



BC GENERATIONS PROJECT

Your time today builds a healthier tomorrow.

Follow-Up Questionnaire



Office use only			
O	O	O	O
L	C	V	QA



Directions For Completing This Questionnaire

Follow-Up Questionnaire may take about 45 to 60 minutes to answer. Please follow the directions carefully. You will be asked to skip certain questions that do not apply to you.

- We appreciate you completing the whole questionnaire. However, if you prefer not to answer a question write '**Decline**' beside it.


- Use a ballpoint pen, **not a felt pen**.

- Shade in the bubbles completely, like this: ●

- Write numbers in boxes like this:

2	1
---	---

If you are writing a single digit where there is more than one box, it does not matter which box you write the number in.

- If you make an error, put an X through the incorrect bubble like this: 

- **Before starting the questionnaire please make sure to gather your prescription medications and a tape measure so these items are handy.**

- Please leave the booklet stapled together. The pages will be separated at the study centre.

If you are not sure how to answer a question, please feel free to contact us:

BC Generations Project:
Lower Mainland 604-675-8221
Within Canada call
Toll Free 1-877-675-8221
bcgenerationsproject@bccrc.ca



DEMOGRAPHIC INFORMATION

DE01 What is your date of birth?

--	--

 /

--	--

 /

--	--	--	--

DE02 What is your sex at birth? Male Female

FAMILY CHARACTERISTICS

FA01 What is your current marital status? Please choose the **ONE** status that best describes your current situation.

- Married and/or living with a partner
- Divorced
- Widowed
- Separated
- Single, never married



HEALTH STATUS

HS01 How would you rate your general health?

- Excellent
- Very good
- Good
- Fair
- Poor

HS02 When was the last time you had a routine medical check-up, undertaken by a doctor or a nurse? A medical check-up is a physical exam that usually includes at least a blood pressure measurement and height and weight measurement.

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago
- Never
- Don't know

HS03 When was the last time you saw a dental professional, including a dentist or a hygienist?

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago
- Never
- Don't know



HS04 When was the last time you had a fecal occult blood test (FOBT) or a fecal immunochemical test (FIT)?
Both are screening tests for colon cancer that check for blood in your stool, and are usually collected at home where you have a bowel movement. The FOBT uses a stick or a small brush to smear a small sample on a special card and is usually collected for two or three days in a row. The FIT uses a stick attached to the cap of a storage bottle to collect one small sample and place it in the bottle.

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago
- Never
- Don't know

HS05 When was the last time you had a colonoscopy?
A colonoscopy is an exam where a long tube is used to examine the entire colon for signs of cancer or other health problems. Before the procedure is done, you are usually given a sedative.

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago
- Never
- Don't know

HS06 When was the last time you had a sigmoidoscopy?
A sigmoidoscopy is an exam where a flexible tube is inserted into the rectum and lower part of the large bowel to look for signs of cancer or other problems. The procedure does **not** usually require sedation.

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago
- Never
- Don't know



HS07 Have you ever had a polyp removed from your colon?
A polyp is an abnormal growth of tissue.

- Yes
- No
- Don't know

HS08 Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half of the days	Nearly every day
a. Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Worrying too much about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Trouble relaxing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Being so restless that it's hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Feeling afraid as if something awful might happen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

If you checked off "Not at all" for all the problems, SKIP TO HS09 (NEXT PAGE)



HS09 Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half of the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling tired of having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

If you checked of "Not at all" for all the problems, SKIP TO THE NEXT PAGE.



MEN ONLY, WOMEN SKIP TO WOMEN'S HEALTH - WH01 (NEXT PAGE)

MEN'S HEALTH

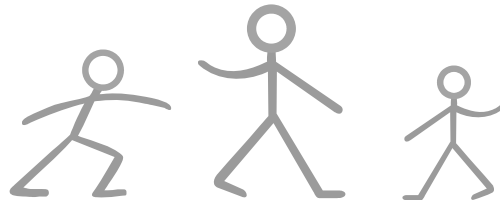
MH01 When was the last time you had a PSA blood test? A PSA test is a specific blood test ordered by a doctor to test men for prostate cancer.

- Less than 6 months ago
- 6 months to less than 1 year ago
- 1 year to less than 2 years ago
- 2 years to less than 3 years ago
- 3 or more years ago
- Never
- Don't know

MH02 How many children have you fathered, including live births only?

Children

- Don't know



WOMEN'S HEALTH

WH01 Have you ever used any hormonal contraceptives for any reason? Hormonal contraceptives include birth control pills, implants, patches, injections, and rings or intra-uterine devices that release female hormones.

Yes

No

Don't know

→ → **SKIP TO WH04 (THIS PAGE)**

WH02 How old were you when you started using hormonal contraceptives?

Age when started using hormonal contraceptives

Don't Know

WH03 In total, how many years or months did you use or have you been using hormonal contraceptives? Add up all the time that you used contraceptives even if you started and stopped several times.

Years **OR** Months

Don't know

WH04 How many times have you been pregnant, including live births, stillbirths, spontaneous miscarriage or therapeutic abortions?

