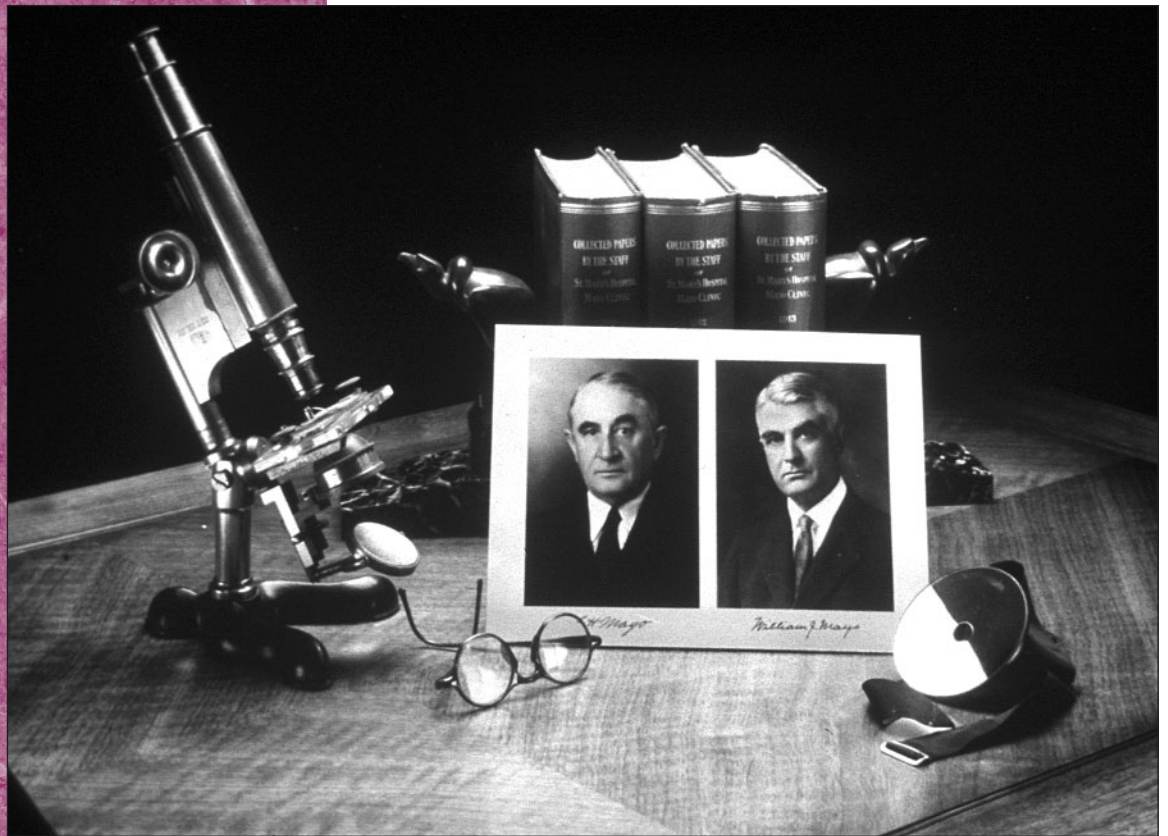
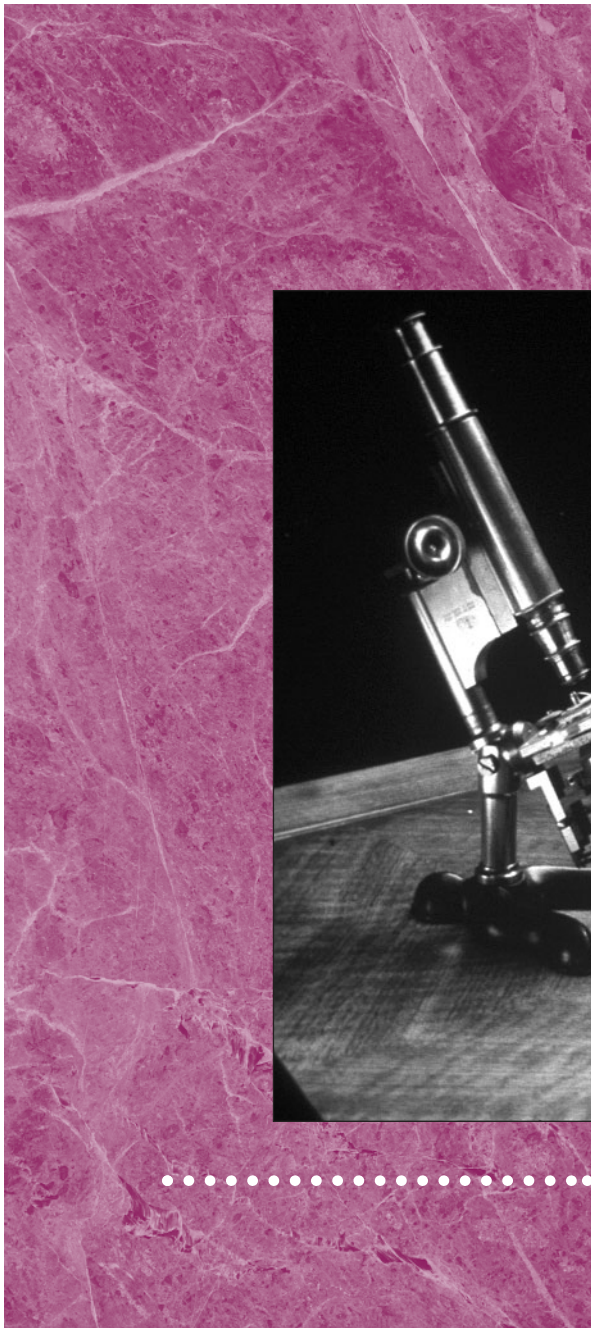


