

D15. Lazy eye (amblyopia)?

D16. Any other trouble seeing with one or both eyes even when wearing glasses?

D17. Very dry eyes requiring eye drops or ointment?

D18. Any other eye problems?

If yes, describe the other eye problem(s). List the age at first occurrence for each problem separately.

Please! Do not mark below this line

Remember, it is very important that you mark an answer for each of the following questions, even if 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. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence
D19. Stammering or stuttering speech?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D20. Any other speech defects? . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe the other speech defect(s). List the age at first occurrence for each defect separately.

D21. Abnormal sense of taste? . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
D22. Loss of taste or smell lasting for 3 months or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

URINARY SYSTEM

E1. Kidney stones?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E2. REPEATED kidney or bladder infections (more than 3 in any 12 month period)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E3. Dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E4. Blood in your urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E5. Urinary incontinence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
E6. Any other kind of kidney, bladder or urinary tract disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe the other disorder(s). List the age at first occurrence for each disorder separately.

HEART AND CIRCULATORY SYSTEM

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

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

If yes, describe the type of problem(s). List the age at first occurrence for each problem separately.

F5. Hypertension (high blood pressure) requiring medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
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If yes, do you currently take hypertension medication?

No Yes

F6. Angina pectoris (chest pains due to lack of oxygen to the heart requiring medication such as nitroglycerin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F7. Pericarditis or fluid around the heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F8. Pericardial constriction (scarring or tightness of the sac around the heart)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F9. Stiff or leaking heart valves? . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F10. Blood clot in head, lung, arm, leg, or pelvis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
F11. Does exercise cause severe chest pain, shortness of breath, or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Please! Do not mark below this line

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

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

If yes, describe the other problem(s). List the age at first occurrence for each problem separately.

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

No Yes Unsure

HORMONAL SYSTEMS

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

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence
G1. An overactive thyroid gland (hyperthyroid)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G2. An underactive thyroid gland (hypothyroid)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G3. Thyroid nodules?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G4. Swollen or enlarged thyroid gland?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

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

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence
G5. Diabetes that can be controlled with diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G6. Diabetes controlled with pills or tablets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G7. Diabetes controlled with insulin shots?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G8. Deficiency of growth hormone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
G9. Have you received injections of growth hormone (such as Nutropin, Genotropin, Humatrope, Norditropin, Saizen)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, do you currently take injections of growth hormone?
 No Yes

G10. Osteoporosis or osteopenia (thin, brittle, or fragile bones)?

G11. Have you ever broken a bone?

If yes, describe all occurrences of broken bones. List the age for each individual occurrence.

G12. Any other hormonal problems?

If yes, describe the other hormonal problem(s). List the age at first occurrence for each problem separately.

Please! Do not mark below this line

Males → **Go to Question H1.**

G13. **FEMALES** - Have you had a menstrual period naturally, that is, without needing hormones or medication?

No Yes

If yes, age at first occurrence:

If no, → **Go to Question G15.**

G14. **FEMALES** - At what age did you last have a menstrual period naturally, without needing hormones or medication?

years and months old

G15. **FEMALES** - Which one of the following statements best describes you? (**Select only one**)

- a. I am having regular periods and I am not taking birth control pills or female hormones (example: Premarin, estrogen)
- b. I am having regular periods but I am using birth control pills to prevent a pregnancy
- c. My menstrual periods are irregular and I am taking birth control pills or female hormones to regulate my periods
- d. My menstrual periods are irregular but I am not using birth control pills or female hormones to regulate my periods
- e. I am currently pregnant
- f. I am not having menstrual periods naturally but I am taking birth control pills or female hormones
- g. I am not having menstrual periods naturally and I am not taking birth control pills or female hormones
- h. Other

If Other, please describe.

If you selected a, b, c, d, or e → **Go to Question H1.**

If you selected f, g, or h → **Go to Question G16.**

G16. **FEMALES** - What caused your menstrual periods to stop? (**Select only one**)

- Normal or early menopause
- Surgery (example: a hysterectomy)
- Pregnancy
- Don't know
- Other

If Other, please describe.

RESPIRATORY SYSTEM

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

	Yes, but the condition is no longer present	Yes, and the condition is still present	No	Not sure	If yes, age at first occurrence
H1. Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
H2. Chronic cough or shortness of breath for more than one month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
H3. Have you had a need for extra oxygen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
H4. Pneumonia, 3 or more times in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
H5. Emphysema or other chronic obstructive pulmonary disease (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
H6. Lung fibrosis or "scarring" of the lung?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
H7. Problems with breathing while at rest that lasted for more than 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
H8. Any other breathing or lung problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>

If yes, describe the other problem(s). List the age at first occurrence for each problem separately.