Number of pregnancies

Never been pregnant

Don't know

→ → **SKIP TO WH08 (NEXT PAGE)**

WH05 Are you currently pregnant?

Yes

No

Don't know

→ In what week are you? Weeks

If yes, and it's your first pregnancy, SKIP TO WH08 (NEXT PAGE)



WH06 How many children have you given birth to, considering live births only?

Live births

Don't know

WH07 How old were you when you last became pregnant?

Age at last pregnancy

Don't know

WH08 Have you gone through menopause, meaning that your menstrual periods stopped for at least one year and did **not** restart?

Yes, natural menopause

Yes, other reasons (hysterectomy, surgery, chemotherapy, medication)

No

Don't know

→

WH09 How old were you when your menstrual periods stopped for at least one year and did **not** restart?

Age when menstrual periods stopped

Don't know

WH10 Have you ever used hormone replacement therapy (HRT) prescribed by a doctor for any reason?

Hormone replacement therapy includes progesterone and/or estrogen. It includes all forms such as patches, rings, creams and other topical forms prescribed by a doctor. It does **not** include thyroid hormone treatment or hormonal contraceptives and it does **not** include other 'natural' treatments that can be bought over the counter. Do **not** include hormonal fertility treatment.

Yes

No

Don't know

→



WH11 Which type of hormone replacement therapy have you used the **most**?
(Choose one only)

- Both Estrogen and Progesterone
- Estrogen (e.g. Premarin, Estrace)
- Progesterone (e.g. Prometrium, Provera)
- Estrogen gel or cream applied to the skin (e.g. Estraderm, Estrogel)
- Intra-uterine device with progesterone
- Don't know

WH12 How old were you when you started using hormone replacement therapy?

Age when started using hormone replacement therapy

- Don't know

WH13 In **total**, for how many years or months did you use, or have you been using, hormone replacement therapy? Add up all the time that you used hormone replacement therapy even if you started and stopped several times.

Years **OR** Months

- Don't know

WH14 Have you ever had a hysterectomy (an operation to have your uterus or womb removed)?

Yes

No



Don't know



SKIP TO WH16 (NEXT PAGE)

WH15 How old were you when you had your hysterectomy?

Age at hysterectomy

- Don't know



WH16 Have you ever had an operation to have your ovaries removed?

Yes

No

Don't know

—————→
—————→
SKIP TO WH20 (THIS PAGE)

WH17 Did you have one or both ovaries removed?

One

Both

Don't know

—————→
SKIP TO WH19 (THIS PAGE)

WH18 Were both of your ovaries removed at the same time?

Yes

No

Don't know

WH19 How old were you when you had your ovary removal surgery? If you had two separate operations to remove your ovaries, please indicate the age of the last surgery.

--	--

Age at last ovary removal surgery

Don't know

WH20 When was the last time you had a mammogram?

A mammogram is a low dose x-ray of the breast in a device that compresses and flattens the breast and is used as a screening test for breast cancer.

Less than 6 months ago

6 months to less than 1 year ago

1 year to less than 2 years ago

2 years to less than 3 years ago

3 or more years ago

Never

Don't know

WH21 When was the last time you had a Pap test or a smear test?

A Pap test (sometimes called a cervical smear) is a test performed by a doctor or a nurse where a sample of cells is taken from the cervix.

Less than 6 months ago

6 months to less than 1 year ago

1 year to less than 2 years ago

2 years to less than 3 years ago

3 or more years ago

Never

Don't know



PERSONAL MEDICAL HISTORY

PM01 Has a doctor ever told you that you had cancer or a malignancy of any kind?

Yes

No

Don't know

SKIP TO PM03 (Page 16)

PM02 What **type** of cancer was it and how **old** were you when the cancer was **first** diagnosed? If you had cancer more than once, select each one separately on the following pages.

First Type of Cancer		
<input type="radio"/> Bladder <input type="radio"/> Brain <input type="radio"/> Breast <input type="radio"/> Cervix <input type="radio"/> Colon <input type="radio"/> Esophagus <input type="radio"/> Kidney <input type="radio"/> Larynx <input type="radio"/> Leukemia <input type="radio"/> Liver <input type="radio"/> Lung and Bronchus <input type="radio"/> Lymphoma (Hodgkin Lymphoma) <input type="radio"/> Lymphoma (Non-Hodgkin Lymphoma) <input type="radio"/> Mouth, Tongue, and Throat	<input type="radio"/> Multiple Myeloma <input type="radio"/> Ovary <input type="radio"/> Pancreas <input type="radio"/> Prostate <input type="radio"/> Rectum <input type="radio"/> Skin (Melanoma) <input type="radio"/> Skin (Non-Melanoma) <input type="radio"/> Small Intestine <input type="radio"/> Stomach <input type="radio"/> Testicle <input type="radio"/> Thyroid <input type="radio"/> Uterus <input type="radio"/> Don't know <input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
Age at first Diagnosis	Treatment	Type of treatment
<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block; margin-right: 5px;"></div> Age at first diagnosis <input type="radio"/> Don't know	Did you receive treatment for this cancer? <input type="radio"/> Yes → <input type="radio"/> No <input type="radio"/> Don't know	What type of treatment was it? (Choose ALL that apply) <input type="radio"/> Chemotherapy <input type="radio"/> Radiation <input type="radio"/> Surgery <input type="radio"/> Laser therapy <input type="radio"/> Stem cell therapy <input type="radio"/> Other (please specify): <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div> <input type="radio"/> Don't know



