For office use only HSC#5929
BSR ID #
MR #
Date of Initial Visit

Biospecimen Shared Resource
Health History Questionnaire (HHQ)
Female Participants

Thank you for participating in the Biospecimen Shared Resource at the University of Kansas Cancer Center. Your participation in our repository is critical to help advance cancer research. Participants are asked to complete the following questionnaire about their family history of cancer, lifestyle, and personal medical history. Please answer all the questions to the best of your ability. If you do not understand any of the questions, please call recruitment/coordinator at 913-588-4765 or toll-free 855-211-1475 for assistance in answering the question. We want to reiterate that the identity of all individuals willing to participate in the Biospecimen Shared Resource will remain confidential as indicated in the consent form. Again, thank you for your participation.

Please return the completed questionnaire to:
The University of Kansas Cancer Center
Biospecimen Shared Resource
3901 Rainbow Blvd
4030 Robinson, MS 1027
Kansas City, KS 66160

Today's Date: _____ / _____ / _____
month day year

Name: _____
(First) (Middle) (Last)

Address: _____
(Street)

_____
(City) (State) (Zip)

Telephone: Home ( )_____ Work ( )_____

Cell ( )_____

Email: _____

Personal Information

1. You are participating in the Repository as a: (please check as many as apply).
   - ☐ Patient
   - ☐ Relative of Patient
   - ☐ Friend of Patient
   - ☐ Volunteer
   - ☐ Employee of Fox Chase
   - ☐ Risk Assessment Program Participant
   - ☐ Other (please specify) _____

2. Your birth date: _____ / _____ / _____
   month day year

3. Are you:
   - ☐ Male
   - ☒ Female

4. What is the highest level of education you have completed? (Check one)
   - ☐ Less than high school
   - ☐ High school graduate
   - ☐ GED
   - ☐ Some College
   - ☐ Associate's Degree
   - ☐ Bachelor's Degree
   - ☐ Graduate Degree
   - ☐ Don't know

5. Marital Status (Check one)
   - ☐ Divorced
   - ☐ Domestic Partnership (living as married)
   - ☐ Married
   - ☐ Never married
   - ☐ Separated
   - ☐ Widowed
   - ☐ Don't know

   Number of marriages:_____ Age at first marriage:_____

6. Occupation (former, if retired): _____

   Since age 18, what is the occupation you have worked most of your life?

   _____

7. In which country were you and your parents born? Grandparents?

Country of Birth

You _____

Your mother _____

Your father _____

Your mother's mother _____

Your mother's father _____

Your father's mother _____

Your father's father _____

7.b. If you were not born in the US, what is the number of years living in the US? _____

7.c. In what country and state have you lived most of your life? _____

8. Please check the religion into which you and your parents were born:

	You	Your Mother	Your Father	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Protestant	☐	☐	☐	☐	☐	☐	☐
Catholic	☐	☐	☐	☐	☐	☐	☐
Buddhism	☐	☐	☐	☐	☐	☐	☐
Ashkenazi Jewish	☐	☐	☐	☐	☐	☐	☐
Sephardic Jewish	☐	☐	☐	☐	☐	☐	☐
Other Jewish	☐	☐	☐	☐	☐	☐	☐
Hinduism	☐	☐	☐	☐	☐	☐	☐
Eastern Orthodox	☐	☐	☐	☐	☐	☐	☐
Muslim	☐	☐	☐	☐	☐	☐	☐
Mormon	☐	☐	☐	☐	☐	☐	☐
7th Day Adventists	☐	☐	☐	☐	☐	☐	☐
None	☐	☐	☐	☐	☐	☐	☐
Other (please specify) _____	☐	☐	☐	☐	☐	☐	☐
Don't Know	☐	☐	☐	☐	☐	☐	☐

9. What is your ethnic background? (please check as many as apply).

- ☐ White, Caucasian
- ☐ Black, African American
- ☐ Mexican, Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Spanish/Hispanic/Latino (please specify) _____
- ☐ Native American (please specify principal tribe) _____
- ☐ Alaska Native ((please specify principal tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (please specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander _____
- ☐ Some other race (please specify) _____

10. Are you a twin?

- ☐ Yes → Are you and your twin identical? ☐ Yes ☐ No ☐ Don't know
- ☐ No

11. Have you ever had colon or rectal polyps?

- ☐ Yes→your age when first told you have a polyp: ____Check here if this is an estimate ☐
- ☐ No
- ☐ Not sure