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

DIGESTIVE SYSTEM

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

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence
11. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
If yes, what type(s)? (Mark all that apply)					
<input type="checkbox"/> Hepatitis A					
<input type="checkbox"/> Hepatitis B					
<input type="checkbox"/> Hepatitis C					
<input type="checkbox"/> Don't know					
<input type="checkbox"/> Other					
12. Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
13. Fatty liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
14. Any other liver trouble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
If yes, describe the other liver problem(s). List the age at first occurrence for each problem separately.					
<input type="text"/>					
15. Intestinal (colon) polyps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
16. Esophageal strictures (narrowing of the esophagus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
17. Rectal or anal fistula?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
18. Rectal or anal stricture (narrowing or scarring)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
19. Any other stomach or digestive trouble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe the other problem(s). List the age at first occurrence for each problem separately.

SURGICAL PROCEDURES

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

	No	Yes	Not sure
J1. Amputation of an arm, leg, hand, foot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, specify (example: left hand, right foot). List the age for each amputation separately.

J2. Scoliosis surgery (insertion of rods or other methods to straighten the spine)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J3. Other surgery of spinal cord or spine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, specify all surgeries of the spinal cord or spine. List the age at which each surgery occurred.

J4. Leg lengthening or shortening procedures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J5. Joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, specify all joint replacements. List the age at which each joint replacement occurred.

Please! Do not mark below this line

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

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

	No	Yes	Not sure
J6. Other bone surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, specify all other bone surgeries. List the age at which each bone surgery occurred.

	No	Yes	Not sure	If yes
J7. Coronary artery bypass surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J8. Pericardiectomy (stripping of the sac around the heart)? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J9. Heart catheterization ("heart cath")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J10. Angioplasty (enlarging a heart vessel using a balloon) or stent placement to keep vessel open?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J11. Surgery for heart valve replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J12. Surgery for pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J13. Other heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, specify all other heart surgeries. List the age at which each heart surgery occurred.

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

	No	Yes	Not sure	If yes, age at first occurrence
J14. Surgery for intestinal obstruction (blocked intestines)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J15. Colostomy or ileostomy (stool going into a bag)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J16. Removal of part or all of the colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J17. Removal of part or all of the rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J18. Biopsy or removal of lump in thyroid gland?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J19. Removal of part or all of the thyroid gland?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J20. Removal of the spleen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J21. Ventriculoperitoneal (VP) shunt (tube from the brain to the abdomen under the skin) that removes excess spinal fluid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J22. Breast biopsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J23. Breast-conserving or breast-sparing surgery (lumpectomy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
J24. Mastectomy or removal of a breast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, was one or both breasts removed?

- Left only
- Right only
- Both

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

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

J25. Any lung surgery?

If yes, specify all lung surgeries. List the age at which each lung surgery occurred.

- | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|---------------------------------------|----------------------|----------------------|
| J26. Periodontal (gum) surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If yes,
age at first
occurrence | <input type="text"/> | <input type="text"/> |
| J27. Heart transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="text"/> | <input type="text"/> |
| J28. Lung transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="text"/> | <input type="text"/> |
| J29. Kidney transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="text"/> | <input type="text"/> |
| J30. Liver transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="text"/> | <input type="text"/> |
| J31. Bone marrow transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="text"/> | <input type="text"/> |
| J32. Other organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="text"/> | <input type="text"/> |

If yes, specify all other organ transplants. List the age for each individual transplant.

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

	Not sure	
No	Yes	If yes, age at first occurrence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

J33. Cataract surgery?

Males → Go to Question J37.

- J34. Removal of one ovary?
- J35. Removal of both ovaries?
- J36. Removal of uterus?

Females → Go to Question J40.

- J37. Removal of one testis?
- J38. Removal of both testes?
- J39. Removal of part or all of the prostate gland (prostatectomy)
- J40. Any other surgery?

If yes, specify all other surgeries. List the age at which each other surgery occurred.

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.

BRAIN AND NERVOUS SYSTEM

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

				Not sure	
	Yes, but the condition is no longer present				
	Yes, and the condition is still present				
	No				
K1. Problems with learning or memory?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, age at first occurrence

If yes and still present, please rate the severity of these problems:

- Mild**; does not interfere with my work, school, or general life. I did not need special help in school.
- Moderate**; interferes with my work, school, or general life, but I am capable of independent living. I used special help in school.
- Severe**; I am significantly impaired in my school or work performance or in my general life.
- Disabling**; I am unable to perform daily activities such as taking care of myself; I require full-time help or I am living in an institution for people with disabling conditions.

K2. Epilepsy, repeated seizures, convulsions, or blackouts? . . .

If yes, describe the problem(s) and list medications. List the age at first occurrence for each problem separately.

If yes, are you currently taking medication for this?