Second Type of Cancer


- Bladder
- Brain
- Breast
- Cervix
- Colon
- Esophagus
- Kidney
- Larynx
- Leukemia
- Liver
- Lung and Bronchus
- Lymphoma (Hodgkin Lymphoma)
- Lymphoma (Non-Hodgkin Lymphoma)
- Mouth, Tongue, and Throat
- Multiple Myeloma
- Ovary
- Pancreas
- Prostate
- Rectum
- Skin (Melanoma)
- Skin (Non-Melanoma)
- Small Intestine
- Stomach
- Testicle
- Thyroid
- Uterus
- Don't know
- Other (Please specify):

Age at first Diagnosis	Treatment	Type of treatment
<div style="display: flex; align-items: center;"> <input style="width: 30px; height: 30px; margin-right: 5px;" type="text"/> <input style="width: 30px; height: 30px; margin-right: 5px;" type="text"/> Age at first diagnosis </div> <p><input type="radio"/> Don't know</p>	<p>Did you receive treatment for this cancer?</p> <p><input type="radio"/> Yes →</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Don't know</p>	<p>What type of treatment was it? (Choose ALL that apply)</p> <p><input type="radio"/> Chemotherapy</p> <p><input type="radio"/> Radiation</p> <p><input type="radio"/> Surgery</p> <p><input type="radio"/> Laser therapy</p> <p><input type="radio"/> Stem cell therapy</p> <p><input type="radio"/> Other (Please specify):</p> <div style="border: 1px solid black; width: 100%; height: 25px; margin-bottom: 5px;"></div> <p><input type="radio"/> Don't know</p>



Third Type of Cancer

- | | |
|---|---|
| <input type="radio"/> Bladder | <input type="radio"/> Multiple Myeloma |
| <input type="radio"/> Brain | <input type="radio"/> Ovary |
| <input type="radio"/> Breast | <input type="radio"/> Pancreas |
| <input type="radio"/> Cervix | <input type="radio"/> Prostate |
| <input type="radio"/> Colon | <input type="radio"/> Rectum |
| <input type="radio"/> Esophagus | <input type="radio"/> Skin (Melanoma) |
| <input type="radio"/> Kidney | <input type="radio"/> Skin (Non-Melanoma) |
| <input type="radio"/> Larynx | <input type="radio"/> Small Intestine |
| <input type="radio"/> Leukemia | <input type="radio"/> Stomach |
| <input type="radio"/> Liver | <input type="radio"/> Testicle |
| <input type="radio"/> Lung and Bronchus | <input type="radio"/> Thyroid |
| <input type="radio"/> Lymphoma (Hodgkin Lymphoma) | <input type="radio"/> Uterus |
| <input type="radio"/> Lymphoma (Non-Hodgkin Lymphoma) | <input type="radio"/> Don't know |
| <input type="radio"/> Mouth, Tongue, and Throat | <input type="radio"/> Other (Please specify): |

Age at first Diagnosis	Treatment	Type of treatment
<input type="text"/> <input type="text"/> Age at first diagnosis <input type="radio"/> Don't know	Did you receive treatment for this cancer? <input type="radio"/> Yes  <input type="radio"/> No <input type="radio"/> Don't know	What type of treatment was it? (Choose ALL that apply) <input type="radio"/> Chemotherapy <input type="radio"/> Radiation <input type="radio"/> Surgery <input type="radio"/> Laser therapy <input type="radio"/> Stem cell therapy <input type="radio"/> Other (Please specify): <input type="text"/> <input type="radio"/> Don't know



PM03 Has a doctor ever told you that you had any of the following conditions? If yes, please provide your **age** when you were first diagnosed and whether you are currently being treated.

Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Diabetes (Endocrine and metabolic conditions)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, which type(s) of diabetes was it? <input type="radio"/> Gestational diabetes only	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Type 1 diabetes	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Type 2 diabetes	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Don't know		
Thyroid disease (Endocrine and metabolic conditions)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, which type(s) of thyroid disease was it? <input type="radio"/> Hypothyroid <input type="radio"/> Hyperthyroid <input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 200px; height: 20px; margin-top: 5px;"></div> <input type="radio"/> Don't know	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
High cholesterol (Endocrine and metabolic conditions)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Heart and circulatory conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes , select all that apply, <input type="radio"/> High blood pressure (Hypertension, not including during pregnancy)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Heart attack (myocardial infarction)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Heart failure	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Atrial fibrillation	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Angina	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Valvular heart disease (e.g. aortic stenosis, mitral valve prolapse)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Atherosclerosis/ Coronary heart disease (including angioplasty or stents)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Respiratory system conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Asthma	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Chronic obstructive pulmonary disease (COPD)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Chronic bronchitis	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Emphysema	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Sleep apnea	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Gastrointestinal conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Crohn's disease	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Ulcerative colitis	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Irritable bowel syndrome	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Stomach ulcers	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Persistent acid reflux/ Gastroesophageal reflux disease (GERD)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 200px; height: 25px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Liver or pancreas conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Liver cirrhosis	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Chronic hepatitis	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Fatty liver (NAFLD-Nonalcoholic fatty liver disease / NASH-Nonalcoholic steatohepatitis)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Pancreatitis	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Gallstones	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Cholecystitis	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 200px; height: 25px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Renal disease/kidney failure conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Weak or failing kidney	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Acute renal failure	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Chronic renal failure	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Kidney stones	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Pyelonephritis (Kidney infection)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 200px; height: 25px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Mental health condition	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes , select all that apply, <input type="radio"/> Major depression	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Minor depression	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Bipolar disorder	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Post-traumatic stress disorder	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Schizophrenia or Schizoaffective	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Obsessive compulsive disorder	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Anxiety disorder	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Eating disorder	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Addiction disorder (e.g. alcohol, drug or gambling dependence)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know

Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Neurological conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Thrombotic stroke	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Hemorrhagic stroke	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Multiple sclerosis	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Migraines	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Epilepsy or Seizures	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Parkinson's disease	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Alzheimer's disease	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Chronic fatigue syndrome	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <input type="text"/>	<input type="text"/> <input type="text"/> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know

Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Bone and joint conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Osteoporosis	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Arthritis If arthritis is selected, which type(s) of arthritis was it? <input type="radio"/> Rheumatoid arthritis <input type="radio"/> Osteoarthritis <input type="radio"/> Don't know <input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 200px; height: 25px; margin-left: 40px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Lupus	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Fibromyalgia	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 200px; height: 25px; margin-left: 40px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Skin conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Eczema	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Psoriasis	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Infectious diseases	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Human Immunodeficiency virus (HIV)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Genital warts / Human papillomavirus (HPV) infection	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Genital herpes	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
Hearing conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Tinnitus (sound in yours ears or head)	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Hearing loss	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Eye or vision conditions	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know If yes, select all that apply, <input type="radio"/> Macular degeneration	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Glaucoma	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Cataracts	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	<input type="radio"/> Other (Please specify): <div style="border: 1px solid black; width: 150px; height: 20px; margin-top: 5px;"></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div> <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



PM04 Do you have or have you had any other **long-term health conditions**?

Yes

No

Don't know

→ **SKIP TO SLEEP PATTERN - SP01 (THIS PAGE)**

Please list these long-term conditions.

Long term condition 1:

Long term condition 2:

Long term condition 3:

SLEEP PATTERN

SP01 On average, how many hours per day do you usually sleep, including naps? A day refers to a 24 hour period. Please think of the total amount of unbroken sleep.

Hours **AND** Minutes

Don't know

SP02 How often do you have trouble going to sleep or staying asleep?

None of the time

A little of the time

Some of the time

Most of the time

All the time

Don't know



PRESCRIBED MEDICATION

ME01 Are you currently taking any medications prescribed by a doctor and dispensed by a pharmacist? Prescription medication could include such things as insulin, nicotine patches, birth control (pills, patches or injections) and other hormonal therapies.

Yes

No

Don't know



SKIP TO ME02
(NEXT PAGE)



If you have access to the bottles and containers, the DIN is an 8 digit number that should be printed on the label that is attached to the container by the pharmacist. It is **not** the prescription number.

For **each** prescribed medication that you are currently taking, please write down the name of the medication and the drug identification number (DIN).


Medication	Name of the Medication	Drug Identification Number (DIN)
1	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
2	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
3	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
4	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
5	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
6	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
7	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
8	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
9	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>
10	<input style="width: 100%; height: 25px;" type="text"/>	<input style="width: 100%; height: 25px;" type="text"/>



ME02 Do you **regularly** take **Aspirin** or **pain relievers 4 times a month or more?**
 (Including aspirin for disease prevention)

Yes

No 

Don't know 

SKIP TO FAMILY HEALTH HISTORY - FM01
 (NEXT PAGE)

If yes , mark all that apply below	Average number of	
	Days per Month	Pills per Day (on days used)
Low-dose or "baby" Aspirin (81 mg tablet)	□ □	□ □
Regular or extra-strength Aspirin (Include Excedrin and powders with Aspirin)	□ □	□ □
Ibuprofen (Such as Motrin, Advil, Nuprin)	□ □	□ □
Acetaminophen (Such as Tylenol)	□ □	□ □
Naproxen (Such as Naprosyn, Aleve)	□ □	□ □
Other NSAID pain relievers (Such as Celebrex, Meloxicam, Diclofenac, Nabumetone, Idomethacin, Sundac or Piroxicam. Do not include narcotics or Lyrica)	□ □	□ □



FAMILY HEALTH HISTORY

For your family health history, please **ONLY** include **immediate blood relatives**, including your mother, father, children, full and half brothers and sisters. Do **not** include relatives by marriage, stepbrothers and stepsisters, parents by adoption, stepchildren or adopted children.

FM01 Have any of your immediate blood relatives, including your mother, father, children, full and half brothers and sisters ever been diagnosed with cancer?

Yes

No →

Don't know →

SKIP TO FM09 (PAGE 34)

FM02 Has your biological mother ever been diagnosed with cancer?