12. Have you ever had cancer?

- ☐ No
- ☐ Yes → Please tell us about all the cancers you have had and how old you were when diagnosed.

a. Type of cancer: _____ Your age at diagnosis _____

b. Type of cancer: _____ Your age at diagnosis _____

c. Type of cancer: _____ Your age at diagnosis _____

Family History of Cancer

Please complete the family history forms for your "blood" relatives, for half siblings please use an ***.** For example, do not include any adopted children or step brothers/sisters. If you are adopted, and you do not know your natural parents, just complete the information about your children. Use a "?" whenever you are not sure of an answer. **If necessary, it is acceptable to estimate a date or an age.**

Please fill in the following information on **yourself, your parents, siblings and children**.

Relationship	Name (Last, first, middle initial)	Date of birth	Was this person ever a smoker?	Has this person ever had colonic polyps?	Has this person ever had cancer?	If yes, please list type of cancer and age at diagnosis	Is this person still living?	If not, please list cause of death and age at death
Your name			YES NO ☐ ☐	Yes No Don't Know ☐ ☐ ☐	Yes No Don't Know ☐ ☐ ☐	TYPE AGE	YES NO ☑ ☐	CAUSE AGE N/A N/A
Mother			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
Father			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
Sister Brother ☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
Your spouse			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
Son Daughter ☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	
☐ ☐			☐ ☐	☐ ☐ ☐	☐ ☐ ☐		☐ ☐	

Cancer Risk Factors

ALCOHOL HISTORY

1. Have you ever had an alcoholic beverage?
   - ☐ Yes **Go to Question 2**
   - ☐ No **Go to Tobacco History section (next page)**

2. Have you ever drank alcohol at least once per week for 6 months or longer?
   - ☐ Yes **Go to Question 3**
   - ☐ No **Go to Tobacco History section (next page)**

3. What age did you **first** start drinking alcohol at least once per week for 6 months or longer?

   _____years old

4. How many years in total have you drank alcohol at least once per week?

   _____years _____ months (if less than 1 year)

5. When you drank alcohol at least once per week, how many drinks do/did you usually have in a week?

   How many of each type of drink do/did you usually have in a week:

   Beer (12 oz can or bottle) _____

   Wine or wine coolers (1 medium glass) _____

   Liquor (1 shot) _____

   ☐ Don't Know

6. Are you currently drinking alcohol at least once per week?
   - ☐ Yes → How many drinks per week? _____
   - ☐ No → At what age did you stop consuming alcohol at least once per week? _____
   - ☐ Don't Know

7. When you drank the most, how many drinks do, or did you have in one week?

   Drinks/week _____ How long? _____ (years)

TOBACCO HISTORY

1. Have you smoked a cigarette, even a puff in the past 30 days?
   - ☐ Yes **Go to <u>Part 2</u> below**
   - ☐ No **Go to Question 2**

2. Have you **ever** smoked at least one cigarette per day for 3 months or longer?
   - ☐ Yes **Go to <u>Part 1</u> below**
   - ☐ No **Go to Exposure History section**

<u>Part 1</u> -- Former Cigarette Smokers ONLY

3. About how old were you when you first started smoking at least one cigarette per day for 3 months or longer? _____ years old
4. When you were smoking at least one cigarette per day, how many cigarettes (not packs) did you smoke on a typical day? ____cigarettes
5. About how old were you when you last quit smoking?_____ years old
6. For how many years did you smoke, at least one cigarette a day?_____ years

<u>Part 2</u> -- Current Cigarette Smokers ONLY

7. For how many years have you smoked at least one cigarette a day? ____ years
8. About how old were you when you first started smoking at least one cigarette a day for 3 months or longer? _____ years old
9. Since you started smoking at least one cigarette per day, about how many cigarettes (not packs) do you smoke on a typical day? ____cigarettes
10. During the past 7 days, how many cigarettes (not packs) did you smoke on a typical day?
    (____) cigarettes
11. Do you smoke your first cigarette during the first 30 minutes after you wake up?
    - ☐ Yes
    - ☐ No

EXPOSURE HISTORY

1. Have any of the people you have lived with (for example, family members, roommates, etc.) smoked in your home (that is, are you or have you been exposed to second hand smoke)?
   - ☐ Yes **Continue**
   - ☐ No **Go to Question 2**
   - ☐ Don‘t Know **Go to Question 2**

