Mayo Clinic Biobank Follow-Up 1 Questionnaire

Your name:

First Name/Middle Initial  Last Name

Your date of birth:  __/__/__ __ __ __

Month  Day  Year

Please enter today's date and your clinic number.

INSTRUCTIONS

• Please take the time to read and answer each question carefully by marking the response that best represents your answer.

• If you are not exactly sure of an answer, please provide your best guess.

• When completed, mail the survey to the Mayo Clinic Biobank, Harwick Building, 6th Floor, in the pre-addressed, pre-paid envelope provided. Rochester (only) participants also have the option to drop the survey off at Desk CA in the Hilton Building subway.

MARKING INSTRUCTIONS

• Use a No. 2 pencil or a blue or black ink pen only.

• Do not use pens with ink that soaks through the paper.

• Make solid marks that fill the response completely.

• If you select the wrong response and cannot erase completely, please place an X through the incorrect response and mark the correct response.

• Make no stray marks on this form.

CORRECT:

INCORRECT:

Please do not write in this area

Sample Only
1. In general, ... 
would you say your health is...

how would you rate your mental health, including your mood and your ability to think?

please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work, and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)

2. In the past 7 days, how would you rate your pain on average?

3. Please indicate the age you were first diagnosed with the following conditions. If you have not been diagnosed with this condition, mark "None."

In addition, please indicate whether or not your family members have had this condition by marking "Yes," "No," or "Don't know." We are only interested in relatives that are related to you by blood.

Self
Age when this condition was first diagnosed.

Relatives
Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition?

Rheumatologic
- Osteoarthritis (cartilage wear)
- Rheumatoid arthritis (swollen joints, autoimmune disease)
- Fibromyalgia
- Autoimmune disorder (lupus, scleroderma)

Gynecologic
- Endometriosis

Liver
- Hepatitis A, B, or C
- Other liver disease

Hematologic
- Organ or bone marrow transplant

Cancer
- Bone cancer
- Breast cancer
- Colon or rectal cancer
- Esophageal cancer
- Kidney cancer
- Leukemia

Continues on next page...
### Cancer (continued)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self Age when this condition was first diagnosed.</th>
<th>Relatives Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver cancer</td>
<td>[ ] None</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>[ ] 19 or younger</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>[ ] 20 to 49</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Melanoma</td>
<td>[ ] 50 to 64</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Nonmelanoma skin cancer</td>
<td>[ ] 65 to 79</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td>[ ] 80 or older</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Sarcoma</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Stomach cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Thyroid cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Urinary/bladder cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Other cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td><strong>Women only:</strong></td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Uterine/endometrial cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td><strong>Men only:</strong></td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Testicular cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Prostate cancer</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
</tbody>
</table>

### Neurologic

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self Age when this condition was first diagnosed.</th>
<th>Relatives Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer's disease</td>
<td>[ ] None</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Parkinson's disease</td>
<td>[ ] 19 or younger</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Dementia</td>
<td>[ ] 20 to 49</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Migraine headaches</td>
<td>[ ] 50 to 64</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Stroke (CVA)</td>
<td>[ ] 65 to 79</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>TIA (mini stroke)</td>
<td>[ ] 80 or older</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Epilepsy (seizure disorder)</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
</tbody>
</table>

### Mental Health

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self Age when this condition was first diagnosed.</th>
<th>Relatives Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>[ ] None</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Depression</td>
<td>[ ] 19 or younger</td>
<td>[ ] No [ ] Yes [ ] Don't know</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>[ ] 20 to 49</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
<tr>
<td>Attention deficit/hyperactivity</td>
<td>[ ] 50 to 64</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
<tr>
<td>disorder</td>
<td>[ ] 65 to 79</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>[ ] 80 or older</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
<tr>
<td>Other psychiatric or mental illness</td>
<td></td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
</tbody>
</table>

### Eye

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self Age when this condition was first diagnosed.</th>
<th>Relatives Do or did any of your first-degree relatives (parents, sisters, brothers, children) have this condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaucoma</td>
<td>[ ] None</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
<tr>
<td>Cataracts</td>
<td>[ ] 19 or younger</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
<tr>
<td>Misalignment, crossing, or</td>
<td>[ ] 20 to 49</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
<tr>
<td>wandering of the eyes (strabismus)</td>
<td>[ ] 50 to 64</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
<tr>
<td>Macular degeneration</td>
<td>[ ] 65 to 79</td>
<td>[ ] No [ ] Yes [ ] Don’t know</td>
</tr>
</tbody>
</table>

Continues on next page...
4. In the last 3 months, how often did you have discomfort or pain anywhere in your abdomen?