Yes

No →

Don't know →

SKIP TO FM04 (PAGE 31)

FM03 Which of the following **types** of cancer was your mother diagnosed with?
(Choose **ALL** that apply)

Bladder

Brain

Breast

Cervix

Colon

Esophagus

Kidney

Larynx

Leukemia

Liver

Lung and Bronchus

Lymphoma (Hodgkin Lymphoma)

Lymphoma (Non-Hodgkin Lymphoma)

Mouth, Tongue and Throat

Multiple Myeloma

Ovary

Pancreas

Rectum

Skin (Melanoma)

Skin (Non-Melanoma)

Small Intestine

Stomach

Thyroid

Uterus

Don't know

Other (please specify) :



FM04 Has your biological father ever been diagnosed with cancer?

Yes

No 

Don't know 

SKIP TO FM06 (THIS PAGE)

FM05 Which of the following **types** of cancer was your father diagnosed with?
(Choose **ALL** that apply)

Bladder

Brain

Breast

Colon

Esophagus

Kidney

Larynx

Leukemia

Liver

Lung and Bronchus

Lymphoma (Hodgkin Lymphoma)

Lymphoma (Non-Hodgkin Lymphoma)

Mouth, Tongue and Throat

Multiple Myeloma

Prostate

Pancreas

Rectum

Skin (Melanoma)

Skin (Non-Melanoma)

Small Intestine

Stomach

Testicle

Thyroid

Don't know

Other (please specify) :

FM06 Have any of your biological siblings ever been diagnosed with cancer?

Yes 

No


I do not have any siblings

Don't know

If yes, how many siblings?

Don't know

FM07 Have any of your biological children ever been diagnosed with cancer?

Yes 

No

I do not have any children

Don't know

If yes, how many children?

Don't know

If "No" OR "Do not have siblings and children" OR "Don't Know" for FM06 AND FM07,
SKIP TO FM09 (Page 34)



FM08 For your biological siblings and children, please indicate how many siblings and children have been diagnosed with the cancer types listed below. Leave blank if none of your siblings or children have been diagnosed with a particular type of cancer.

Cancer type	Number of siblings diagnosed	Number of children diagnosed
Bladder	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Brain	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Breast	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Cervix	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Colon	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Esophagus	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Kidney	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Larynx	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Leukemia	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Liver	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Lung and Bronchus	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Lymphoma (Hodgkin Lymphoma)	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Lymphoma (Non-Hodgkin Lymphoma)	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Mouth, Tongue and Throat	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Multiple Myeloma	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Ovary	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children



Cancer type	Number of siblings diagnosed	Number of children diagnosed
Pancreas	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Prostate	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Rectum	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Skin (Melanoma)	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Skin (Non-Melanoma)	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Small Intestine	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Stomach	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Testicle	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Thyroid	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Uterus	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Other	<input type="text"/> <input type="text"/> Number of siblings Please specify the cancer type <input type="text"/>	<input type="text"/> <input type="text"/> Number of children Please specify the cancer type <input type="text"/>
Don't Know	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children



FM09 Have any of your immediate blood relatives, including mother, father, children, full and half brothers and sisters, ever been diagnosed by a medical doctor with any of the following long-term health conditions?

	Health Condition			
Mother	Heart attack (Myocardial infarction)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Stroke	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Chronic obstructive pulmonary disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	High blood pressure	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Asthma	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Major depression	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Liver cirrhosis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Chronic hepatitis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Crohn's disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Ulcerative colitis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Irritable bowel syndrome	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Eczema	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Lupus	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Psoriasis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Multiple sclerosis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Osteoporosis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Arthritis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Other (Please specify):	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
<input style="width: 250px; height: 20px;" type="text"/>				



	Health Condition			
Father	Heart attack (Myocardial infarction)	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Stroke	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Diabetes	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Chronic obstructive pulmonary disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	High blood pressure	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Asthma	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Major depression	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Liver cirrhosis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Chronic hepatitis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Crohn's disease	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Ulcerative colitis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Irritable bowel syndrome	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Eczema	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Lupus	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Psoriasis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Multiple sclerosis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Osteoporosis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Arthritis	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
	Other (Please specify):	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Don't Know
<input style="width: 250px; height: 20px;" type="text"/>				



	Health Condition	
Siblings <input type="radio"/> I do not have any siblings	Heart attack (Myocardial infarction) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Stroke <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Diabetes <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Chronic obstructive pulmonary disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	High blood pressure <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Asthma <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Major depression <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Liver cirrhosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Chronic hepatitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Crohn's disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Ulcerative colitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Irritable bowel syndrome <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Eczema <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Lupus <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Psoriasis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Multiple sclerosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
Arthritis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>	
Other (Please specify): <input type="text"/> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>	



	Health Condition	
Children <input type="radio"/> I do not have any children	Heart attack (Myocardial infarction) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Stroke <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Diabetes <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Chronic obstructive pulmonary disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	High blood pressure <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Asthma <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Major depression <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Liver cirrhosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Chronic hepatitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Crohn's disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Ulcerative colitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Irritable bowel syndrome <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Eczema <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Lupus <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Psoriasis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Multiple sclerosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
Arthritis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>	
Other (Please specify): <input type="text"/> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>	



ALCOHOL USE

AU01 Have you ever consumed alcohol?