   1.a. **If yes**, for how long?
   - ☐ 6 months or less
   - ☐ 6 month to 1 year
   - ☐ 1-2 years
   - ☐ 2-3 years
   - ☐ 3-4 years
   - ☐ 4-5 years
   - ☐ More than 5 years

   1.b. **If yes,** is there secondhand smoke in your home now?
   - ☐ Yes
   - ☐ No
   - ☐ Don‘t Know

2. Have you been exposed to second hand smoke in the workplace?
   - ☐ Yes **Continue**
   - ☐ No **Go to Question 3**
   - ☐ Don‘t Know **Go to Question 3**

   2.a **If yes**, for how long?
   - ☐ Less than 6 months
   - ☐ 6 month to 1 year
   - ☐ 1-2 years
   - ☐ 2-3 years
   - ☐ 3-4 years
   - ☐ 4-5 years
   - ☐ More than 5 years

   2.b **If yes,** is there secondhand smoke in your workplace now?
   - ☐ Yes
   - ☐ No
   - ☐ Don‘t Know

3. Have you ever used products which contain talc (e.g. dusting powder with talc)?
   - ☐ Yes
   - ☐ No
   - ☐ Don‘t Know

4. Are you currently using any of the following?

	Yes	No	How often?
Cigars			_____Times every: ☐ day ☐ week ☐ month
Chewing Tobacco			_____Times every: ☐ day ☐ week ☐ month
Dip or snuff			_____Times every: ☐ day ☐ week ☐ month
Hookah (water pipe)			_____Times every: ☐ day ☐ week ☐ month
Pipe			_____Times every: ☐ day ☐ week ☐ month
Marijuana			_____Times every: ☐ day ☐ week ☐ month

5. Have you **EVER** been exposed to either of the following?

	Yes	No	Don't Know	Where Exposed?	How long (years)
Asbestos					
Radon					

6. Are you **CURRENTLY** being exposed to either of the following?

	Yes	No	Don't Know	Where Exposed?	How long (years)
Asbestos					
Radon					

7. Have you ever worked in any of the following industries?

Industry	Yes	No	Don't Know	Years Worked
Ship fitting				
Paint manufacturing				
Printing				
Farming				
Mining				
Construction				

8. Have you ever used any of the following at work or as part of a hobby?

Material	Yes	No	Don't Know	Years Used
Cadmium				
Heavy metals				
Rubber				
Chemicals/Solvents				

9. Have you ever had any of the following types of x-rays that included the **chest area**?

	Yes	No	Don't Know	# of x-rays	Age of first x-ray
Chest x-ray					
Chest Cat Scan					
Heart Catheterization					
Scoliosis x-ray					
Other_____					

10. Have you ever had any of the following types of x-rays that included the **lower abdomen or pelvic area**?

	Yes	No	Don't Know	# of x-rays	Age of first x-ray
Barium Enema					
Cat Scan					
Spinal x-ray					
Pelvic x-ray					
Other_____					

11. Have you ever had **treatment with radiation** that included the **chest area** for any of the following?

	Yes	No	Don't Know	# of radiation treatments	Age of first radiation treatment
Cancer					
Acne					
Mastitis					
Enlarged Thymus					
Tuberculosis					
Other_____					

12. Have you ever had **treatment with radiation** that included the **lower abdomen or pelvic area** for any of the following?

	Yes	No	Don't Know	# of radiation treatments	Age of first radiation treatment
Cancer					
Bleeding in the uterus					
Growth on the uterus					
Other_____					

13. Have you been diagnosed with any of the following infections? (check all that apply)

	Yes	No	Don't Know
Hepatitis B Virus			
Hepatitis C Virus			
Herpes Simplex			
Human Papilloma Virus (HPV)			
Epstein Barr Virus (EBV) mononucleosis			
H Pylori			
Human Immunodeficiency Virus (HIV)			
Other_____			

14. Did your mother take a drug called diethylstilbesterol or "DES" while she was pregnant with you?
    - ☐ Yes → If yes, how many _____ weeks?
    - ☐ No
    - ☐ Don't Know

PHYSICAL ACTIVITY HISTORY

Directions: Please think about your current physical activities including **exercise, recreation, or physical activities other than your regular job duties.**

Please read each question carefully, answer yes or no, and report how many times per week, month **OR** year you performed these activities.