No Yes

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

				Not sure	
	Yes, but the condition is no longer present				
	Yes, and the condition is still present				
	No				
K3. Migraine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
K4. Other severe headaches? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, age at first occurrence

If yes, list medications if required to control migraine or other severe headaches.

K5. Problems with balance, equilibrium, or ability to reach for or manipulate objects? . . .

If yes and still present, please rate the severity of these problems:

- Mild**; does not affect walking or my daily routine.
- Moderate**; it is bothersome and affects my walking but I am able to do my daily routine.
- Severe**; this problem significantly affects my walking and my daily routine.
- Disabling**; I require a wheelchair or cannot walk because of this problem.

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. . .

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence
K6. Tremors or problems with movements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
K7. Problems chewing or swallowing solids or liquids? . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
K8. Decreased sense of touch or feeling in hands, fingers, arms or legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
K9. Prolonged pain in arms, legs or back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
K10. Abnormal sensation in arms, legs or back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
K11. Weakness or inability to move arm(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
K12. Weakness or inability to move leg(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
K13. Paralysis of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, describe the paralysis. List the age at first occurrence for each episode of paralysis separately.

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

	No	Yes, but the condition is no longer present	Yes, and the condition is still present	Not sure	If yes, age at first occurrence
K14. A stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If no, → Go to Question K15.

If yes, as a result of the stroke . . .

- Did the symptoms last more than 24 hours?
 No Yes
- Did it affect:
 - Speech.
 - Only one side of the body .
 - Both sides of the body . . .
- Did you lose consciousness?
 No Yes
- Did you have weakness or inability to move arm(s)? . . .
- Did you have weakness or inability to move leg(s)? . . .
- Did you have paralysis of any kind?

If yes, describe the paralysis. List the age at first occurrence for each episode of paralysis separately.

K15. Any other brain or nervous system problems?

If yes, describe the other problem(s). List the age at first occurrence for each problem separately.

FEELINGS/EMOTIONS

Questions L1 to L18 relate to the past 7 days.

Below is a list of problems people sometimes have. Please read each one carefully and mark the box that best describes how much that problem has distressed or bothered you during the past 7 days including today.

(Mark only one answer for each problem and try not to skip any items.)

	Not at all	A little bit	Moderately	Quite a bit	Extremely
L1. Nervousness or shaking inside.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L2. Faintness or dizziness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L3. Pains in heart or chest.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L4. Thoughts of ending your life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L5. Suddenly scared for no reason.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L6. Feeling lonely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L7. Feeling blue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L8. Feeling no interest in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L9. Feeling fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L10. Nausea or upset stomach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L11. Trouble getting your breath.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L12. Numbness or tingling in parts of your body.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L13. Feeling hopeless about the future. . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L14. Feeling weak in parts of your body . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L15. Feeling tense or keyed up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L16. Spells of terror or panic.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L17. Feeling so restless you couldn't sit still.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L18. Feelings of worthlessness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MARITAL STATUS

M1. What is your current living arrangement?

(Mark all that apply)

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

Specify

M2. Which of the following best describes your current marital status?

- Single, never married or never lived with partner as married
- Married
- Living with partner as married
- Widowed
- Divorced
- Separated or no longer living as married

→ Go to Question N1, next page.

M3. How many times have you been married or lived as married?

- | | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9+ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

HEALTH HABITS

Alcohol

N1. In your entire life, have you ever had at least 2 drinks of any kind of alcoholic beverage?

- No → **Go to Question N7.**
 Yes

N2. How old were you when you first started drinking alcohol?

--	--

 years old

N3. During the last 12 months, how many alcoholic drinks did you have on a typical day when you drank alcohol? (If less than one per day, enter 0.)

Wine
(4 oz. glass):

--	--

Glasses a day

Beer
(12 oz. can):

--	--

Cans a day

Mixed drink
(1 shot):

--	--

Drinks a day

N4. During the last 12 months, what is the largest number of drinks you had on any single day? Was it . . .

- 24+ drinks
 12-23 drinks
 8-11 drinks
 5-7 drinks
 4 drinks
 3 drinks
 2 drinks
 1 drink
 0 drinks → **Go to Question N7.**

N5. During the last 12 months, how often did you usually have any kind of drink containing alcohol?

- Every day
 5 to 6 times a week
 3 to 4 times a week
 twice a week
 once a week
 2 to 3 times a month
 once a month
 3 to 11 times in the past year
 1 or 2 times in the past year
 Never in the past year

N6. During the last 12 months, how often did you have 5 or more (males) or 4 or more (females) drinks containing any kind of alcohol in a single day?

- Every day
 5 to 6 days a week
 3 to 4 days a week
 two days a week
 one day a week
 2 to 3 days a month
 one day a month
 3 to 11 days in the past year
 1 or 2 days in the past year
 Never in the past year

Smoking

The following questions are referring to cigarettes containing tobacco.