Yes

No

Don't know

SKIP TO TOBACCO USE - TU01 (PAGE 40)

AU02 On average, over the last year, how often did you drink **alcohol**?

6 to 7 times a week

4 to 5 times a week

2 to 3 times a week

Once a week

2 to 3 times a month

About once a month

Less than once a month

Never

Don't know

SKIP TO AU04 (NEXT PAGE)

SKIP TO TOBACCO USE - TU01 (PAGE 40)

AU03 On average, how many drinks do you have during a typical week?

A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43ml) of liquor.

	Drink(s) per week		
Red Wine	<input type="text"/> <input type="text"/>	<input type="radio"/> None	<input type="radio"/> Don't know
White Wine	<input type="text"/> <input type="text"/>	<input type="radio"/> None	<input type="radio"/> Don't know
Beer	<input type="text"/> <input type="text"/>	<input type="radio"/> None	<input type="radio"/> Don't know
Liquor/Spirits	<input type="text"/> <input type="text"/>	<input type="radio"/> None	<input type="radio"/> Don't know
Other Alcohol	<input type="text"/> <input type="text"/>	<input type="radio"/> None	<input type="radio"/> Don't know



MEN ONLY, WOMEN SKIP TO AU05 (THIS PAGE)

AU04 During the past 12 months, how often did you have **five or more drinks** at the **same sitting** or occasion?

A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43ml) of liquor.

- 6 to 7 times a week
- 4 to 5 times a week
- 2 to 3 times a week
- Once a week
- 2 to 3 times a month
- About once a month
- 6 to 11 times a year
- 1 to 5 times a year
- Never
- Don't know

WOMEN ONLY, MEN SKIP TO TOBACCO USE - TU01 (NEXT PAGE)

AU05 During the past 12 months, how often did you have **four or more drinks** at the **same sitting** or occasion?

A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43ml) of liquor.

- 6 to 7 times a week
- 4 to 5 times a week
- 2 to 3 times a week
- Once a week
- 2 to 3 times a month
- About once a month
- 6 to 11 times a year
- 1 to 5 times a year
- Never
- Don't know



TOBACCO USE

This section is about tobacco. The first questions are about **CIGARETTE SMOKING**. The term "cigarette" refers to cigarettes that are bought ready-made as well as those you roll yourself. Do **not** include cigars, cigarillos or pipes when you answer these first questions about cigarettes.

In this section, **read the directions and follow the arrows carefully**. There are different "paths" for non-smokers, daily smokers, and occasional smokers.

TU01 Have you smoked at least 100 cigarettes in your life? (About 4 - 5 packs)

- Yes
- No
- Don't know

TU02 At the present time, do you smoke cigarettes daily, occasionally, or not at all?

- Daily (At least one cigarette every day for the past 30 days) →

GO TO TU03 (THIS PAGE)

- Occasionally (At least one cigarette in the past 30 days, but not every day) →

GO TO TU06 (NEXT PAGE)

- Not at all (You did not smoke at all in the past 30 days) →

GO TO MU01 (NEXT PAGE)

TU03 At what age did you begin smoking cigarettes daily?

--	--

 Age

TU04 How many cigarettes do you smoke each day now?

- 1 - 5 cigarettes
- 6 - 10 cigarettes
- 11 - 15 cigarettes
- 16 - 20 cigarettes
- 21 - 25 cigarettes
- 26+ cigarettes → If 26+, how many?

--	--



TU05 How easy or difficult would you find it to go without smoking for a whole day?

- Very easy
- Fairly easy
- Fairly difficult
- Very difficult



If you currently smoke daily, SKIP TO MU01 (THIS PAGE)

TU06 On how many of the last 30 days did you smoke at least one cigarette?

- 1 - 5 days
- 6 - 10 days
- 11 - 20 days
- 21 - 29 days

TU07 On the days that you smoked, how many cigarettes did you usually smoke?

- 1 - 5 cigarettes
- 6 - 10 cigarettes
- 11 - 15 cigarettes
- 16 - 20 cigarettes
- 21 - 25 cigarettes
- 26 + cigarettes

MARIJUANA USE

Please remember that your answers to these questions are strictly confidential. The following questions ask about use of marijuana and hashish. Marijuana is also called pot or grass. Marijuana is usually smoked, either in cigarettes, called joints, or in a pipe. It is sometimes cooked in food. Hashish is a form of marijuana that is also called 'hash'. It is usually smoked in a pipe. Another form of hashish is hash oil.

MU01 Do you currently have a prescription for medical marijuana?

- Yes
- No
- Don't know



MU02 Have you ever, even once, used marijuana or hashish?

- Yes
- No
- Prefer not to answer
- Don't know

→ → →

SKIP TO ELC01 (PAGE 44)

MU03 How old were you the first time you used marijuana or hashish?

--	--

- Prefer not to answer
- Don't know

MU04 Have you ever smoked marijuana or hashish at least once a month for more than one year?