Choose the best answer for each question.

Check **only one** box for each question.

		No	**Yes**	**Frequency:** Fill in the number of times and check week, month or year Example: __4__Times every: ☐ week ☒ month ☐ year
1	Do you participate in **any** recreational physical activities or exercises?			_____Times every: ☐ week ☐ month ☐ year
2	Do you participate in **vigorous** activities (jogging, swimming laps, singles tennis, rollerblading, ice skating, skiing, karate, kick boxing, soccer)?			_____Times every: ☐ week ☐ month ☐ year

3	Do you participate in **moderate** activities (aerobics, doubles tennis, social dancing, leisurely bike riding, hiking, horseback riding, canoeing, volleyball?			_____Times every: ☐ week ☐ month ☐ year
4	Do you participate in **light** activities (softball, golf, bowling, fishing, sailing, yoga, gardening, walking)?			_____Times every: ☐ week ☐ month ☐ year
5	Do you do physical activities specifically designed to **strengthen** your muscles (lifting weights or doing calisthenics)?			_____Times every: ☐ week ☐ month ☐ year

DIET HISTORY

1. Are you a vegetarian?
   - ☐ Yes
   - ☐ No
   - ☐ Don‘t Know

2. How many servings of fruits and vegetables do you usually eat a day?
   - ☐ 0
   - ☐ 1
   - ☐ 2
   - ☐ 3
   - ☐ 4
   - ☐ 5 or more
   - ☐ Don‘t Know

3. Do you eat red meat?
   - ☐ Yes → If yes, how often? _____
   - ☐ No
   - ☐ Don‘t Know

Directions: Please think about what you usually ate or drank **during the past month**, that is, the past 30 days. Please read each question carefully and:

- Report how many times per day, week **or** month you ate each food
- Choose the best answer for each question
- Mark only one response for each question

	Example: How often did you **usually** eat cold cereals?	✓ Never OR ____Times every: ☐ day ☐ week ☐ month
	Example: How often did you eat **French fries, home fries or hash brown potatoes**?	____ Never OR __2__Times every: ☐ day ☒ week ☐ month
1	How often did you **usually** eat cold cereals?	____ Never OR ____Times every: ☐ day ☐ week ☐ month
2	How often did you use **milk**, either to drink or on cereal? **If yes**, what kind of milk did you usually use? Check one→	____ Never OR ____Times every: ☐ day ☐ week ☐ month ☐ Whole ☐ 2% ☐ 1% ☐ ½% ☐ Non-fat or skim
3	How often did you **usually** eat **bacon or sausage**, not including low fat, light, or turkey varieties?	____ Never OR ____Times every: ☐ day ☐ week ☐ month
4	How often did you eat **hot dogs** made of beef or pork?	____ Never OR ____Times every: ☐ day ☐ week ☐ month
5	How often did you **eat whole grain bread** including toast, rolls and in sandwiches? Whole grain breads include wheat, rye, oatmeal and pumpernickel.	____ Never OR ____Times every: ☐ day ☐ week ☐ month
6	How often did you drink **100% fruit juice** such as orange, grapefruit, apple and grape juices? **Do not count fruit drinks** such as Kool-Aid, lemonade, cranberry juice cocktail, Hi-C and Tang.	____ Never OR ____Times every: ☐ day ☐ week ☐ month
7	How often did you eat **fruit**? **Count** fresh, frozen or canned. **Do not count** juices.	____ Never OR ____Times every: ☐ day ☐ week ☐ month