N7. Have you smoked at least 100 cigarettes since you last provided us this information on

No → **Go to Question N13, next page.**

Yes ↴

N8. How old were you when you started smoking?

--	--

N9. Do you smoke cigarettes now?

- No
- Yes

N10. On average, how many cigarettes a day do/did you smoke?

N11. How many years, in total, have you smoked?

N12. If you currently smoke, how many times in the past 12 months have you tried to quit smoking and not smoked for at least 24 hours?

N13. In the past year, have you ever used any of these products?
(Mark all that apply)

	Never used	No longer use	Occasionally use	Regularly use
Chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snuff tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pipes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have never used any of these products, → Go to Question N15.

N14. For any of those that you have used or are currently using, how long have you used it?

	Less than 1 year	1 - 2 years	3 - 4 years	5 - 10 years	11+ years
Chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snuff tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pipes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E-cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Activity

The following questions are about exercise, recreation, or physical activities other than your regular job duties.

N15. During the past month, did you participate in any physical activities or exercises such as running, aerobics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

- No
- Yes

We are interested in three types of physical activity: vigorous, moderate, and light.

- Vigorous activities cause large increases in breathing or heart rate.
- Moderate activities cause small increases in breathing or heart rate.
- Light activities cause no increase in breathing or heart rate.

N16. Now thinking about the vigorous physical activities you do in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, wheelchair basketball, heavy yard work, or anything else that causes large increases in breathing or heart rate?

- No → Go to Question N19, next page.
- Yes ↓

N17. How many days per week do you do these vigorous activities for at least 10 minutes at a time?

 Days per week

N18. On days when you do vigorous activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

 Minutes per day

Continue on next page.

We are interested in three types of physical activity: vigorous, moderate, and light.

- Vigorous activities cause large increases in breathing or heart rate.
- Moderate activities cause small increases in breathing or heart rate.
- Light activities cause no increase in breathing or heart rate.

N19. Now, thinking about the moderate physical activities you do in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, gardening, manual operation of a wheelchair, or anything else that causes small increases in breathing or heart rate?

No → Go to Question N22.

Yes

N20. How many days per week do you do these moderate activities for at least 10 minutes at a time?

Days per week

N21. On days when you do moderate activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

Minutes per day

N22. Now, thinking about the light physical activities you do in a usual week, do you do light activities for at least 10 minutes at a time, such as a slow casual walk, or anything else that does not cause an increase in your breathing or heart rate?

No → Go to Question N25.

Yes

N23. How many days per week do you do these light activities for at least 10 minutes at a time?

Days per week

N24. On days when you do light activities for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

Minutes per day

N25. 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

N26. 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

N27. Does any impairment or health problem keep you from holding a job or attending school?

- No
 Yes

N28. Do you currently have a driver's license?

- No
 Yes

N29. Over the last 2 years, how long (if at all) has your health limited you in each of the following activities?

(Mark one box for each item.)	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The kinds or amounts of moderate activities you can do, like moving a table, carrying groceries or bowling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Walking uphill or climbing a few flights of stairs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bending, lifting, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Walking one block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Eating, dressing, bathing, or using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DAILY ACTIVITIES

Previously, we asked you for information on activities in the last two years. This section is about your health and daily activities during the **PAST 4 WEEKS**. Please try to answer every question as accurately as you can.

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

- Excellent
- Very good
- Good
- Fair
- Poor

02. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
- Somewhat better now than one year ago
- About the same as one year ago
- Somewhat worse now than one year ago
- Much worse now than one year ago

03. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- | | No, not limited at all | Yes, limited a little | Yes, limited a lot |
|---|--------------------------|--------------------------|--------------------------|
| a. <u>Vigorous Activities</u> , such as running, lifting heavy objects, participating in strenuous sports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <u>Moderate Activities</u> , such as moving a table, bowling, or playing golf | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Lifting or carrying groceries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Climbing <u>several</u> flights of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Climbing <u>one</u> flight of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Bending, kneeling, or stooping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Walking <u>more than a mile</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Walking <u>several hundred yards</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Walking <u>one hundred yards</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Bathing or dressing yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

04. During the **PAST 4 WEEKS**, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- | | None of the time | A little of the time | Some of the time | Most of the time | All of the time |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Cut down on the <u>amount of time</u> you spent on work or other activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <u>Accomplished less</u> than you would like | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Were limited in the <u>kind</u> of work or other activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

05. During the **PAST 4 WEEKS**, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- | | None of the time | A little of the time | Some of the time | Most of the time | All of the time |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Cut down on the <u>amount of time</u> you spent on work or other activities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. <u>Accomplished less</u> than you would like | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Did work or activities <u>less carefully than usual</u> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Please! Do not mark below this line

06. During the **PAST 4 WEEKS**, to what extent has your **physical health** or **emotional problems** interfered with your normal social activities with family, friends, neighbors, or groups?

