Mayo Study of Lymphoma and Leukemia (Main Questionnaire)
Clinic Number: __ - __ __ __ - __ __ __

**INSTRUCTIONS: PLEASE CHECK THE APPROPRIATE BOX OR FILL IN THE BLANK AS INDICATED.**

Today’s Date: __ __/ __ __/ __ __ __  
Month  Day  Year

1. What is your date of birth?

   __ __/ __ __/ __ __ __  
   Month  Day  Year

2. What is your gender?

   1  [ ] Male  2  [ ] Female

3. What is your marital status?

   1  [ ] Married or living as married  
   2  [ ] Widowed  
   3  [ ] Divorced or separated  
   4  [ ] Single, never married

4. What is the **highest** level of schooling you have completed? (Mark one.)

   1  [ ] 1 to 8 years  
   2  [ ] Some high school  
   3  [ ] High school graduate  
   4  [ ] GED (high school equivalency)  
   5  [ ] 1 to 3 years vocational education beyond high school  
   6  [ ] Some college  
   7  [ ] College graduate  
   8  [ ] One or more years of graduate or professional school  
   9  [ ] Other, please specify:

   __________________________________________
Most people in the United States have ancestors who came from other parts of the world. Some people have mixed ethnic backgrounds.

5. What is the ethnic background of your biological father? (Please record primary and secondary ethnicity if your father has more than one ethnic background.)

<table>
<thead>
<tr>
<th>Ethnic Background</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>English, Scotch, Welsh</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>French</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>German</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Greek</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Irish</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Italian</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Spanish, Portuguese</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Scandinavian (Swedish, Norwegian, Danish, Finnish, Icelandic)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Polish</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Czech/Slovak</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hungarian</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Russian</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other Eastern European (Lithuanian, Romanian, Ukrainian, etc.)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other European</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>American Indian</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Canadian (non-French)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>French Canadian</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mexican</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Central American</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>South American</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>West Indian</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Indian, Pakistani</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Korean</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Japanese</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other Asian countries or Pacific Islanders</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>African</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other, specify:</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

6. What is the ethnic background of your biological mother? (Please record primary and secondary ethnicity if your mother has more than one ethnic background.)

<table>
<thead>
<tr>
<th>Ethnic Background</th>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>English, Scotch, Welsh</td>
<td>1</td>
<td>2</td>
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<tr>
<td>French</td>
<td>1</td>
<td>2</td>
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<tr>
<td>German</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Greek</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Irish</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Italian</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Spanish, Portuguese</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Scandinavian (Swedish, Norwegian, Danish, Finnish, Icelandic)</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Polish</td>
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<td>2</td>
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<td>Hungarian</td>
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<td>2</td>
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<td>Russian</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Other European</td>
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<td>2</td>
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<td>2</td>
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<tr>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mexican</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Central American</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>South American</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>West Indian</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Chinese</td>
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<td>2</td>
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<td>Korean</td>
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<tr>
<td>Japanese</td>
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<td>2</td>
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</tr>
<tr>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other, specify:</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
6. What has been your usual job during most of your adult life, that is, the job or type of job you have held the longest? (Please record your job title, e.g., gasoline engine assembler, grinder operator, farmer, homemaker, sales manager, military - with highest rank, registered nurse, etc.)

<table>
<thead>
<tr>
<th>Job title</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
</tr>
</tbody>
</table>

7. For how many years did you work at this job?   ___ ___ Years

8. If you held any other jobs (at least 10 hours per week) for longer than 5 years, please fill in the information below. (If you have had more than five other jobs, please list the five jobs you have held the longest.)

<table>
<thead>
<tr>
<th>Job title</th>
<th>Age first worked</th>
<th>Number of years worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>93-98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99-104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>105-110</td>
<td></td>
<td></td>
</tr>
<tr>
<td>111-116</td>
<td></td>
<td></td>
</tr>
<tr>
<td>117-122</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Did you ever live on a farm for more than one year? (Do not include hobby farms.)

1 [ ] No
2 [x] Yes

At what age did you first live on a farm? (If less than 1 year old or born on a farm, please enter 00.)

___ ___ Age

What is the total number of years that you lived on a farm? (Do not include time when you did not live on a farm.)

___ ___ Years

Are you currently living on a farm?

1 [ ] No  2 [x] Yes

At what age did you last live on a farm?  ___ ___ Age
10. Have you ever used any tobacco products for six months or longer? (Please include cigarettes, cigars, pipes, snuff, and chewing tobacco.)

1 □ No  [Go to question 12 on page 5.]

2 □ Yes

If yes, have you ever smoked cigarettes for six months or longer?

1 □ No  2 □ Yes

If yes, at what age did you start smoking cigarettes?

__ __ Age  1 □ Don’t know

Do you smoke cigarettes now?

1 □ No

What year did you stop smoking cigarettes?

__ __ __ __ Year  1 □ Don’t know

Before stopping, how many cigarettes did you usually smoke per day?

__ __ Cigarettes per day  1 □ Don’t know

How many cigarettes do you usually smoke per day?

__ __ Cigarettes per day  1 □ Don’t know
11. Prior to 2 years ago, did you use any of these tobacco products for twelve months or longer?