How many times per day, week **or** month did you eat each food in the <u>past month</u>?		
8	How often did you use **regular fat salad dressing or mayonnaise,** including on salad and sandwiches? **Do not count** low-fat, light or diet dressings.	____ Never OR ____Times every: ☐ day ☐ week ☐ month
9	How often did you eat **lettuce or green leafy salad**, with or without other vegetables?	____ Never OR ____Times every: ☐ day ☐ week ☐ month
10	How often did you eat **French fries, home fries or hash brown potatoes**?	____ Never OR ____Times every: ☐ day ☐ week ☐ month
11	How often did you **eat other white potatoes**? **Count** baked potatoes, boiled potatoes, mashed potatoes and potato salad. **Do not** include yams or sweet potatoes.	____ Never OR ____Times every: ☐ day ☐ week ☐ month
12	How often did you eat **cooked dried beans**, such as refried beans, baked beans, bean soup, and pork and beans?	____ Never OR ____Times every: ☐ day ☐ week ☐ month
13	How often did you **usually** eat **other vegetables** raw, cooked, canned or frozen? **Do not count** lettuce, white potatoes, rice or cooked dried beans.	____ Never OR ____Times every: ☐ day ☐ week ☐ month
14	How often did you **usually** eat **any kind of pasta**? **Count** spaghetti, noodles, macaroni and cheese, pasta salad, rice noodles, soba and any other kind of pasta.	____ Never OR ____Times every: ☐ day ☐ week ☐ month
15	How often did you eat **peanuts, walnuts, seeds or other nuts**? **Do not** include peanut butter.	____ Never OR ____Times every: ☐ day ☐ week ☐ month
16	How often did you eat **regular fat potato chips, tortilla chips or corn chips**? Do not include low-fat chips.	____ Never OR ____Times every: ☐ day ☐ week ☐ month

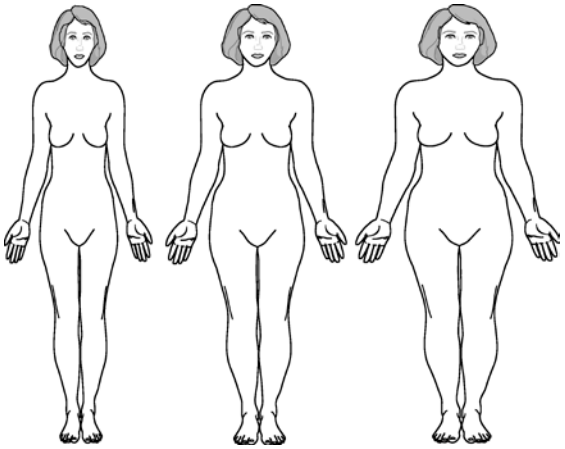
Personal Medical History

1. What is your current weight? _____lbs.

2. What was your approximate weight two years ago? _____ lbs

3. What is your current height? _____ft. _____ in.

4. What body shape would you say you most resemble?
   Please check the appropriate box underneath the figure shown on the right.



☐ ☐ ☐

5. Skin type:
   - ☐ Always burns & never tans
   - ☐ Usually burns & tans a little
   - ☐ Burns rarely & tans gradually
   - ☐ Never burns & always tans
   - ☐ Naturally brown complexion
   - ☐ Naturally black complexion

6. Natural hair color at age 16:
   - ☐ Red
   - ☐ Blonde
   - ☐ Brown
   - ☐ Black

7. Eye color:
   - ☐ Blue
   - ☐ Green
   - ☐ Hazel
   - ☐ Brown

8. Are you left or right handed?
   - ☐ Left
   - ☐ Right

9. Has a doctor ever told you that you have any of the following diseases/conditions?

Please check yes, no or don't know for each.	Yes	No	Don't Know
Allergies			
Alzheimer's Disease			
Arthritis			
Asthma			
Autoimmune Disorder Please specify_____			
Barrett's Esophagus			
Benign breast disease			

Please check yes, no or don't know for each.	Yes	No	Don't Know
Non-cancerous cyst or lump			
Hyperplasia (could be ductal or lobular)			
Hyperplasia with atypia (atypical hyperplasia) (could be ductal or lobular)			
Lobular carcinoma in situ (LCIS)			
Cataracts			
Celiac Disease			
Chronic Bronchitis			
Chronic Obstructive Pulmonary Disease (COPD)			
Crohn's disease			
Cystic Fibrosis			
Depression/anxiety/stress problem for which you took medicine			
Diabetes Type I (Insulin Dependent)			
Diabetes Type II (Non-Insulin Dependent)			
Diverticulitis			
Dysplastic Nevi (pre-cancerous moles)			
Emphysema			
Endometriosis			
Epilepsy/seizures			
Gastrointestinal Reflux Disease (GERD)			
Glaucoma			
Heart attack/myocardial infarction			
Heart problems (other) - specify type if you know			
Hemophilia			
High cholesterol			
Hypertension/high blood pressure			
Irritable Bowel Syndrome (IBS)			
Leukoplakia (white patches in mouth)			
Migraine headaches			
Multiple Sclerosis			
Peptic or stomach ulcer			
Pelvic Inflammatory Disease			
Pneumonia			