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely

07. How much **bodily pain** have you had during the **PAST 4 WEEKS**?

- None
- Very mild
- Mild
- Moderate
- Severe
- Very severe

08. During the **PAST 4 WEEKS**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

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

HEALTH AND WELL-BEING

P1. These questions are about how you feel and how things have been with you during the **PAST 4 WEEKS**.

For each question, please mark the one answer that comes closest to the way you have been feeling. How much of the time during the **PAST 4 WEEKS**...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you been very nervous? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you felt calm and peaceful? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Did you have a lot of energy? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you felt downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you been happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

P2. During the **PAST 4 WEEKS**, how much of the time has your **physical health** or **emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time
- A little of the time
- Most of the time
- None of the time
- Some of the time

P3. How **TRUE** or **FALSE** is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I expect my health to get worse . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

PROBLEM SOLVING

Q. Below is a list of statements that describe problems people can have. We would like to know if you have had any of these problems over the PAST 6 MONTHS. Please complete all items. Please think about yourself as you read these statements and mark one response on each line.

	Often a problem	Sometimes a problem	Never a problem
1. I get upset easily-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. It takes me longer to complete my work-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I am disorganized-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I forget instructions easily-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I have problems completing my work-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I have difficulty recalling things I had previously learned (e.g., names, places, events, activities)-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I get frustrated easily-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. My mood changes frequently-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I have trouble finding things in my bedroom, closet or desk-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I forget what I am doing in the middle of things-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I have problems getting started on my own-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I am easily overwhelmed-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I have trouble doing more than one thing at a time-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. My desk/workspace is a mess-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I have trouble remembering things, even for a few minutes (such as directions, phone numbers, etc.)-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I have trouble prioritizing my activities-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I read slowly-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I am slower than others when completing my work-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I have trouble solving math problems in my head-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I don't work well under pressure-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I have trouble staying on the same topic when talking-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I have a messy closet-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. People say I am easily distracted-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I have angry outbursts-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I have a short attention span-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I overreact emotionally-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I have trouble organizing work-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. I overreact to small problems-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I have problems organizing activities-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I have emotional outbursts for little reason-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. I leave the bathroom a mess-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. I react more emotionally to situations than my friends-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. I leave my room or home a mess-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Sometimes" or "Often" to any of the questions in Section Q, to what extent do the problems you may have checked interfere with your ability to function?

	Not applicable	Often	Sometimes	Never
1. In your home-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. At your job-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In social situations-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In educational activities-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER ISSUES

Please rate how concerned you are about the following:

	Not at all concerned	Not very concerned	Concerned	Somewhat concerned	Very concerned
R1. Your future health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R2. Your ability to have children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R3. Developing a cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R4. Your ability to get health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R5. Your ability to get life insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R6. Your ability to cover expenses for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R7. Your ability to cover expenses for prescribed medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R8. Any other issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please specify.

Please! Do not mark below this line

CANCER, LEUKEMIA, OR TUMOR

S1.