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>1</th>
<th>No</th>
<th>2</th>
<th>Yes</th>
<th>For how many years? __ __ Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigar</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Yes</td>
<td>For how many years? __ __ Years</td>
</tr>
<tr>
<td>Pipe</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Yes</td>
<td>For how many years? __ __ Years</td>
</tr>
<tr>
<td>Snuff</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Yes</td>
<td>For how many years? __ __ Years</td>
</tr>
<tr>
<td>Chewing Tobacco</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Yes</td>
<td>For how many years? __ __ Years</td>
</tr>
</tbody>
</table>

12. Did you ever live in the same household with someone who smoked cigarettes regularly while in your presence?

1  | No | 2  | Yes

For how many years altogether was this the case?

__ __ Years

Generally speaking, how many hours each day were or are you around people from your household while they were or are smoking?

__ __ Hours per day

13. Did you ever work in an area where others smoked regularly in your presence?

1  | No | 2  | Yes

For how many years altogether was this the case?

__ __ Years

Generally speaking, how many hours each day were or are you in the same work area as others while they were or are smoking?

__ __ Hours per day
14. During your entire life, have you had 12 drinks or more of any kind of alcoholic drink? (One drink of alcohol is equal to one can of beer, one glass of wine, or one shot of liquor, e.g., whiskey, brandy, or gin.)

1 □ No 2 □ Yes

If yes, for each age group given below, how many drinks of alcohol did you usually have?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>None</th>
<th>Less than 1 month</th>
<th>1 to 3 each month</th>
<th>1 to 2 each week</th>
<th>3 to 6 each week</th>
<th>1 to 2 each day</th>
<th>3 or more each day</th>
</tr>
</thead>
<tbody>
<tr>
<td>From age 14 to 17</td>
<td>0 □</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
</tr>
<tr>
<td>From age 18 to 22</td>
<td>0 □</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
</tr>
<tr>
<td>From age 23 to 29</td>
<td>0 □</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
</tr>
<tr>
<td>From age 30 to 49</td>
<td>0 □</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
</tr>
<tr>
<td>About 2 years ago</td>
<td>0 □</td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
<td>6 □</td>
</tr>
</tbody>
</table>

Physical Activity

15. During most of your adult life, when walking outside of your home, how often did you walk for more than 10 minutes without stopping?

1 □ Rarely or never
2 □ 1 to 3 times each month
3 □ 1 time each week
4 □ 2 to 3 times each week
5 □ 4 to 6 times each week
6 □ 7 or more times each week

How many minutes did you usually walk?

   __ __ __ Minutes

What was your usual speed?

1 □ Casual (less than 2 miles an hour)
2 □ Average or normal (2 to 3 miles an hour)
3 □ Fairly fast (3 to 4 miles an hour)
4 □ Very fast (more than 4 miles an hour)
5 □ Don’t know

Continue on next page.
16. **During most of your adult life, how often did you usually do strenuous or very hard exercise?** (Exercise where you work up a sweat and your heart beats fast, e.g., aerobics, aerobic dancing, jogging, tennis, swimming laps, or vigorous yard or housework.) (Exclude walking outside of your home and any physical activity associated with any jobs you had.)

1. Rarely or never
2. 1 to 3 days per month
3. 1 day per week
4. 2 days per week
5. 3 to 4 days per week
6. 5 or more days per week

**How many minutes did you usually exercise like this at one time?**

___ ___ ___ Minutes

17. **During most of your adult life, how often did you usually do moderate exercise?** (Exercise that is not exhausting, but your breathing and heart rate are above resting levels, e.g., biking outdoors, using an exercise machine like a stationary bike or treadmill, calisthenics, easy swimming, popular or folk dancing, golfing without a cart, or moderate yard or housework.) (Exclude walking outside of your home and any physical activity associated with any jobs you had.)

1. Rarely or never
2. 1 to 3 days per month
3. 1 day per week
4. 2 days per week
5. 3 to 4 days per week
6. 5 or more days per week

**How many minutes did you usually exercise like this at one time?**

___ ___ ___ Minutes

18. **During most of your adult life, how often did you usually do mild exercise?** (Exercise that is not exhausting, e.g., slow dancing, bowling, golfing with a cart, hunting, gardening, light housework.) (Exclude walking outside of your home and any physical activity associated with any jobs you had.)

1. Rarely or never
2. 1 to 3 days per month
3. 1 day per week
4. 2 days per week
5. 3 to 4 days per week
6. 5 or more days per week

**How many minutes did you usually exercise like this at one time?**

___ ___ ___ Minutes

Continue on next page.
19. For each of the ages below, did you usually do strenuous or very hard exercises at least 3 times per week? (This would include exercise that was long enough to work up a sweat and make your heart beat fast. Be sure to mark “No” if you did not do very hard exercises at the ages listed below.)

12 years old . . . 1 □ No  2 □ Yes  3 □ Don’t know
18 years old . . . 1 □ No  2 □ Yes  3 □ Don’t know
35 years old . . . 1 □ No  2 □ Yes  3 □ Don’t know (Leave blank if less than 35 years old.)

20. For the job (includes homemaking) you held the longest, approximately what percent of the time were you engaged in each of the following physical activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Standing</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Walking</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Light manual labor</td>
<td>___ ___ %</td>
</tr>
<tr>
<td>Heavy manual labor</td>
<td>___ ___ %</td>
</tr>
</tbody>
</table>

Medical History

The following six questions are about your height and weight at different ages. If you don’t remember exactly what they were, please give your best estimate. (Women, if you were pregnant at any of these ages, please provide your weight when you were not pregnant.)