Mayo Study of Lymphoma and Leukemia (Main Questionnaire)



1-7

Clinic Number: __ - __ __ __ - __ __ __

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

8-15

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

16-23

1. What is your date of birth?

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

24_

2. What is your gender?

1 Male 2 Female

25_

3. What is your marital status?

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

26_

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.)

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

	1 <input type="checkbox"/> Don't know	Primary	Secondary
27:58			
28:59	English, Scotch, Welsh	1 <input type="checkbox"/>	2 <input type="checkbox"/>
29:60	French	1 <input type="checkbox"/>	2 <input type="checkbox"/>
30:61	German	1 <input type="checkbox"/>	2 <input type="checkbox"/>
31:62	Greek	1 <input type="checkbox"/>	2 <input type="checkbox"/>
32:63	Irish	1 <input type="checkbox"/>	2 <input type="checkbox"/>
33:64	Italian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
34:65	Spanish, Portuguese	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	Scandinavian (Swedish, Norwegian, Danish, Finnish, Icelandic)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
35:66			
36:67	Polish	1 <input type="checkbox"/>	2 <input type="checkbox"/>
37:68	Czech/Slovak	1 <input type="checkbox"/>	2 <input type="checkbox"/>
38:69	Hungarian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
39:70	Russian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	Other Eastern European (Lithuanian, Romanian, Ukrainian, etc.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
40:71			
41:72	Other European	1 <input type="checkbox"/>	2 <input type="checkbox"/>
42:73	American Indian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
43:74	Canadian (non-French)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
44:75	French Canadian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
45:76	Mexican	1 <input type="checkbox"/>	2 <input type="checkbox"/>
46:77	Puerto Rican	1 <input type="checkbox"/>	2 <input type="checkbox"/>
47:78	Central American	1 <input type="checkbox"/>	2 <input type="checkbox"/>
48:79	South American	1 <input type="checkbox"/>	2 <input type="checkbox"/>
49:80	West Indian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
50:81	Chinese	1 <input type="checkbox"/>	2 <input type="checkbox"/>
51:82	Indian, Pakistani	1 <input type="checkbox"/>	2 <input type="checkbox"/>
52:83	Korean	1 <input type="checkbox"/>	2 <input type="checkbox"/>
53:84	Japanese	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	Other Asian countries or Pacific Islanders	1 <input type="checkbox"/>	2 <input type="checkbox"/>
54:85			
55:86	African	1 <input type="checkbox"/>	2 <input type="checkbox"/>
56:87	Middle Eastern	1 <input type="checkbox"/>	2 <input type="checkbox"/>
57:88	Other, specify: _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>