Please check yes, no or don't know for each.	Yes	No	Don't Know
Sexually Transmitted Disease			
Sickle Cell Anemia			
Stroke			
Thyroid problems (Explain)			
Tuberculosis			
Ulcerative colitis			
Others Please specify_____			

10. Have you ever had a breast biopsy (breast tissue removed by a surgery) finding benign breast disease, such as a non-cancerous cyst or breast lump? Do not include a fine needle aspiration.
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know

11. Have you ever had a breast completely removed?
    - ☐ Yes
    - ☐ No **Go to Question 12**
    - ☐ Don't Know **Go to Question 12**

    11.a. **If yes**, at what age did you have your breast(s) removed?
    - ☐ Left breast What age? _____years
    - ☐ Right breast What age? _____years

    11.b. If yes, why did you have your breast(s) removed? (Check all that apply)
    - ☐ Genetic alteration
    - ☐ Breast cancer
    - ☐ Decrease my risk of developing breast cancer
    - ☐ Other _____

12. Has a doctor ever said that you had cysts in one or both ovaries?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know

13. Have you ever had an ovary completely removed?
    - ☐ Yes
    - ☐ No **Go to Question 14**
    - ☐ Don't Know **Go to Question 14**

    13.a **If yes,** at what age did you have your ovaries removed?
    - ☐ First ovary What age? _____years

- ☐ Second ovary What age? _____years

13.b **If yes**, why did you have your ovaries removed? (Check all that apply)

- ☐ Genetic alteration
- ☐ Ovarian cancer
- ☐ Decrease my risk of developing ovarian cancer
- ☐ Other _____

14. Have you ever had a hysterectomy (surgical removal of the uterus)?

- ☐ Yes How old were you? _____ years old
- ☐ No
- ☐ Don‘t Know

15. Have you ever had a bronchoscopy (a procedure that allows your doctor to look at your airway through a thin instrument)?

- ☐ Yes
- ☐ No
- ☐ Don‘t Know

15.a. If yes, did you have a biopsy?

- ☐ Yes
- ☐ No
- ☐ Don‘t Know

15.b. If yes, date of the biopsy? _____ / _____ / _____
month day year

16. Are you, or or have you ever been a participant in a cancer prevention trial?

- ☐ Yes
- ☐ No
- ☐ Don‘t Know

16.a. If yes, was it: (Check all that apply)

- ☐ Tamoxifen trial
- ☐ Dietary trial
- ☐ Other Please specify _____
- ☐ Don't know

Medication History

1. From the list below, please check **ALL medications, vitamins or supplements** you are using, or have ever used**.**

Ever used?		Type of Drug, Vitamin & Supplement	Age First Started	Still taking	
Yes	No			Yes	No
		Heart or Blood Pressure Medications			
		Diuretics (for example, Diuril, Demadex)			
		Beta Blockers (for example, Lopressor, Inderal)			
		ACE Inhibitors (for example, Monopril, Vasotec)			
		Calcium channel blockers (for example, Norvasc, Cleviprex)			
		Cholesterol lowering drugs (for example, Lipitor, Zocor)			
		Blood Thinners (for example, Coumadin, Heparin)			
		Other Heart or Blood Pressure Medication: *please tell us the name:*_____			
		Pain Medication			
		Narcotic analgesics (for example, Oxycontin, Methadone)			
		Nonnarcotic analgesics (for example, Tylenol, Anacin-3)			
		Non-Steroidal Anti-inflammatory Drug (NSAIDS (for example, Motrin, Celebrex)			
		Aspirin (for example, Bufferin, Excedrin)			
		Other Pain Medication: *please tell us the name:*_____			
		Pulmonary (Lung) Medications			
		Antihistamines (for example, Claritin-D, Allegra)			
		Bronchodilators (for example, ProAirÂ® HFA, Aerospan)			
		Nasal steroid inhalers (for example, Flonase, Singulair)			
		Antitussives (for example, Robitussin, Vicks Formula-44)			
		Other Pulmonary (Lung) Medication: *please tell us the name:*_____			
		Endocrine Medications			
		Blood glucose/sugar regulators (diabetes)			
		Thyroid/antithyroid (hyper and hypothyroidism)			
		Other Endocrine Medication: *please tell us the name:*_____			
		Neurologic Medications			
		Anti-seizure drugs (for example, Dilantin, Depakote)			