21. What was your weight 2 years ago?    ___ ___ Pounds

22. How tall were you (without shoes on) at about age 18?    ___ Feet   ___ Inches
   (Round up ½ inch.)

23. What was your weight at about age 18?    ___ ___ Pounds

24. What was your weight at about age 35?    ___ ___ Pounds   (Leave blank if less than 35 years old.)

25. What was your weight at about age 50?    ___ ___ Pounds   (Leave blank if less than 50 years old.)

26. What is your maximum adult weight (the most you ever weighed since you were 18 years old)? (Remember, do not include pregnancy weight.)

    ___ ___ Pounds
27. Excluding the last 2 years, did you ever have a blood transfusion?

1 □ No  2 □ Yes

If yes, please list the condition (e.g., neonatal jaundice, anemia, childbirth, trauma) or surgical procedure (e.g., heart surgery or hip surgery) for which you had the blood transfusion. Start with the one when you were the youngest first and fill in as many details as you remember. Please write “DK” if you “don’t know.”

<table>
<thead>
<tr>
<th>Condition or surgical procedure</th>
<th>Age at transfusion</th>
<th>Number of transfusions</th>
<th>How much of this blood was your own?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ___________________________</td>
<td>__ __</td>
<td>__ __</td>
<td>1 □ None 3 □ All 2 □ Some 4 □ Don’t know</td>
</tr>
<tr>
<td>2. ___________________________</td>
<td>__ __</td>
<td>__ __</td>
<td>1 □ None 3 □ All 2 □ Some 4 □ Don’t know</td>
</tr>
<tr>
<td>3. ___________________________</td>
<td>__ __</td>
<td>__ __</td>
<td>1 □ None 3 □ All 2 □ Some 4 □ Don’t know</td>
</tr>
<tr>
<td>4. ___________________________</td>
<td>__ __</td>
<td>__ __</td>
<td>1 □ None 3 □ All 2 □ Some 4 □ Don’t know</td>
</tr>
<tr>
<td>5. ___________________________</td>
<td>__ __</td>
<td>__ __</td>
<td>1 □ None 3 □ All 2 □ Some 4 □ Don’t know</td>
</tr>
</tbody>
</table>

1 □ Check this box if you were transfused for more than five conditions or surgical procedures. Please provide details on the last condition or surgical procedure for which you were transfused, excluding the last 12 months.

| Last __________________________ | __ __               | __ __                  | 1 □ None 3 □ All 2 □ Some 4 □ Don’t know |

28. Excluding the last 2 years, did you ever receive a general anesthetic for dental work or any other surgery?

1 □ No  2 □ Yes

For how many of these procedures/surgeries did the anesthetic make you lose consciousness or go to sleep?

1 □ 1 to 2  2 □ 3 to 5  3 □ 6 to 10  4 □ 11 to 15  5 □ 16 or more
29. Did you ever have an organ transplant (including a bone marrow transplant)?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, what organs were transplanted and what year did you receive them?

<table>
<thead>
<tr>
<th>Organ</th>
<th>Year received</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

30. Were you told by a doctor or other health professional that you had any of the following conditions? (Please mark a box even if you have never had the condition.)

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Not sure</th>
<th>Yes</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease, angina or heart attack</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes mellitus (sugar diabetes not associated with pregnancy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Osteoarthritis (degenerative arthritis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td></td>
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<td></td>
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<tr>
<td>Ulcerative colitis</td>
<td></td>
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<td></td>
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<tr>
<td>Celiac disease</td>
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<tr>
<td>Sjögren’s disease or sicca syndrome</td>
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<td></td>
<td></td>
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<tr>
<td>Lupus or SLE</td>
<td></td>
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<td></td>
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<tr>
<td>Polymyositis, dermatomyositis, or polymyalgia rheumatica</td>
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</tbody>
</table>

Continued next page...
### Condition Diagnosis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>325-327 Eczema</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>328-330 Contact dermatitis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>331-333 Cirrhosis of the liver or liver damage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>334-336 Infectious mononucleosis (“mono”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>337-339 Chronic fatigue syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>340-342 Depression, requiring medication or shock therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>343-345 Epilepsy (convulsions or seizures not related to high fever)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 31. Have you ever been diagnosed with cancer?  
1. No  
2. Yes

#### If yes, please provide:

<table>
<thead>
<tr>
<th>Type of cancer</th>
<th>Age you were first diagnosed</th>
<th>Treatments received (Mark all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>347-357</td>
<td>22</td>
<td>Surgery, Radiation, Chemotherapy, Other, specify:</td>
</tr>
<tr>
<td>358-368</td>
<td>33</td>
<td>Surgery, Radiation, Chemotherapy, Other, specify:</td>
</tr>
<tr>
<td>369-379</td>
<td>44</td>
<td>Surgery, Radiation, Chemotherapy, Other, specify:</td>
</tr>
</tbody>
</table>
32. Excluding the last 2 years, have you ever been told by a doctor or other health professional that you had asthma?

1 □ No 2 □ Yes

If yes, thinking back over the past 10 years, have you needed to take daily medication for your asthma for a period of at least 6 months?

1 □ No 2 □ Yes

Excluding the last 2 years, about how many times were you hospitalized or treated in an emergency room for your asthma?