	1 <input type="checkbox"/> Don't know	Primary	Secondary
27:58			
28:59	English, Scotch, Welsh	1 <input type="checkbox"/>	2 <input type="checkbox"/>
29:60	French	1 <input type="checkbox"/>	2 <input type="checkbox"/>
30:61	German	1 <input type="checkbox"/>	2 <input type="checkbox"/>
31:62	Greek	1 <input type="checkbox"/>	2 <input type="checkbox"/>
32:63	Irish	1 <input type="checkbox"/>	2 <input type="checkbox"/>
33:64	Italian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
34:65	Spanish, Portuguese	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	Scandinavian (Swedish, Norwegian, Danish, Finnish, Icelandic)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
35:66			
36:67	Polish	1 <input type="checkbox"/>	2 <input type="checkbox"/>
37:68	Czech/Slovak	1 <input type="checkbox"/>	2 <input type="checkbox"/>
38:69	Hungarian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
39:70	Russian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	Other Eastern European (Lithuanian, Romanian, Ukrainian, etc.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
40:71			
41:72	Other European	1 <input type="checkbox"/>	2 <input type="checkbox"/>
42:73	American Indian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
43:74	Canadian (non-French)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
44:75	French Canadian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
45:76	Mexican	1 <input type="checkbox"/>	2 <input type="checkbox"/>
46:77	Puerto Rican	1 <input type="checkbox"/>	2 <input type="checkbox"/>
47:78	Central American	1 <input type="checkbox"/>	2 <input type="checkbox"/>
48:79	South American	1 <input type="checkbox"/>	2 <input type="checkbox"/>
49:80	West Indian	1 <input type="checkbox"/>	2 <input type="checkbox"/>
50:81	Chinese	1 <input type="checkbox"/>	2 <input type="checkbox"/>
51:82	Indian, Pakistani	1 <input type="checkbox"/>	2 <input type="checkbox"/>
52:83	Korean	1 <input type="checkbox"/>	2 <input type="checkbox"/>
53:84	Japanese	1 <input type="checkbox"/>	2 <input type="checkbox"/>
	Other Asian countries or Pacific Islanders	1 <input type="checkbox"/>	2 <input type="checkbox"/>
54:85			
55:86	African	1 <input type="checkbox"/>	2 <input type="checkbox"/>
56:87	Middle Eastern	1 <input type="checkbox"/>	2 <input type="checkbox"/>
57:88	Other, specify: _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>

Occupation

89-90_ 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.)

 Job title

91-92_ 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.)

	<u>Job title</u>	<u>Age first worked</u>	<u>Number of years worked</u>
93-98	_____	__ __ Age	__ __ Years
99-104	_____	__ __ Age	__ __ Years
105-110	_____	__ __ Age	__ __ Years
111-116	_____	__ __ Age	__ __ Years
117-122	_____	__ __ Age	__ __ Years

123_ 9. Did you ever live on a farm for more than one year? (Do not include hobby farms.)

1 No

2 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 Yes

At what age did you last live on a farm? __ __ Age

131_ 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?

132_ 1 No 2 Yes

133-135 If yes, at what age did you start smoking cigarettes?
__ __ Age 1 Don't know

136_ Do you smoke cigarettes now?
1 No → What year did you stop smoking cigarettes?
__ __ __ __ Year 1 Don't know

137-141 Before stopping, how many cigarettes did you usually smoke per day?
__ __ Cigarettes per day 1 Don't know

142-144 2 Yes → How many cigarettes do you usually smoke per day?
__ __ Cigarettes per day 1 Don't know

145-147

11. Prior to 2 years ago, did you use any of these tobacco products for twelve months or longer?

148_
149-150

Cigar

1 No 2 Yes

For how many years? __ __ Years

151_
152-153

Pipe

1 No 2 Yes

For how many years? __ __ Years

154_
155-156

Snuff

1 No 2 Yes

For how many years? __ __ Years

157_
158-159

Chewing Tobacco

1 No 2 Yes

For how many years? __ __ Years

160_

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

1 No 2 Yes

161-162

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

163-164

165_

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

1 No 2 Yes

166-167

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

168-169

170_ 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?	None	Less than 1 each month	1 to 3 each month	1 to 2 each week	3 to 6 each week	1 to 2 each day	3 or more each day
	▼	▼	▼	▼	▼	▼	▼
171_ From age 14 to 17	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
172_ From age 18 to 22	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
173_ From age 23 to 29	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
174_ From age 30 to 49	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
175_ About 2 years ago . . .	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

Physical Activity

176_ 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?