- Yes
- No
- Prefer not to answer
- Don't know

→ → →

SKIP TO ELC01 (PAGE 44)

MU05 How old were you when you started smoking marijuana or hashish at least once a month for one year?

--	--

- Prefer not to answer
- Don't know

MU06 How long has it been since you last smoked marijuana or hashish at least once a month for one year? (Please enter answer in the most appropriate box)

--	--

Years

--	--

Months

--	--

Weeks

--	--

Days

- Prefer not to answer
- Don't know



MU07 During the time that you smoked marijuana or hashish, how often would you usually use it?

- Once per month
- 2 - 3 times per month
- 4 - 8 times per month (about 1-2 times per week)
- 9 - 24 times per month (about 3-6 times per week)
- 25 - 30 times per month (one or more times per day)
- Prefer not to answer
- Don't know

MU08 During the time that you smoked marijuana or hashish, how many joints or pipes would you usually smoke in a day?

- 1 per day
- 2 per day
- 3 - 5 per day
- 6 or more per day
- Prefer not to answer
- Don't know

MU09 How long has it been since you last used marijuana or hashish? (Please enter answer in most appropriate box)

Years Months Weeks Days

- Prefer not to answer
- Don't know

MU10 During the past 30 days, on how many days did you use marijuana or hashish?

Days

- Prefer not to answer
- Don't know



E-CIGARETTE USE

ELC01 Have you ever tried an electronic cigarette, also known as an e-cigarette?

- Yes
- No
- Don't know

→
→
SKIP TO EX01 (THIS PAGE)

ELC02 In the past 30 days did you use an electronic cigarette, also known as an e-cigarette?

- Yes
- No
- Don't know

ELC03 The last time you used an e-cigarette, did it contain nicotine?

- Yes
- No
- Don't know

ELC04 In the past two years, did you ever use the e-cigarette as an aid while attempting to quit smoking?

- Yes
- No
- Don't know

EXPOSURE TO SECOND HAND SMOKE

EX01 How often are you usually exposed to other people's tobacco smoke?

- Every day
- Almost every day
- At least once a week
- At least once a month
- Less than once a month
- Never
- Don't know



WORKING STATUS

WS01 Which of the following best describes your current employment status?

(Choose **ALL** that apply)

Full time means 30 hours or more per week. Part time means less than 30 hours per week.

- Full-time employed / self-employed
- Part-time employed / self-employed
- Retired
- Looking after home and/or family
- Unable to work because of sickness or disability
- Unemployed
- Doing unpaid or voluntary work
- Student

HOUSEHOLD INCOME

The next question asks for your household income. We understand that this information is very private but the question is important because it helps to determine whether the study includes a wide range of participants.

HI01 What was the approximate total household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.

- Less than \$10,000
- \$10,000 - \$24,999
- \$25,000 - \$49,999
- \$50,000 - \$74,999
- \$75,000 - \$99,999
- \$100,000 - \$149,999
- \$150,000 - \$199,999
- \$200,000 or more
- Don't know
- Prefer not to answer

ANTHROPOMETRIC MEASUREMENTS

Weight

- Adjust your scale to zero.
- Weigh yourself with your clothes off, or wear light clothing. Remember to remove your shoes.
- Step on the scale. Make sure both feet are fully on the scale.
- Record your weight in pounds or kilograms.

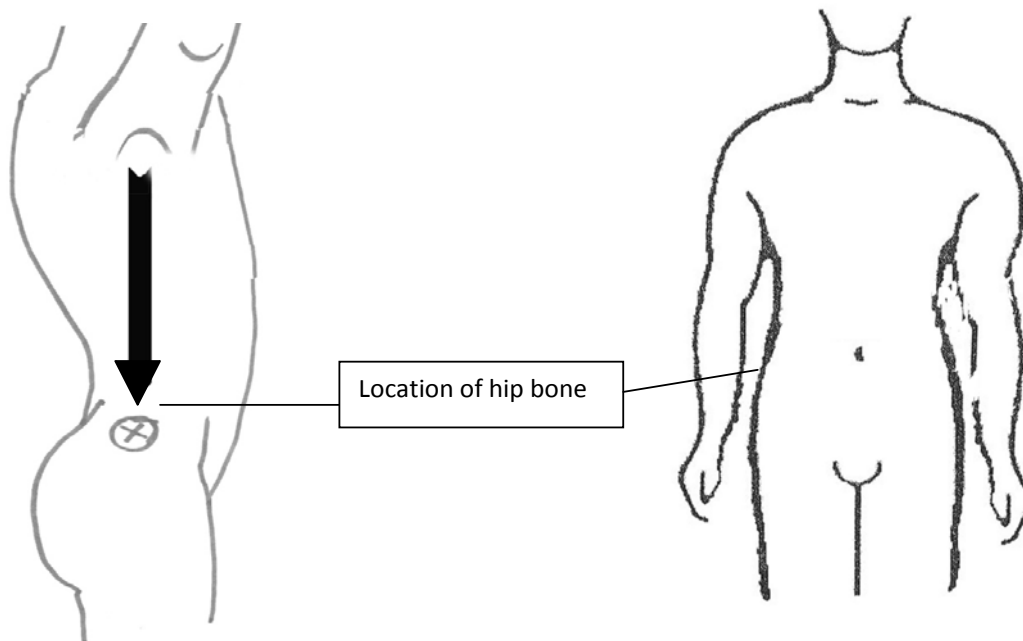
AM01 Weight Measurement Pounds **OR** Kilograms