1 □ None 2 □ 1 to 4 3 □ 5 to 14 4 □ 15 to 24 5 □ 25 to 49 6 □ 50 or more

At what age were you first told by a doctor or other health professional that you had asthma? ___ ___ Age

33. Excluding the last 2 years, have you ever been told by a doctor or other health professional that you had high cholesterol?

1 □ No 2 □ Yes

At what age were you first told by a doctor or other health professional that you had high cholesterol? ___ ___ Age

Did you ever take any medications for your high cholesterol?

1 □ No medications 2 □ Dietary changes only 3 □ Yes

What medications and for how long?

<table>
<thead>
<tr>
<th>Medication</th>
<th>How long?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___ Months OR ___ Years</td>
</tr>
<tr>
<td></td>
<td>___ Months OR ___ Years</td>
</tr>
<tr>
<td></td>
<td>___ Months OR ___ Years</td>
</tr>
</tbody>
</table>
34. Excluding the last 2 years, have you ever been told by a doctor or other health professional that you had a stomach ulcer?

1 □ No 2 □ Yes

At what age were you first told by a doctor or other health professional that you had a stomach ulcer? __ __ Age

Did you take any of the following medications?

- **H2 blocker** [e.g., Zantac, Pepcid, Tagamet, Axid (ranitidine, cimetidine), etc.].
  
  No □ Yes □ Age first taken __ __

- **Other acid-suppression capsules/tablets** [e.g., Prilosec, Cytotec, Prevacid, etc.].
  
  No □ Yes □ Age first taken __ __

- **Other antacids** [e.g., Tums, Rolaids, Maalox, Mylanta, etc.].
  
  No □ Yes □ Age first taken __ __

35. Excluding the last 2 years, were you ever told by a doctor or other health professional that you had chickenpox?

1 □ No 2 □ Yes 3 □ Yes, but not by a health care professional

How many times have you had chickenpox?

1 □ 1 2 □ 2 or more

At what age did you first have chickenpox?

__ __ Age

36. Excluding the last 2 years, have you been told by a doctor or other health professional that you had shingles (herpes zoster)?

1 □ No 2 □ Yes 3 □ Yes, but not by a health care professional

How many times have you had shingles?

1 □ 1 to 2 2 □ 3 to 4 3 □ 5 to 9 4 □ 10 to 14 5 □ 15 or more

At what age did you first have shingles?

__ __ Age
37. Excluding the last 2 years, have you been told by a doctor or other health professional that you had herpes simplex (or cold sores) on the lip or around the outside of the mouth?

1 ☐ No 2 ☐ Yes 3 ☐ Yes, but not by a health care professional

How many times have you had herpes simplex on the lip or around the outside of the mouth. (Please indicate the total number of episodes, even if they were not diagnosed by a doctor.)

1 ☐ 1 to 2 2 ☐ 3 to 4 3 ☐ 5 to 9 4 ☐ 10 to 14 5 ☐ 15 or more

At what age did you first have herpes simplex of the mouth (or cold sores)? __ __ Age

38. Excluding the last 2 years, were you ever told by a doctor or other health professional that you had genital herpes?

1 ☐ No 2 ☐ Yes 3 ☐ Yes, but not by a health care professional

How many times have you had genital herpes? (Please indicate the total number of episodes, even if they were not diagnosed by a doctor.)

1 ☐ 1 to 2 2 ☐ 3 to 4 3 ☐ 5 to 9 4 ☐ 10 to 14 5 ☐ 15 or more

At what age did you have your first episode of genital herpes? __ __ Age

39. Excluding the last 2 years, were you ever told by a doctor or other health professional that you had infectious hepatitis?

1 ☐ No 2 ☐ Yes

What type(s) of infectious hepatitis did the doctor or other health professional tell you that you had?

1 ☐ Hepatitis A 2 ☐ Hepatitis B 3 ☐ Hepatitis C 4 ☐ Non-A, non-B hepatitis 5 ☐ Other, please specify type:

At what age were you first told by a doctor or other health professional that you had infectious hepatitis? __ __ Age
40. Has a doctor or other health professional ever told you that you have plant allergies (e.g., allergies to trees, grass, weeds, pollen, etc.)?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, At what age were you first told?

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What symptoms have you had from your plant allergies? (Mark all that apply.)

<table>
<thead>
<tr>
<th></th>
<th>Burning, itching, watery eyes</th>
<th>Runny nose</th>
<th>Sneezing or congestion</th>
<th>Difficulty breathing</th>
<th>Hives or skin rash</th>
<th>Severe swelling</th>
<th>Anaphylactic shock (severe allergic reaction affecting your breathing and requiring you to need treatment with adrenaline or epinephrine)</th>
<th>Other, list:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

What plant(s) are you specifically allergic to?

______________________
______________________
______________________
______________________

At what age did you have your most recent allergy attack?

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On average, how many months per year do you have plant allergies?

<table>
<thead>
<tr>
<th></th>
<th>1 or less</th>
<th>2 to 6 months</th>
<th>7 to 11 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Have you ever taken medications, allergy shots, or other treatments for your plant allergies?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which treatments? (Check all that apply.)

<table>
<thead>
<tr>
<th></th>
<th>Over-the-counter drugs</th>
<th>Other, please specify:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Allergy shots</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What is the total number of years you took allergy shots for plant allergies?