- Never — Skip to question 14 on page 5.
- Less than 1 day a month
- 1 day a month
- 2 to 3 days a month
- 1 day a week
- More than 1 day a week
- Every day

5. For women: Did this discomfort or pain occur only during your menstrual bleeding and not at other times?

- No
- Yes
- Does not apply because I have had the change of life (menopause) or I am a male

6. Have you had this discomfort or pain 6 months or longer?

- No
- Yes
7. How often did this discomfort or pain get better or stop after you had a bowel movement?

8. When this discomfort or pain started, did you have more frequent bowel movements?

9. When this discomfort or pain started, did you have less frequent bowel movements?

10. When this discomfort or pain started, were your stools (bowel movements) looser?

11. When this discomfort or pain started, how often did you have harder stools?

12. In the last 3 months, how often did you have hard or lumpy stools?

13. In the last 3 months, how often did you have loose, mushy, or watery stools?

14. Do you currently have a daily cough that has lasted for 8 weeks or more?

15. During the past 12 months, have you used the following medicines on a regular basis, that is, at least once per week? If so, please indicate how long you have taken each medication.

- Aspirin — full or extra strength
- Aspirin — low dose
- Tylenol
- Advil, Aleve, Motrin, or other nonsteroidal, anti-inflammatory drugs
- Cox 2 inhibitors (Celebrex, Vioxx, Bextra, etc.)
- Other drug taken for pain relief

16. Do you currently smoke cigarettes?

17. Do you currently use chewing tobacco, snuff, or snus every day, some days, or never? (Snus, Swedish for snuff, is a moist smokeless tobacco, usually sold in small pouches that are placed under the lip against the gum.)
18. How often did you have a drink containing alcohol in the past 12 months? (Consider a "drink" to be a can or bottle of beer, a glass of wine, a wine cooler, or 1 cocktail or a shot of hard liquor; eg, scotch, gin, or vodka.) (If you were pregnant in the past 12 months, please report your usual intake when you were not pregnant.)

- Never — Skip to question 19 below.
- Once a month or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 to 5 times a week
- 6 or more times a week

19. Considering a 7-day period (a week), how many times on average do you do the following kinds of exercise for more than 15 minutes during your free time?

- Strenuous exercise (heart beats rapidly)
  (ie, running, jogging, vigorous swimming, vigorous long-distance bicycling, hockey, basketball, cross-country skiing, soccer)
  - None
  - 1 time
  - 2 times
  - 3 times
  - 4 times
  - 5 times
  - 6 times
  - 7 times
  - 8 times or more

- Moderate exercise (not exhausting)
  (ie, fast walking, easy swimming, alpine skiing, popular and folk dancing, tennis, easy bicycling, baseball, volleyball)
  - None
  - 1 time
  - 2 times
  - 3 times
  - 4 times
  - 5 times
  - 6 times
  - 7 times
  - 8 times or more

- Mild exercise (minimal effort)
  (ie, easy walking, archery, bowling, horseshoes, golf, snowmobiling)
  - None
  - 1 time
  - 2 times
  - 3 times
  - 4 times
  - 5 times
  - 6 times
  - 7 times
  - 8 times or more

20. In a typical day, ...

- how many servings of fruit do you eat?
- how many servings of vegetables do you eat?
  (One serving: 1 cup raw, leafy vegetables, ½ cup cooked vegetables, or ¾ cup vegetable juice.)
- how many times do you eat high-fat food such as fried food, whole milk, regular cheese, ice cream, baked goods, or regular salad dressing?
21. Over the past 2 years, on average, how often did you eat a serving of red meat (not poultry or fish) in a typical day? (A serving of red meat is: 2 to 3 ounces of red meat; or a piece about the size of a deck of cards. Red meats include: beef, steak, hamburger, prime rib, ribs, veal, lamb, pork bacon, pork sausages.)

- 0 to 1
- 2
- 3
- 4
- 5 or more
- Don't eat red meat

22. Over the past 2 years, on average, how often did you eat a serving of fish (not poultry or meat) in a typical day? (A serving of fish is a piece about the size of a deck of cards.)

- 0 to 1
- 2
- 3
- 4
- 5 or more
- Don't eat fish

23. Over the past 2 years, on average, how often did you eat a serving of poultry (including chicken or turkey — not meat or fish) in a typical day? (A serving of poultry is a piece about the size of a deck of cards.)