- 177-179
- 180_
- 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

<p>How many minutes did you usually walk?</p> <p>___ ___ Minutes</p> <p>What was your usual speed?</p> <ul style="list-style-type: none"> 1 <input type="checkbox"/> Casual (less than 2 miles an hour) 2 <input type="checkbox"/> Average or normal (2 to 3 miles an hour) 3 <input type="checkbox"/> Fairly fast (3 to 4 miles an hour) 4 <input type="checkbox"/> Very fast (more than 4 miles an hour) 5 <input type="checkbox"/> Don't know

Continue on next page.

181_ 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

182-184

185_ 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

186-188

189_ 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

190-192

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.)

- 193_ 12 years old . . . 1 No 2 Yes 3 Don't know
 194_ 18 years old . . . 1 No 2 Yes 3 Don't know
 195_ 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?

	<u>Activity</u>	<u>Percent of time</u>
196-198	Sitting	___ ___ %
199-201	Standing	___ ___ %
202-204	Walking	___ ___ %
205-207	Light manual labor	___ ___ %
208-210	Heavy manual labor	___ ___ %

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.)

- 211-213 21. What was your weight 2 years ago? ___ ___ Pounds
- 214-216 22. How tall were you (without shoes on) at about age 18? ___ Feet ___ ___ Inches
(Round up 1/2 inch.)
- 217-219 23. What was your weight at about age 18? ___ ___ Pounds
- 220-222 24. What was your weight at about age 35? ___ ___ Pounds (Leave blank if less than 35 years old.)
- 223-225 25. What was your weight at about age 50? ___ ___ Pounds (Leave blank if less than 50 years old.)
- 226-228 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

229_

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."

230-237

<u>Condition or surgical procedure</u>	<u>Age at transfusion</u>	<u>Number of transfusions</u>	<u>How much of this blood was your own?</u>
1. _____	__ __ Age	__ __ Number	1 <input type="checkbox"/> None 3 <input type="checkbox"/> All 2 <input type="checkbox"/> Some 4 <input type="checkbox"/> Don't know

238-245

2. _____	__ __ Age	__ __ Number	1 <input type="checkbox"/> None 3 <input type="checkbox"/> All 2 <input type="checkbox"/> Some 4 <input type="checkbox"/> Don't know
----------	--------------	-----------------	---

246-253

3. _____	__ __ Age	__ __ Number	1 <input type="checkbox"/> None 3 <input type="checkbox"/> All 2 <input type="checkbox"/> Some 4 <input type="checkbox"/> Don't know
----------	--------------	-----------------	---

254-261

4. _____	__ __ Age	__ __ Number	1 <input type="checkbox"/> None 3 <input type="checkbox"/> All 2 <input type="checkbox"/> Some 4 <input type="checkbox"/> Don't know
----------	--------------	-----------------	---

262-269

5. _____	__ __ Age	__ __ Number	1 <input type="checkbox"/> None 3 <input type="checkbox"/> All 2 <input type="checkbox"/> Some 4 <input type="checkbox"/> Don't know
----------	--------------	-----------------	---

270_

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.

271-278

Last _____	__ __ Age	__ __ Number	1 <input type="checkbox"/> None 3 <input type="checkbox"/> All 2 <input type="checkbox"/> Some 4 <input type="checkbox"/> Don't know
------------	--------------	-----------------	---

279_

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?

280_

1 1 to 2 2 3 to 5 3 6 to 10 4 11 to 15 5 16 or more

281_

29. Did you ever have an organ transplant (including a bone marrow transplant)?

1 No 2 Yes

↓

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

<u>Organ</u>	<u>Year received</u>
	_ _ _ _
	_ _ _ _

282-286

287-291

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.)

If yes, age you were first diagnosed _____

	<u>Condition</u>			
292-294	Heart disease, angina or heart attack	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
295-297	High blood pressure	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
298-300	Diabetes mellitus (sugar diabetes not associated with pregnancy)	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
301-303	Rheumatoid arthritis	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
304-306	Osteoarthritis (degenerative arthritis)	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
307-309	Crohn's disease	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
310-312	Ulcerative colitis	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
313-315	Celiac disease	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
316-318	Sjögren's disease or sicca syndrome	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
319-321	Lupus or SLE	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age
322-324	Polymyositis, dermatomyositis, or polymyalgia rheumatica	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes →
				_ _ _ Age

Continued next page...