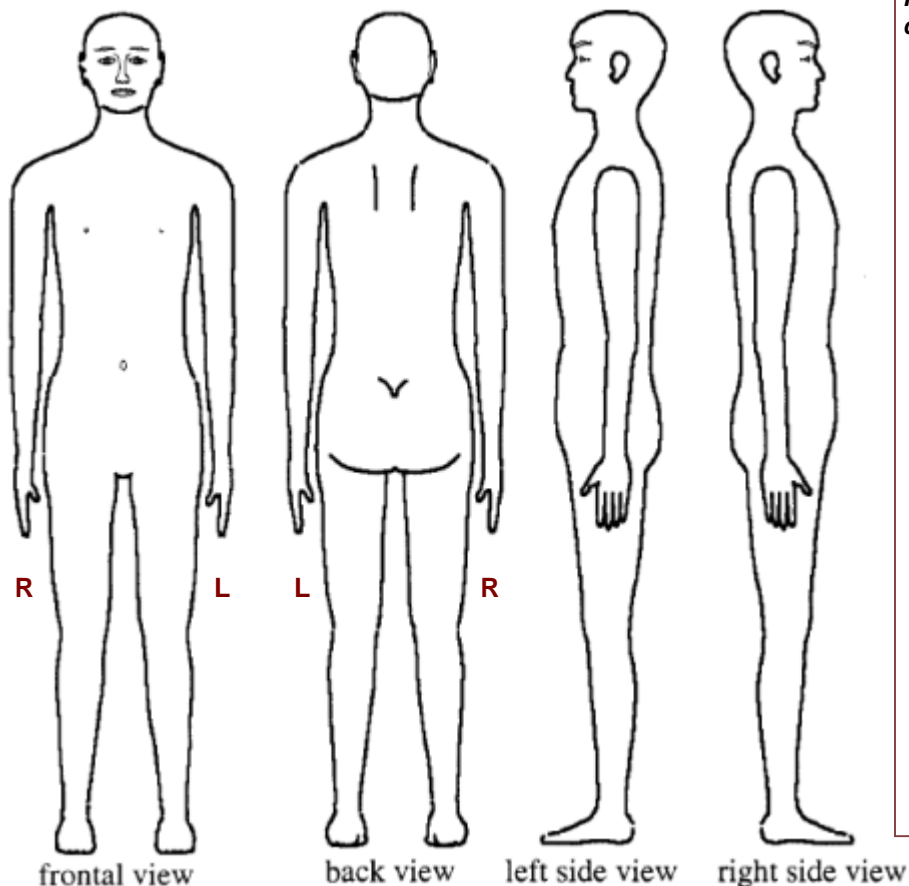
No → **Go to Question T1, page 28.**

Yes ↴

S2. What was the name of this disease?

S3. Where was it located? (Example: right upper arm, left ear)

If the condition in item S2 above was a skin cancer or solid tumor (not a leukemia), please mark an "X" at the location(s) of your cancer(s). We are interested in the most exact location(s) you can provide so please be as specific as possible.



S4. Where was this diagnosed?

Doctor's name
Hospital or clinic
Address
City, State, Zip code

S5. Was this a:

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

Date of New Diagnosis:

--	--	--	--	--	--

Month (mm) Year (yyyy)

Please use this space to provide any additional details on tumor location.

Please! Do not mark below this line

S6.

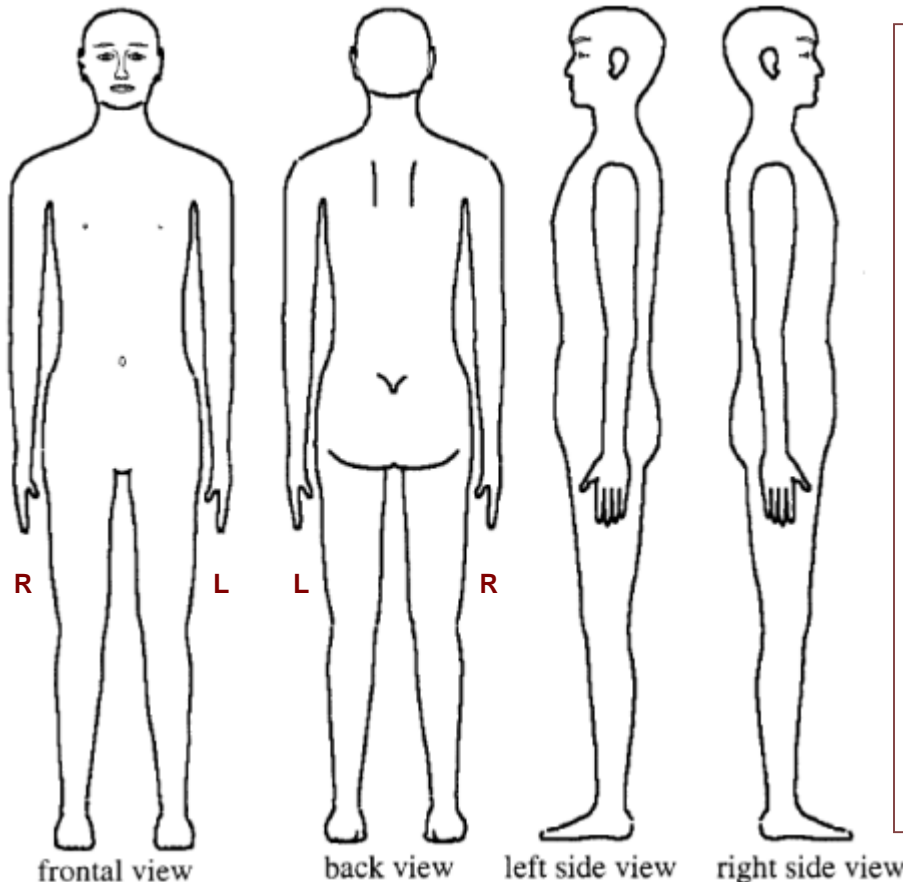
No → **Go to Question T1, next page.**

Yes ↴

S7. What was the name of this disease?

S8. Where was it located? (Example: right upper arm, left ear)

If the condition in item S7 above was a skin cancer or solid tumor (not a leukemia), please mark an "X" at the location(s) of your cancer(s). We are interested in the most exact location(s) you can provide so please be as specific as possible.



S9. Where was this diagnosed?