<table>
<thead>
<tr>
<th></th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
41. Has a doctor or other health professional ever told you that you have allergies to foods like eggs, dairy products, shellfish or seafood, wheat, peanuts, or other foods?

1 □ No  2 □ Yes

If yes,

At what age were you first told?

___ ___ Age

What food(s) are you specifically allergic to?

____________________
____________________
____________________

What symptoms have you had from your food allergies? (Mark all that apply.)

1 □ Burning, itching, watery eyes
1 □ Runny nose
1 □ Sneezing or congestion
1 □ Difficulty breathing
1 □ Hives or skin rash
1 □ Severe swelling
1 □ Anaphylactic shock (severe allergic reaction affecting your breathing and requiring you to need treatment with adrenaline or epinephrine)
1 □ Other, list: _________________________________

What is the total number of times you have had an allergic reaction to food?

1 □ 1  2 □ 2 to 5  3 □ 6 to 10  4 □ 11 to 20  5 □ 21 or more

Have you ever taken medications, allergy shots, or other treatments for your food allergies?

1 □ No  2 □ Yes

Which treatments? (Check all that apply.)

1 □ Over-the-counter drugs  1 □ Other, please specify: _________________________________
1 □ Prescription drugs
1 □ Allergy shots

What is the total number of years you took allergy shots for food allergies?

___ ___ Years
42. Has a doctor or other health professional ever told you that you have animal allergies?

1 □ No 2 □ Yes

If yes, At what age were you first told?

___ □ Age

What animal(s) are you specifically allergic to?

______________________
______________________
______________________
______________________

What symptoms have you had from your animal allergies? (Mark all that apply.)

1 □ Burning, itching, watery eyes 1 □ Runny nose
1 □ Sneezing or congestion 1 □ Difficulty breathing
1 □ Hives or skin rash 1 □ Severe swelling
1 □ Anaphylactic shock (severe allergic reaction affecting your breathing and requiring you to need treatment with adrenaline or epinephrine)
1 □ Other, list: _________________________________

At what age did you have your most recent allergy attack?

___ □ Age

For how many total years have you lived with an animal that you are allergic to?

1 □ Less than 1 2 □ 1 to 5 3 □ 6 to 10 4 □ 11 to 20 5 □ 21 or more

Have you ever taken medications, allergy shots, or other treatments for your animal allergies?

1 □ No 2 □ Yes

Which treatments? (Check all that apply.)

1 □ Over-the-counter drugs 1 □ Other, please specify: ____________________________
1 □ Prescription drugs
1 □ Allergy shots

What is the total number of years you took allergy shots for animal allergies?

___ □ Years
43. Has a doctor or other health professional ever told you that you have dust allergies?

1 □ No  2 □ Yes

If yes,
At what age were you first told?

__ __ Age

What type of dust are you specifically allergic to?

____________________
____________________
____________________
____________________

What symptoms have you had from your dust allergies? (Mark all that apply.)

1 □ Burning, itching, watery eyes
1 □ Runny nose
1 □ Sneezing or congestion
1 □ Difficulty breathing
1 □ Hives or skin rash
1 □ Severe swelling
1 □ Anaphylactic shock (severe allergic reaction affecting your breathing and requiring you to need treatment with adrenaline or epinephrine)
1 □ Other, list: _________________________________

At what age did you have your most recent allergy attack?

__ __ Age

On average, how many months per year do you have dust allergies?

1 □ 1 or less  2 □ 2 to 6 months  3 □ 7 to 11 months  4 □ 12 months

Have you ever taken medications, allergy shots, or other treatments for your dust allergies?

1 □ No  2 □ Yes

Which treatments? (Check all that apply.)

1 □ Over-the-counter drugs
1 □ Prescription drugs
1 □ Allergy shots
1 □ Other, please specify: _________________________________

What is the total number of years you took allergy shots for dust allergies?

__ __ Years
44. Has a doctor or other health professional ever told you that you have insect allergies?

1 [ ] No  
2 [ ] Yes

If yes,  

At what age were you first told?  

[ ] Age

What insect(s) are you specifically allergic to?  

______________________  
______________________  
______________________  
______________________

What symptoms have you had from your insect allergies? (Mark all that apply.)

1 [ ] Burning, itching, watery eyes
2 [ ] Runny nose
3 [ ] Sneezing or congestion
4 [ ] Difficulty breathing
5 [ ] Hives or skin rash
6 [ ] Severe swelling
7 [ ] Anaphylactic shock (severe allergic reaction affecting your breathing and requiring you to need treatment with adrenaline or epinephrine)
8 [ ] Other, list: _________________________________

At what age did you have your most recent allergy attack?  

[ ] Age

What is the total number of times you have had an allergic reaction to an insect?  

1 [ ] 1 or less  2 [ ] 2 to 5  3 [ ] 6 to 10  4 [ ] 11 to 20  5 [ ] 21 or more

Have you ever taken medications, allergy shots, or other treatments for your insect allergies?

1 [ ] No  
2 [ ] Yes

Which treatments? (Check all that apply.)

1 [ ] Over-the-counter drugs  1 [ ] Other, please specify: _________________________________
2 [ ] Prescription drugs
3 [ ] Allergy shots

What is the total number of years you took allergy shots for insect allergies?  

[ ] Years
45. Has a doctor or other health professional ever told you that you have a mold allergy?