	<u>Condition</u>	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Not sure	3 <input type="checkbox"/> Yes	<u>If yes, age you were first diagnosed</u>
325-327	Eczema			→	___ Age
328-330	Contact dermatitis			→	___ Age
331-333	Cirrhosis of the liver or liver damage			→	___ Age
334-336	Infectious mononucleosis ("mono")			→	___ Age
337-339	Chronic fatigue syndrome			→	___ Age
340-342	Depression, requiring medication or shock therapy			→	___ Age
343-345	Epilepsy (convulsions or seizures not related to high fever)			→	___ Age

346_ 31. Have you ever been diagnosed with cancer? 1 No 2 Yes

If yes, please provide:		
<u>Type of cancer</u>	<u>Age you were first diagnosed</u>	<u>Treatments received (Mark all that apply.)</u>
347-357 1. _____	___ Age	1 <input type="checkbox"/> Surgery 1 <input type="checkbox"/> Radiation 1 <input type="checkbox"/> Chemotherapy 1 <input type="checkbox"/> Other, specify: _____ 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Don't know
358-368 2. _____	___ Age	1 <input type="checkbox"/> Surgery 1 <input type="checkbox"/> Radiation 1 <input type="checkbox"/> Chemotherapy 1 <input type="checkbox"/> Other, specify: _____ 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Don't know
369-379 3. _____	___ Age	1 <input type="checkbox"/> Surgery 1 <input type="checkbox"/> Radiation 1 <input type="checkbox"/> Chemotherapy 1 <input type="checkbox"/> Other, specify: _____ 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Don't know

380_

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

381_

382_

383-384

385_

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?

Medication

How long?

_____ Months OR _____ Years

_____ Months OR _____ Years

_____ Months OR _____ Years

386-387

388_

389-412

413-436

437-460

461_

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?			
	No	Yes	
H2 blocker [e.g., Zantac, Pepcid, Tagamet, Axid (ranitidine, cimetidine), etc.]	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Age first taken: ___ __ Total number of years taken: ___ __
Other acid-suppression capsules/tablets [e.g., Prilosec, Cytotec, Prevacid, etc.]	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Age first taken: ___ __ Total number of years taken: ___ __
Other antacids [e.g., Tums, Rolaids, Maalox, Mylanta, etc.]	1 <input type="checkbox"/>	2 <input type="checkbox"/>	Age first taken: ___ __ Total number of years taken: ___ __

462-463

464-468

469-473

474-478

479_

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 <input type="checkbox"/> 1 2 <input type="checkbox"/> 2 or more
At what age did you <i>first</i> have chickenpox?
___ __ Age

480_

481-482

483_

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 <input type="checkbox"/> 1 to 2 2 <input type="checkbox"/> 3 to 4 3 <input type="checkbox"/> 5 to 9 4 <input type="checkbox"/> 10 to 14 5 <input type="checkbox"/> 15 or more
At what age did you <i>first</i> have shingles?
___ __ Age

484_

485-486

487_ 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

488_

489-490

491_ 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

492_

493-494

495_ 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 4 Non-A, non-B hepatitis
2 Hepatitis B 5 Other, please specify type:
3 Hepatitis C _____

At what age were you *first* told by a doctor or other health professional that you had infectious hepatitis? __ __ Age

496_

497-498

Allergies

499_ 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.)?

1 No 2 Yes



If yes,

At what age were you *first* told?

500-501 ___ Age
502_

503_ What plant(s) are you
504_ specifically allergic to?
505_ _____
506_ _____
507_ _____
508_ _____
509_ _____
510_ _____

What symptoms have you had from your plant 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?

511-512 ___ Age

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

513_ 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 plant allergies?

514_ 1 No 2 Yes

515-518 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 plant allergies?

519-520 ___ Years

521_ 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 Prescription drugs
- 1 Allergy shots
- 1 Other, please specify: _____

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

___ Years

570_ 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?

571-572 ___ Age

573_ **What animal(s) are you specifically allergic to?**

574_ _____
575_ _____
576_ _____
577_ _____
578_ _____
579_ _____
580_ _____
581_ _____

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?

582-583 ___ Age

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

- 584_ 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?

585_ 1 No 2 Yes

Which treatments? (Check all that apply.)

- 586-589
- 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?

590-591 ___ Years

592_ 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 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: _____

What type of dust are you specifically allergic to?

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

614_

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
- 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: _____

615-616

617_

618_

619_

620_

621_

622_

623_

624_

625_

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

__ __ Age

626-627

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

628_

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

1 No 2 Yes

629_

Which treatments? (Check all that apply.)