Doctor's name
Hospital or clinic
Address
City, State, Zip code

S10. Was this a:

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

Date of Recurrence or New Diagnosis:

--	--	--	--	--	--

Month (mm) Year (yyyy)

Please use a separate sheet of paper for additional cancers

Please use this space to provide any additional details on tumor location.

Please! Do not mark below this line

TREATMENT FOR NEW OR RECURRENT TUMOR OR CANCER

We are interested in whether you have had any radiation or chemotherapy for cancer or similar illness. Radiation is a treatment you would have received in a radiation therapy department and does not include CAT scans, MRI's, or diagnostic x-rays.

T1. Have you ever received any radiation treatment?

- No **→ Go to Question T2.**
- Yes
- Not sure

T1a. If yes, please indicate the date of any (additional) radiation treatment you received for a recurrence or a new cancer.

Date of Treatment

--	--	--	--	--	--

Month (mm) Year (yyyy)

T1b. Please indicate the reason for radiation.

T1c. Where did you receive the radiation treatment?

Hospital or clinic
Address
City, State, Zip code
Doctor's name

T2. Have you ever received any chemotherapy treatment?

- No **→ Go to Question U1, next page.**
- Yes
- Not sure

T2a. If yes, please indicate the date of any (additional) chemotherapy treatment you received for a recurrence or a new cancer.

Date of Treatment

--	--	--	--	--	--

Month (mm) Year (yyyy)

T2b. Please indicate the reason for chemotherapy.

T2c. Where did you receive the chemotherapy treatment?

Hospital or clinic
Address
City, State, Zip code
Doctor's name

HOSPITALIZATIONS

We are interested in any admissions to the hospital for illness, surgical, or diagnostic procedures, including psychiatric/mental health hospitalization or short stays of 24 hours or less that you may have had in the last 12 months. **DO NOT INCLUDE PREGNANCY RELATED ADMISSIONS or EMERGENCY ROOM VISITS.**

U1. Have you been admitted to a hospital in the last 12 months?

- No **→ Go to Section V, next page.**
 Yes

U2. How many times have you been admitted to a hospital in the last 12 months?

U3. What was the reason for the first hospitalization?

U3a. What procedures/surgeries were performed?

U3b. Where were you hospitalized?

Hospital
Address
City, State, Zip code
Doctor's name

U3c. Date of first hospitalization:

Month (mm) Year (yyyy)

U4. What was the reason for the second hospitalization?

U4a. What procedures/surgeries were performed?

U4b. Where were you hospitalized?

Hospital
Address
City, State, Zip code
Doctor's name

U4c. Date of second hospitalization:

Month (mm) Year (yyyy)

Please use a separate sheet of paper for additional hospitalizations

PREGNANCY AND OFFSPRING

Female

V1.

No → **Go to page 31.**

Yes ↓

V2. Are you currently pregnant?

No

Yes

Continue to Question V5 below.

Male

V3.

No → **Go to page 31.**

Yes ↓

V4. Is she currently pregnant?

No

Yes

Continue to Question V5 below.

V5.

Pregnancy outcome

	Live birth	Stillbirth	Miscarriage	Medical abortion	Currently pregnant	Your age at start of pregnancy	Partner's age at start of pregnancy	Weeks pregnancy lasted
Pregnancy 1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pregnancy 8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please attach a separate sheet of paper, if more than 8 pregnancies

Please! Do not mark below this line

GENETIC CONDITIONS

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

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

W1a. Have you ever been told by a doctor that you have...

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

If yes, describe this disorder.

W1b. If you have children (blood relatives only), have they ever had any of the conditions in Question W1a? (Mark all that apply)

What conditions?

Son →

Daughter →

CONDITIONS PRESENT AT BIRTH

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

W2. Have you ever had genetic counseling for cancer risk?

- No
- Yes

Continue on next page.

W3a. To the best of your knowledge, were you born with. . .

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

If other, please specify.

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

If other, please specify.

W3b. If you have children (blood relatives only), have they ever had any of the conditions in Question W3a? (Mark all that apply)

What conditions?

Son →

Daughter →

W4. If you have children (blood relatives only), have they ever had cancer? (Mark all that apply)

What types?

Son →

Daughter →

Continue on next page.

HIPAA Authorization Form

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


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

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


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

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

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

!  _____
Printed name of research participant

Signature of research participant or legal guardian

_____ Date 

Printed name of legal guardian

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

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

Please! Do not mark below this line

1. Do you use a cell phone?

Yes No → **Go to question 3.**

1a. Would you be willing to send/receive study-related texts?

Yes No My phone is not text capable

2. Do you use a "smartphone" that can access the internet or download "apps" (e.g. iPhone, Android, Blackberry, Windows)?