1 □ No  2 □ Yes

If yes,

At what age were you first told?

__ __ Age

What symptoms have you had from your mold allergy? (Mark all that apply.)

1 □ Burning, itching, watery eyes
1 □ Runny nose
1 □ Sneezing or congestion
1 □ Difficulty breathing
1 □ Hives or skin rash
1 □ Severe swelling
1 □ Anaphylactic shock (severe allergic reaction affecting your breathing and requiring you to need treatment with adrenaline or epinephrine)
1 □ Other, list: ________________________________

At what age did you have your most recent allergy attack?

__ __ Age

On average, how many months per year do you have a mold allergy?

1 □ 1 or less  2 □ 2 to 6 months  3 □ 7 to 11 months  4 □ 12 months

Have you ever taken medications, allergy shots, or other treatments for your mold allergy?

1 □ No  2 □ Yes

Which treatments? (Check all that apply.)

1 □ Over-the-counter drugs  1 □ Other, please specify: ________________________________
1 □ Prescription drugs
1 □ Allergy shots

What is the total number of years you took allergy shots for your mold allergy?

__ __ Years
46. Has a doctor or other health professional ever told you that you have allergies to drugs, medications, vaccinations, or other chemicals?

1 □ No  2 □ Yes

If yes,

At what age were you first told?

___ ___ Age

What drug(s), medication(s), or vaccination(s) are you specifically allergic to?

________________________________
________________________________
________________________________

What symptoms have you had from your drug, medication or vaccination allergies? (Mark all that apply.)

1 □ Burning, itching, watery eyes
1 □ Runny nose
1 □ Sneezing or congestion
1 □ Difficulty breathing
1 □ Hives or skin rash
1 □ Severe swelling
1 □ Anaphylactic shock (severe allergic reaction affecting your breathing and requiring you to need treatment with adrenaline or epinephrine)

1 □ Other, list: ______________________

What is the total number of times you have had an allergic reaction to drugs, medications, or vaccinations?

1 □ Less than 1  2 □ 1 to 5  3 □ 6 to 10  4 □ 11 to 20  5 □ 21 or more
47. Have you ever received the following immunizations or vaccinations?

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Age at first shot</th>
<th>Age at last shot</th>
<th>Total number of shots</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Chickenpox</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Influenza (flu)</td>
<td>□ No</td>
<td>□ Yes</td>
<td></td>
</tr>
</tbody>
</table>

48. Excluding the last 2 years, did you take corticosteroids, such as cortisone or prednisone?

1 □ No              2 □ Yes

Excluding the last 2 years, if you added up all the time that you took corticosteroids, how long would that be?

1 □ Less than 3 months 4 □ 1 to 5 years 7 □ Greater than 20 years
2 □ 3 to 6 months      5 □ 6 to 10 years
3 □ 7 to 11 months     6 □ 11 to 20 years

How old were you when you first took corticosteroids?

___ ___ Age

How old were you when you last took corticosteroids? ___ ___ Age

For what illnesses or conditions did you take corticosteroids?

________________________________________________________________________
49. Excluding the last 2 years, did you take any of the following medications?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Age first taken</th>
<th>Total number of years taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>Pills for sugar diabetes (or to lower blood sugar)</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>Medication for an overactive thyroid</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>Medication for an underactive thyroid</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>Medication to control epilepsy (convulsions or seizures)</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>“Statin” cholesterol-lowering drugs [e.g., Mevacor (lovastatin), Prevacol (pravastatin), Zocor (simvastatin), Lipitor, etc.]</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>Other cholesterol-lowering drugs</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>Prozac, Zoloft, Paxil, Celexa</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>Other antidepressants [e.g., Elavil, Tofranil, Pameler]</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
<tr>
<td>Digoxin (e.g., Lanoxin)</td>
<td>1 No 2 Yes</td>
<td>__ Age __ Years</td>
</tr>
</tbody>
</table>

50. Excluding the last two years, did you regularly take any of the following medications? (Exclude occasional use of less than once per month.)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Average days per month used</th>
<th>On days used, number of pills taken</th>
<th>Total number of years taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin (baby or low-dose) (162 mg or less)</td>
<td>1 No 2 Yes</td>
<td>__</td>
<td>__</td>
</tr>
<tr>
<td>Aspirin (regular or extra strength) (163 mg or more, e.g., Bufferin, Anacin, Bayer, Excedrin, Ecotrin, etc.)</td>
<td>1 No 2 Yes</td>
<td>__</td>
<td>__</td>
</tr>
<tr>
<td>Ibuprofen (e.g., Motrin, Advil, Nuprin, Mediprin, etc.)</td>
<td>1 No 2 Yes</td>
<td>__</td>
<td>__</td>
</tr>
<tr>
<td>Acetaminophen (e.g., Tylenol, Phenaphen, etc.)</td>
<td>1 No 2 Yes</td>
<td>__</td>
<td>__</td>
</tr>
<tr>
<td>Other anti-inflammatory analgesics (e.g., Naprosyn, Anaprox, Aleve, Voltaren, Feldene, Toradol, Indocin, etc.)</td>
<td>1 No 2 Yes</td>
<td>__</td>
<td>__</td>
</tr>
<tr>
<td>COX-2 inhibitors (e.g., Celebrex, Vioxx, etc.)</td>
<td>1 No 2 Yes</td>
<td>__</td>
<td>__</td>
</tr>
</tbody>
</table>
51. Were you adopted?  1 □ No  2 □ Yes  (Please provide any information you are aware of about your blood relatives.)