Ever used?		Type of Drug, Vitamin & Supplement	Age First Started	Still taking	
Yes	No			Yes	No
		Antidepressants (for example, Paxil, Zoloft)			
		Antianxiety drugs (for example, BuSpar, Inderal)			
		Other Neurologic Medication: *please tell us the name:*_____			
		Gastrointestinal Medications			
		Acid reflux/ulcers drugs (for example Prevacid, Zantac, antacids)			
		Other Gastrointestinal Medication: *please tell us the name:*_____			
		Other Medications			
		Tamoxifen (Nolvadex)			
		Raloxifene (Evista)			
		Aromatase inhibitors (Arimidex, Femara)			
		Other Medications not listed above: *name:*_____ *name:* _____			
		Vitamins			
		Calcium			
		Folic Acid			
		Vitamin D			
		Herbal Supplements			
		Ginkgo Biloba			
		White tea			
		Black tea			
		Green tea			
		St. Johns Wort			
		Licorice			
		Ginseng			
		Soy			
		Vitamin			

Reproductive History

1. Have you ever had a menstrual period?
   - ☐ Yes
   - ☐ No

1.a **If yes**, how old were you when your periods started? _____ Years old

1.b **If yes**, when did your last menstrual period start? _____ / _____ / _____
month day year

1.c **If yes**: The average menstrual cycle (days from the start of one period to the start of the next period) is 28 days. How long is, or was **your** menstrual cycle? ____ days

2. Have you ever been pregnant?
   - ☐ Yes **If you are currently pregnant for the <u>FIRST TIME</u> go to question 8.**
   - ☐ No **Go to Question 8**
   - ☐ Don't Know **Go to Question 8**

2.a **If yes,** how many times have you been pregnant? (If pregnant, include current pregnancy.)
_____ times

Please complete questions 3, 4 and 5 for each pregnancy. If you are currently pregnant, complete questions 3, 4 and 5 for your **<u>previous pregnancies</u>**.

	1st pregnancy	2nd pregnancy	3rd pregnancy	4th pregnancy
3. What was the outcome of each pregnancy?	☐ Single live birth ☐ Multiple live births ☐ Miscarriage/ spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion	☐ Single live birth ☐ Multiple live births ☐ Miscarriage/ spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion	☐ Single live birth ☐ Multiple live births ☐ Miscarriage/ spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion	☐ Single live birth ☐ Multiple live births ☐ Miscarriage/ spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion
4. How long was this pregnancy?	☐ 3 months or less ☐ 4-6 months ☐ 7 months or more ☐ Don't know	☐ 3 months or less ☐ 4-6 months ☐ 7 months or more ☐ Don't know	☐ 3 months or less ☐ 4-6 months ☐ 7 months or more ☐ Don't know	☐ 3 months or less ☐ 4-6 months ☐ 7 months or more ☐ Don't know

For live births only **5. Did you breast feed this child?**	☐ Yes ☐ No If yes, how long ☐ under 1 month ☐ 1-5 months ☐ 6-11 months ☐ 12-24 months ☐ over 24 months ☐ Don't know	☐ Yes ☐ No If yes, how long ☐ under 1 month ☐ 1-5 months ☐ 6-11 months ☐ 12-24 months ☐ over 24 months ☐ Don't know	☐ Yes ☐ No If yes, how long ☐ under 1 month ☐ 1-5 months ☐ 6-11 months ☐ 12-24 months ☐ over 24 months ☐ Don't know	☐ Yes ☐ No If yes, how long ☐ under 1 month ☐ 1-5 months ☐ 6-11 months ☐ 12-24 months ☐ over 24 months ☐ Don't know