- 0 to 1
- 2
- 3
- 4
- 5 or more
- Don't eat poultry

24. How many servings of milk and other dairy products or calcium supplements do you get in a typical day?

- 1 or no servings (or less than 600 mg dose supplements)
- 2 to 3 servings (or between 600 and 1,200 mg dose supplements)
- 4 or more servings (or more than 1,200 mg dose supplements)

25. Do you drink coffee or tea?

- No — Skip to question 26 below.
- Yes

If you do drink coffee or tea, please fill in for all that you drink in the four categories below. (1 cup = 8 ounces.)

<table>
<thead>
<tr>
<th>Coffee (caffeinated)</th>
<th>Coffee (decaffeinated)</th>
<th>Tea (caffeinated)</th>
<th>Tea (decaffeinated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ None</td>
<td>○ None</td>
<td>○ None</td>
<td>○ None</td>
</tr>
<tr>
<td>○ Less than 1 cup per month</td>
<td>○ Less than 1 cup per month</td>
<td>○ Less than 1 cup per month</td>
<td>○ Less than 1 cup per month</td>
</tr>
<tr>
<td>○ 1 cup per week</td>
<td>○ 1 cup per week</td>
<td>○ 1 cup per week</td>
<td>○ 1 cup per week</td>
</tr>
<tr>
<td>○ 2 to 4 cups per week</td>
<td>○ 2 to 4 cups per week</td>
<td>○ 2 to 4 cups per week</td>
<td>○ 2 to 4 cups per week</td>
</tr>
<tr>
<td>○ 5 to 6 cups per week</td>
<td>○ 5 to 6 cups per week</td>
<td>○ 5 to 6 cups per week</td>
<td>○ 5 to 6 cups per week</td>
</tr>
<tr>
<td>○ 1 cup per day</td>
<td>○ 1 cup per day</td>
<td>○ 1 cup per day</td>
<td>○ 1 cup per day</td>
</tr>
<tr>
<td>○ 2 to 3 cups per day</td>
<td>○ 2 to 3 cups per day</td>
<td>○ 2 to 3 cups per day</td>
<td>○ 2 to 3 cups per day</td>
</tr>
<tr>
<td>○ 4 to 5 cups per day</td>
<td>○ 4 to 5 cups per day</td>
<td>○ 4 to 5 cups per day</td>
<td>○ 4 to 5 cups per day</td>
</tr>
<tr>
<td>○ 6 or more cups</td>
<td>○ 6 or more cups</td>
<td>○ 6 or more cups</td>
<td>○ 6 or more cups</td>
</tr>
</tbody>
</table>

26. How many servings of diet soft drinks (pop or soda) do you have per day?

- None — Skip to question 27 on page 8.
- Less than 1 serving
- 1 to 2 servings
- 3 to 4 servings
- 5 to 6 servings
- 7 to 9 servings
- 10 or more servings

How many of these diet soft drinks (pop or soda) contain caffeine?

- All
- Some
- None
27. How many servings of regular (nondiet) soft drinks (pop or soda) do you have per day?
   (A serving size is one can or glass.)
   ○ None — Women skip to question 28 below; Men skip to question 30 below.
   ○ Less than 1 serving
   ○ 1 to 2 servings
   ○ 3 to 4 servings
   ○ 5 to 6 servings
   ○ 7 to 9 servings
   ○ 10 or more servings

   How many of these regular soft drinks (pop or soda) contain caffeine?
   ○ All
   ○ Some
   ○ None

   WOMEN ONLY

28. Have you ever used birth control pills, patches, implants, or shots?
   ○ No
   ○ Yes, currently
   ○ Yes, but not currently

29. Among the following, which answer best describes your current menstrual status?
   (Please choose only one response.)
   ○ I am pregnant
   ○ I am breast-feeding (either with or without oral contraceptive use)
   ○ I am premenopausal and taking oral contraceptives
   ○ I am premenopausal and not taking oral contraceptives or hormone therapy
   ○ I began taking hormone therapy before my periods stopped and am still taking hormones
   ○ I began taking hormone therapy before my periods stopped; I have stopped taking these hormones
   ○ My periods have stopped on their own (naturally)
   ○ My periods stopped after radiation or chemotherapy
   ○ My periods stopped after surgery which removed my uterus or both ovaries

30. What is your current weight? (Please round to the nearest whole number. If you are currently pregnant, report your prepregnancy weight.)

   Thank you for taking the time to complete the survey!


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