52. Counting only persons related to you by blood, please provide numbers for each of the following. (Write in “0” if you have none, and “DK” if you don’t know.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many brothers do/did you have? (include half-brothers)</td>
<td>__ __ Brothers</td>
</tr>
<tr>
<td>How many sisters do/did you have? (include half-sisters)</td>
<td>__ __ Sisters</td>
</tr>
<tr>
<td>How many sons do/did you have?</td>
<td>__ __ Sons</td>
</tr>
<tr>
<td>How many daughters do/did you have?</td>
<td>__ __ Daughters</td>
</tr>
</tbody>
</table>

53. Have your parents, brothers, sisters, sons, or daughters related by blood (include half-brothers and -sisters) ever been diagnosed as having cancer? (Please include non-Hodgkin lymphoma, Hodgkin’s disease, multiple myeloma, and melanoma, as well as any other cancer.)

<table>
<thead>
<tr>
<th>Yes/No</th>
<th></th>
<th>Age</th>
<th>Person is deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 □ Don’t know</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please provide any other information or family history of cancer:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Page 24
54. How old was your mother when you were born?

   ___  ___ Age 1 [ ] Don’t know

55. What was your birth order? (Include only live births.)

   1 [ ] First child  2 [ ] Second child  3 [ ] Third child  4 [ ] Fourth child  5 [ ] Fifth child or greater  6 [ ] Don’t know

56. What was your birth weight?

   ___ ___ Pounds  ___ ___ Ounces 1 [ ] Don’t know

57. When you were born, were you a:

   1 [ ] Singleton  2 [ ] Twin  3 [ ] Triplet or more

   If you were a twin, is your twin male or female?

   1 [ ] Male  2 [ ] Female

   Are you and your twin:

   1 [ ] Identical (monozygotic)  2 [ ] Fraternal (dizygotic)  3 [ ] Don’t know

58. When you were born, were you:

   1 [ ] Full term (pregnancy lasted about 9 months)  2 [ ] 4 or more weeks premature

59. Did your mother have eclampsia or preeclampsia (toxemia of pregnancy) while pregnant with you?

   1 [ ] No  2 [ ] Yes  3 [ ] Don’t know
60. When you were born, were you treated for neonatal jaundice?

1 □ No  2 □ Yes  3 □ Don’t know

61. Were you breastfed as a baby?

1 □ No  2 □ Yes  3 □ Don’t know

For how long were you breastfed?

1 □ Less than 1 month
2 □ 1 to 6 months
3 □ 7 to 12 months
4 □ 12 months or more
5 □ Don’t know

62. Counting yourself, how many people usually slept in your bedroom up until you were 12 years old?

___ ___ People

63. Think back to the ages listed below. Compared to other girls/boys your age, was your height short, average, or tall?

At age...

7 years (about 1st grade) ...............1 □ 2 □ 3 □ 4 □

12 years (about 6th grade) ..............1 □ 2 □ 3 □ 4 □

18 years (about 12th grade) ............1 □ 2 □ 3 □ 4 □

64. Think back to your weight at the ages listed below. Compared to other girls/boys your age and height, were you thin, average, or heavy?

At age...

7 years (about 1st grade) ..................1 □ 2 □ 3 □ 4 □

12 years (about 6th grade) ............1 □ 2 □ 3 □ 4 □

18 years (about 12th grade) ..........1 □ 2 □ 3 □ 4 □
65. How old were you when you stopped getting taller?

___ ___ Age 1  Don’t know

66. How much did you weigh when you stopped getting taller?

___ ___ ___ Pounds 1  Don’t know

---

**Sun Exposure**

67. Would you describe your complexion as: 1 Light  2 Medium  3 Dark

68. Suppose you spent an hour in bright sunlight for the first time in summer in the middle of the day without any protection. Which of these reactions best describes what would happen to your skin?

1  A sunburn with blisters  4  A tan with no sunburn
2  A sunburn without blisters  5  No change in skin color
3  A mild sunburn without blisters

69. Have you ever had a mole removed?

1  No  2  Yes

Were any of them diagnosed as dysplastic (atypical, abnormal, pre-cancerous)?

1  No  2  Yes  3  Don’t know

Were any of them diagnosed as melanoma (cancer in a mole)?

1  No  2  Yes  3  Don’t know

70. What would happen to your skin if it was repeatedly exposed to bright sunlight in summer months?

1  Get no suntan at all, or only get freckled, or only turn pink
2  Mild or occasionally tanned
3  Moderately tanned
4  Go very brown and deeply tanned
5  Don’t know
71. Do you have skin that freckles as a result of exposure to the sun?

1. Yes, I always freckle as a result of prolonged sun exposure
2. Yes, I sometimes freckle or get a moderate amount of freckles as a result of prolonged sun exposure
3. No, I very rarely or never freckle as a result of prolonged sun exposure
4. Don’t know

72. How many freckles do you currently have?

1. None
2. Few (1 to 25)
3. Moderate (26 to 100)
4. Extensive cover (101 or more)

The next several questions ask about sun exposure at different times in your life. Please fill out one answer for each of the time periods on the left. If you are not yet the age specified in the range, please answer not applicable for that age range.