WAIST AND HIPS

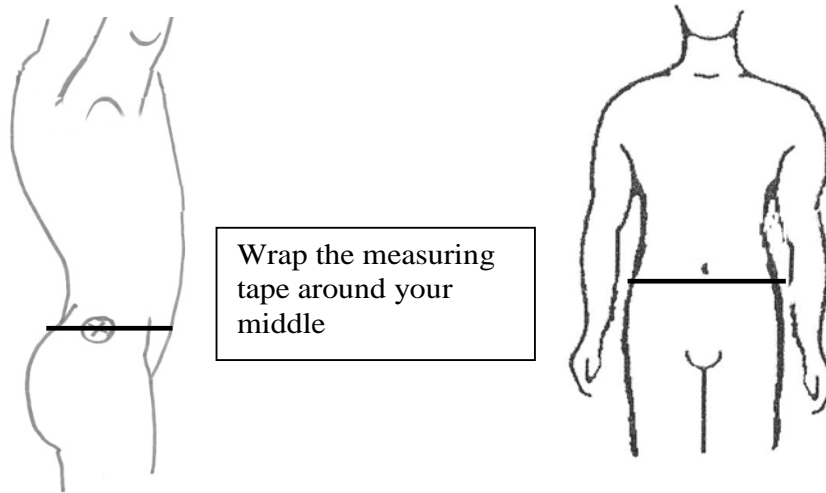
1. Take the next set of measurements either unclothed or in tight fitting underwear.
2. Stand in front of a mirror to help position the measuring tape correctly.
3. Pull the measuring tape tight enough that it does not slide, but not too tight to indent the skin.
4. Record the measurement in inches or centimeters.

Waist

- This measurement is taken at a specific spot found along your side. To find the spot simply place your thumb under your armpit, then slide your thumb straight down until you find the hip bone. (see diagram)



- Place your measuring tape over that spot where your thumb found the bone, then wrap the measuring tape around your middle.



- Look in the mirror and turn in a circle to ensure the measuring tape is level all around and not twisted at any point. Take the measurement, EVEN IF THIS IS NOT YOUR USUAL WAISTLINE.
- Measure twice. The two measurements should be within a half inch (or one centimetre) of each other. If they are not, take a third measurement and record the closest two measurements.
- Record your measurement to the nearest half inch or centimetre.

AM02 First Measurement inches **OR** centimetres

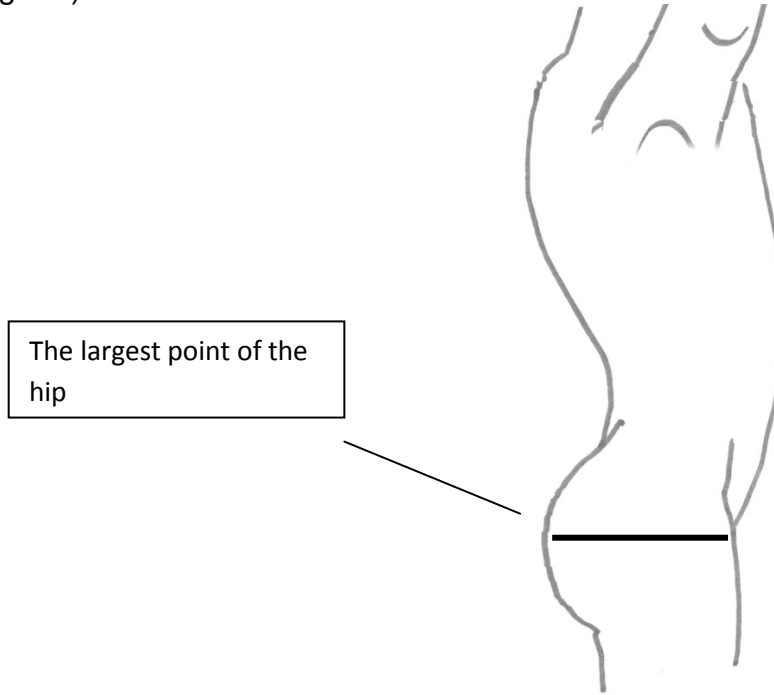
AM03 Second Measurement inches **OR** centimetres

Hip measurements on the last page



Hips

- Stand in profile to a mirror with your feet shoulder width apart.
- Look for the largest point of your buttocks and place the measuring tape at that position. (See diagram)



- Now turn in a full circle in front of the mirror to be certain the measuring tape is level all the way around your body. Take the measurement.
- Measure twice. The two measurements should be within a half inch (or one centimetre) of each other. If not, take a third measurement and record the closest two measurements.
- Record the size of your buttocks to the nearest half inch or centimetre.

AM04 First Measurement inches **OR** centimetres

AM05 Second Measurement inches **OR** centimetres

This is the end of the questionnaire!
Thank you for taking the time to complete this questionnaire.