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

630-633

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

__ __ Years

634-635

657_

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

658-659

660-679

680-699

700-719

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728_

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

	<u>Medication</u>	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	<u>Age first taken</u>	<u>Total number of years taken</u>
810_ 811-814	Insulin			___ Age	___ Years
815_ 816-819	Pills for sugar diabetes (or to lower blood sugar)			___ Age	___ Years
820_ 821-824	Medication for an <u>overactive</u> thyroid			___ Age	___ Years
825_ 826-829	Medication for an <u>underactive</u> thyroid			___ Age	___ Years
830_ 831-834	Medication to control epilepsy (convulsions or seizures)			___ Age	___ Years
835_ 836-839	“Statin” cholesterol-lowering drugs [e.g., Mevacor (lovastatin), Pravachol (pravastatin), Zocor (simvastatin), Lipitor, etc.]			___ Age	___ Years
840_ 841-844	Other cholesterol-lowering drugs			___ Age	___ Years
845_ 846-849	Prozac, Zoloft, Paxil, Celexa			___ Age	___ Years
850_ 851-854	Other antidepressants [e.g., Elavil, Tofranil, Pamelor]			___ Age	___ Years
855_ 856-859	Digoxin (e.g., Lanoxin)			___ Age	___ Years

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

	<u>Medication</u>	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	<u>Average days per month used</u>	<u>On days used, number of pills taken</u>	<u>Total number of years taken</u>
860_ 861-866	Aspirin (baby or low-dose) (162 mg or less)			___	___	___
867_ 868-873	Aspirin (regular or extra strength) (163 mg or more, e.g., Bufferin, Anacin, Bayer, Excedrin, Ecotrin, etc.).			___	___	___
874_ 875-880	Ibuprofen (e.g., Motrin, Advil, Nuprin, Mediprin, etc.)			___	___	___
881_ 882-887	Acetaminophen (e.g., Tylenol, Phenaphen, etc.)			___	___	___
888_ 889-894	Other anti-inflammatory analgesics (e.g., Naprosyn, Anaprox, Aleve, Voltaren, Feldene, Toradol, Indocin, etc.)			___	___	___
895_ 896-901	COX-2 inhibitors (e.g., Celebrex, Vioxx, etc.)			___	___	___

Family Health History

902_ 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.)

903-904 How many brothers do/did you have? (include half-brothers) ___ __ Brothers

905-906 How many sisters do/did you have? (include half-sisters) ___ __ Sisters

907-908 How many sons do/did you have? ___ __ Sons

909-910 How many daughters do/did you have? ___ __ Daughters

911_ 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.)

1 No 2 Yes 3 Don't know

	If yes, <u>Who had the cancer?</u>	<u>What type of cancer was it?</u>	<u>What was their age at first diagnosis?</u>	<u>Check here if person is deceased.</u>
912-917	<input type="checkbox"/> Mother	_____	___ __ Age	1 <input type="checkbox"/>
918-923	<input type="checkbox"/> Father	_____	___ __ Age	1 <input type="checkbox"/>
924-929	<input type="checkbox"/> Brother #1	_____	___ __ Age	1 <input type="checkbox"/>
930-935	<input type="checkbox"/> Brother #2	_____	___ __ Age	1 <input type="checkbox"/>
936-941	<input type="checkbox"/> Brother #3	_____	___ __ Age	1 <input type="checkbox"/>
942-947	<input type="checkbox"/> Sister #1	_____	___ __ Age	1 <input type="checkbox"/>
948-953	<input type="checkbox"/> Sister #2	_____	___ __ Age	1 <input type="checkbox"/>
954-959	<input type="checkbox"/> Sister #3	_____	___ __ Age	1 <input type="checkbox"/>
960-965	<input type="checkbox"/> Son #1	_____	___ __ Age	1 <input type="checkbox"/>
966-971	<input type="checkbox"/> Son #2	_____	___ __ Age	1 <input type="checkbox"/>
972-977	<input type="checkbox"/> Son #3	_____	___ __ Age	1 <input type="checkbox"/>
978-983	<input type="checkbox"/> Daughter #1	_____	___ __ Age	1 <input type="checkbox"/>
984-989	<input type="checkbox"/> Daughter #2	_____	___ __ Age	1 <input type="checkbox"/>
990-995	<input type="checkbox"/> Daughter #3	_____	___ __ Age	1 <input type="checkbox"/>
996_	Please provide any other information or family history of cancer:			