73. How much midday (10 a.m to 2 p.m.) sun exposure, on average, did you have in each of the following age groups?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Not applicable</th>
<th>Don’t know</th>
<th>Practically none (3 hrs or less per week)</th>
<th>Little (4 to 7 hrs per week)</th>
<th>Moderate (8 to 14 hrs per week)</th>
<th>Extensive (15+ hrs per week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 12</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>13 years to 21 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>22 years to 40 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>41 years or older</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

74. In each of the following age groups, how frequently did you wear sunscreen or protective clothing (hat or long-sleeved shirt) when in the bright sun for more than 15 minutes?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Not applicable</th>
<th>Don’t know</th>
<th>Rarely (less than 20%)</th>
<th>Most times (20% to 80%)</th>
<th>Usually (more than 80%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 12</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13 years to 21 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22 years to 40 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>41 years or older</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
75. Please indicate the most severe sunburn you had in each of the following age groups?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Not applicable</th>
<th>Don't know</th>
<th>Practically never had sunburn</th>
<th>Mild sunburns (mild redness only)</th>
<th>Moderate sunburns (redness and/or pain)</th>
<th>Severe without blistering (painful)</th>
<th>Severe with blistering (painful)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 12</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>13 years to 21 years</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>41 years or older</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

76. Have you ever used a sunlamp or tanning bed?

1 □ No  2 □ Yes

How old were you the first time you used a sunlamp or tanning bed?

1 □ 9 years of age or younger
2 □ 10 to 19 years old
3 □ 20 to 29 years old
4 □ 30 to 39 years old
5 □ 40 years of age or older

How old were you the last time you used a sunlamp or tanning bed?

1 □ 9 years of age or younger
2 □ 10 to 19 years old
3 □ 20 to 29 years old
4 □ 30 to 39 years old
5 □ 40 years of age or older

About how many times have you ever used a sunlamp or tanning bed?

1 □ 1 or 2 times
2 □ 3 to 9 times
3 □ 10 to 19 times
4 □ 20 times or more
### Have insecticides (chemicals that kill insects) ever been used around your home, lawn/yard, or family garden at any of the residences where you have lived?

1. **No**  
2. **Yes**

If yes, approximately how many years (total) were these products used?

1. _4 years or less_  
2. _5 to 15 years_  
3. _16 to 30 years_  
4. _31 years or more_

Did you personally handle any of these products?

1. **No**  
2. **Yes**

If yes, what percent of the total years that these products were used did you personally handle these products?

1. _4 percent or less_  
2. _5 to 50 percent_  
3. _51 percent or more_

### Have herbicides (chemicals that kill weeds) ever been used around your home, lawn/yard, or family garden at any of the residences where you have lived?

1. **No**  
2. **Yes**

If yes, approximately how many years (total) were these products used?

1. _4 years or less_  
2. _5 to 15 years_  
3. _16 to 30 years_  
4. _31 years or more_

Did you personally handle any of these products?

1. **No**  
2. **Yes**

If yes, what percent of the total years that these products were used did you personally handle these products?

1. _4 percent or less_  
2. _5 to 50 percent_  
3. _51 percent or more_
79. Have fertilizers ever been used on lawns/yards at any of the residences where you have lived?

1  No  2  Yes

If yes, approximately how many years (total) were these products used?

1  4 years or less  2  5 to 15 years  3  16 to 30 years  4  31 years or more

Did you personally handle any of these products?

1  No  2  Yes

If yes, what percent of the total years that these products were used did you personally handle these products?

1  4 percent or less  2  5 to 50 percent  3  51 percent or more

80. Have pesticides or chemicals to control or prevent termites ever been used at any of the residences where you have lived?

1  No  2  Yes

If yes, approximately how many years (total) were these products used?

1  4 years or less  2  5 to 15 years  3  16 to 30 years  4  31 years or more

Did you personally handle any of these products?

1  No  2  Yes

If yes, what percent of the total years that these products were used did you personally handle these products?

1  4 percent or less  2  5 to 50 percent  3  51 percent or more

81. Have pesticides or chemicals to control cockroaches, ants, or insects other than termites ever been used at any of the residences where you have lived?

1  No  2  Yes

If yes, approximately how many years (total) were these products used?

1  4 years or less  2  5 to 15 years  3  16 to 30 years  4  31 years or more

Did you personally handle any of these products?

1  No  2  Yes

If yes, what percent of the total years that these products were used did you personally handle these products?

1  4 percent or less  2  5 to 50 percent  3  51 percent or more
82. Have you ever had cats as pets?
   1 □ No   2 □ Yes

   If yes, did a veterinarian ever tell you that any of your cats had viral leukemia or lymphoma?
   1 □ No   2 □ Yes

   If yes, how many of your cats had viral leukemia or lymphoma?
   ___ ___ Cats

83. Which best describes your racial background?
   1 □ American Indian/Alaska Native   5 □ White
   2 □ Asian
   3 □ Native Hawaiian or other Pacific Islander
   4 □ Black or African American
   6 □ None of the above
   7 □ I don’t know
   8 □ Refuse

84. Are you of Hispanic or Latino origin?
   1 □ No   2 □ Yes   3 □ I don’t know   4 □ Refuse

We welcome any comments you may wish to provide.

Thank you for taking the time to participate in this survey!