Yes No

3. Which of the following types of devices do you use to access the internet? *(Mark all that apply)*

- Computer or laptop
- Tablet (iPad or similar)
- Smartphone
- Other, specify: _____
- I don't access the internet

4. If available in the future, how likely would you be to use a LTFU Study app on your smartphone, tablet, or computer to do the following:

	Very unlikely	Possibly	Very likely
a. Read study newsletters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Access health information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Answer future questionnaires?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Participate in electronic health monitoring studies (e.g. using monitors of heart rate, activity, or other health-related measures)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have an email address we could use to contact you? No Yes →

Your Email Address:

We have your current address and phone as:

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

Correct Not correct Moving

If this information is not correct, please give us your correct address or location:

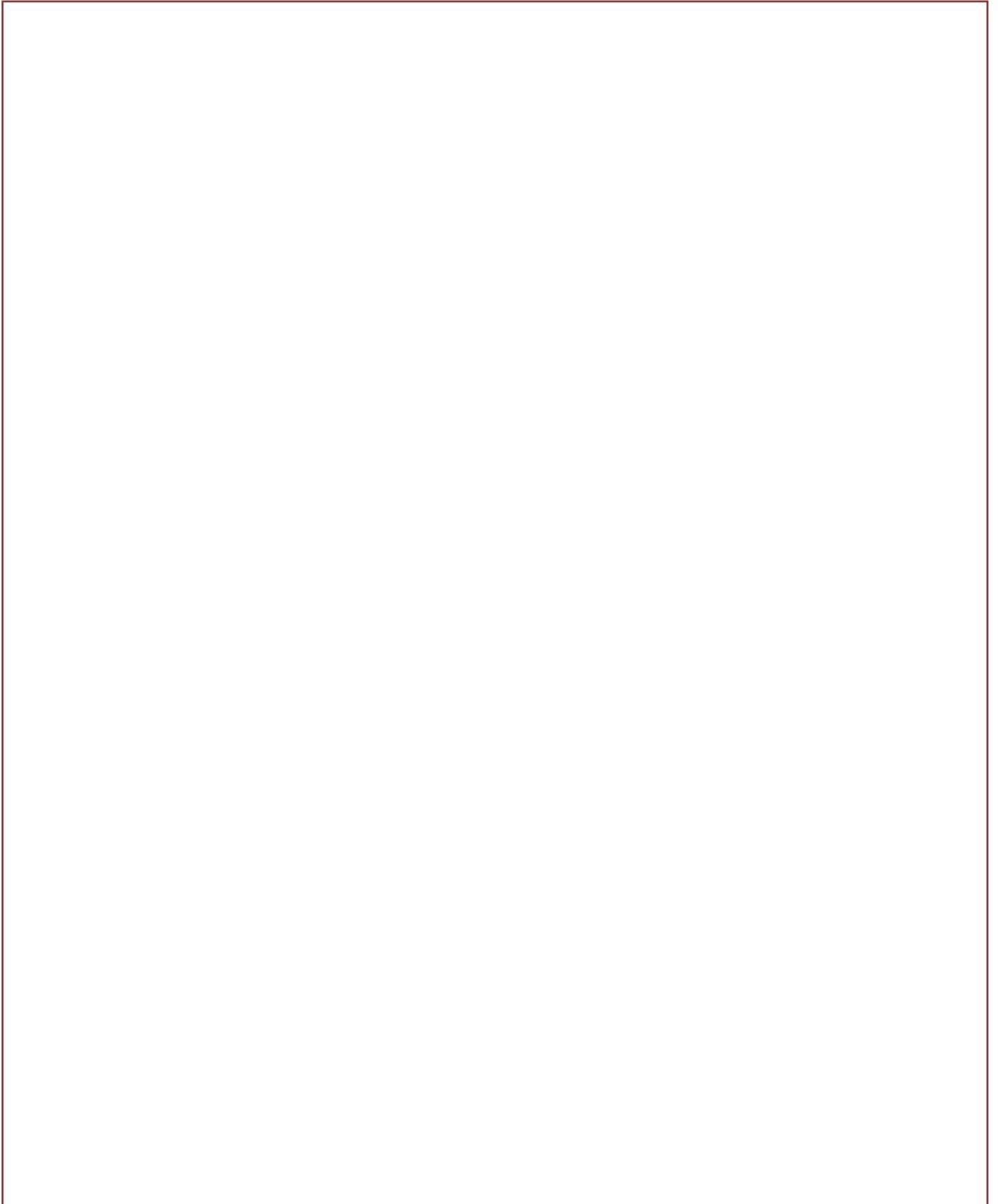
Address:			
City:		State:	
Zip code:	Cell phone:	Home phone:	Work phone:

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

Name:			
Address:		Relationship to	
City:		State:	
Zip code:	Cell phone:	Home phone:	Work phone:

Please! Do not mark below this line

**We are always interested in your input in the follow-up study.
Use this space for any additional comments you may have:**



Please! Do not mark below this line

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

Mail to:

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

Thank you!