Early Childhood and Adolescence

ADULT HEALTH MAY BE AFFECTED BY EVENTS OR EXPOSURES THAT OCCURRED IN EARLY CHILDHOOD AND ADOLESCENCE. PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

997-999

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

___ Age 1 Don't know

1000_

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

1001-1005

56. What was your birth weight?

___ Pounds ___ Ounces 1 Don't know

1006_

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

1007_

1008_

1009_

58. When you were born, were you:

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

1010_

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

1 No 2 Yes 3 Don't know

1011_ 60. When you were born, were you treated for neonatal jaundice?

1 No 2 Yes 3 Don't know

1012_ 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

1013_

1014_ 62. Counting yourself, how many people usually slept in your bedroom up until you
1015_ 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...	Short ▼	Average ▼	Tall ▼	Don't know ▼
1016_ 7 years (about 1st grade)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
1017_ 12 years (about 6th grade)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
1018_ 18 years (about 12th grade)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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...	Thin ▼	Average ▼	Heavy ▼	Don't know ▼
1019_ 7 years (about 1st grade)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
1020_ 12 years (about 6th grade)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
1021_ 18 years (about 12th grade)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

1022-
1024

65. How old were you when you stopped getting taller?

__ __ Age 1 Don't know

1025-
1028

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

__ __ __ Pounds 1 Don't know

Sun Exposure

1029_

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

1030_

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

1031_

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

1032_

1033_

1034_

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

1035_

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

1036_

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?

	Not applicable	Don't know	Practically none (3 hrs or less per week)	Little (4 to 7 hrs per week)	Moderate (8 to 14 hrs per week)	Extensive (15+ hrs per week)
1037_ Birth to age 12	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
1038_ 13 years to 21 years	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
1039_ 22 years to 40 years	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
1040_ 41 years or older	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

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?

	Not applicable	Don't know	Never	Rarely (less than 20%)	Most times (20% to 80%)	Usually (more than 80%)
1041_ Birth to age 12	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
1042_ 13 years to 21 years	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
1043_ 22 years to 40 years	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
1044_ 41 years or older	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

75. Please indicate the most severe sunburn you had in each of the following age groups?

	Not applicable	Don't know	Practically never had sunburn	Mild sunburns (mild redness only)	Moderate sunburns (redness and/or pain)	Severe without blistering (painful)	Severe with blistering (painful)
1045_ Birth to age 12	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
1046_ 13 years to 21 years	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
1047_ 22 years to 40 years	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
1048_ 41 years or older	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

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

Information About Your Home

WE ARE INTERESTED IN CHEMICALS THAT MAY HAVE BEEN USED IN PLACES WHERE YOU LIVED, INCLUDING INSIDE HOMES, ON LAWNS/YARDS, OR ON FAMILY GARDENS. DO NOT INCLUDE USE OF THESE CHEMICALS IF THEY WERE USED AS PART OF YOUR JOB (E.G., FARMING ACTIVITIES, WORK AT A NURSERY, OR OTHER WORKPLACE THAT USES THESE CHEMICALS).

1053_ 77. 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?

1054_ 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?

1055_ 1 No 2 Yes

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

1056_ 1 4 percent or less 2 5 to 50 percent 3 51 percent or more

1057_ 78. 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?

1058_ 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?

1059_ 1 No 2 Yes

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

1060_ 1 4 percent or less 2 5 to 50 percent 3 51 percent or more

1061_ 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

1065_ 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

1069_ 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

1073_ **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

1074_

1075-
1076

1077_ **83. Which best describes your racial background?**

- | | |
|--|--|
| 1 <input type="checkbox"/> American Indian/Alaska Native | 5 <input type="checkbox"/> White |
| 2 <input type="checkbox"/> Asian | 6 <input type="checkbox"/> None of the above |
| 3 <input type="checkbox"/> Native Hawaiian or other Pacific Islander | 7 <input type="checkbox"/> I don't know |
| 4 <input type="checkbox"/> Black or African American | 8 <input type="checkbox"/> Refuse |

1078_ **84. Are you of Hispanic or Latino origin?**

1 No 2 Yes 3 I don't know 4 Refuse

1079_ **We welcome any comments you may wish to provide.**

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



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