	5th pregnancy	**6th pregnancy**	**7th pregnancy**	**8th pregnancy**
3. What was the outcome of each pregnancy?	☐ Single live birth ☐ Multiple live births ☐ Miscarriage/ spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion	☐ Single live birth ☐ Multiple live births ☐ Miscarriage/ spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion	☐ Single live birth ☐ Multiple live births ☐ Miscarriage/ spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion	☐ Single live birth ☐ Multiple live births ☐ Miscarriage/ spontaneous abortion ☐ Tubal pregnancy ☐ Induced abortion
4. How long was this pregnancy?	☐ 3 months or less ☐ 4-6 months ☐ 7 months or more ☐ Don't know	☐ 3 months or less ☐ 4-6 months ☐ 7 months or more ☐ Don't know	☐ 3 months or less ☐ 4-6 months ☐ 7 months or more ☐ Don't know	☐ 3 months or less ☐ 4-6 months ☐ 7 months or more ☐ Don't know
For live births only **5. Did you breast feed this child?**	☐ Yes ☐ No If yes, how long ☐ under 1 month ☐ 1-5 months ☐ 6-11 months ☐ 12-24 months ☐ over 24 months ☐ Don't know	☐ Yes ☐ No If yes, how long ☐ under 1 month ☐ 1-5 months ☐ 6-11 months ☐ 12-24 months ☐ over 24 months ☐ Don't know	☐ Yes ☐ No If yes, how long ☐ under 1 month ☐ 1-5 months ☐ 6-11 months ☐ 12-24 months ☐ over 24 months ☐ Don't know	☐ Yes ☐ No If yes, how long ☐ under 1 month ☐ 1-5 months ☐ 6-11 months ☐ 12-24 months ☐ over 24 months ☐ Don't know

6. How many live births have you had? ________

7. Your age when your first child was born? ______

8. Did you ever try to get pregnant for a year or more and not become pregnant?
   - ☐ Yes
   - ☐ No **Go to Question 9**

- ☐ Don't Know **Go to Question 9**
- ☐ Never Tried **Go to Question 9**

8.a **If yes,** have you ever gone to the doctor because you had trouble getting pregnant?

- ☐ Yes → Did you take fertility drugs? ☐ Yes ☐ No ☐ Don't Know
- ☐ No

9. Do you still have menstrual periods?

- ☐ Yes **Go to question 11**
- ☐ No

9.a **If no**, how old were you when your periods stopped? _____ years old

10. Did you have natural menopause?

- ☐ Yes
- ☐ No **Go to question 11**

10.a. **If yes,** how old were you when menopause began? _____ years old

11. Have you ever used **hormonal contraceptives** including birth control pills, implants, the patch, or injections?

- ☐ Yes
- ☐ No **Go to question 12**
- ☐ Don't Know **Go to question 12**

11.a. How old were you when you first used hormonal contraceptives? _____Yrs

11.b. Are you currently using hormonal contraceptives?

- ☐ Yes
- ☐ No
- ☐ Don't Know

11.c. How old were you when you last used hormonal contraceptives? _____Yrs

11.d. Why did you use hormonal contraceptives? (Please check all that apply)

- ☐ Birth control
- ☐ Regulate periods
- ☐ Treatment for acne
- ☐ Treatment for menopausal symptoms
- ☐ Other (specify) _____

12. Have you ever used estrogen, progestin, or other female hormones **for menopause**? Include pills (other than birth control pills), injections/shots, skin patches, vaginal creams, and vaginal suppositories.

- ☐ Yes
- ☐ No

- ☐ Don’t Know

12.a. **If yes**, what are, or were you using? _____

12.b. **If yes**, at what age did you begin using? _____

12.c. **If yes**, are you currently using?

- ☐ Yes
- ☐ No
- ☐ Don’t Know

Cancer Screening History

1. Have you ever had any of the following **breast cancer** screenings?

	Yes	No	Don't Know	Age at first test	Date of last test (mo/yr)	How many in your lifetime?	Ever Abnormal? Please Circle
Mammogram							Yes No
MRI							Yes No
Clinical Breast Examination							Yes No
How many times did you examine your breasts in the last six months? _____ times							

2. Have you ever had any of the following screening tests for **cervical cancer**?

	Yes	No	Don't Know	Age at first test	Date of last test (mo/yr)	How many in your lifetime?	Ever Abnormal? Please Circle
Pap Smear							Yes No
Pelvic Exam							Yes No

3. Have you ever had any of the following screening tests for **ovarian cancer**?

	Yes	No	Don't Know	Age at first test	Date of last test (mo/yr)	How many in your lifetime?	Ever Abnormal? Please Circle
CA-125 (a blood test that may be used to screen ovarian cancer)							Yes No
Pelvic or transvaginal ultrasound							Yes No

4. Have you ever had any of the following screening tests for **colon cancer**?

	Yes	No	Don't Know	Age at first test	Date of last test (mo/yr)	How many in your lifetime?	Ever Abnormal? Please Circle
Fecal Occult Blood Test (test for blood in the stool)							Yes No
Sigmoidoscopy							Yes No
Colonoscopy							Yes No

Sun Exposure

1. Did you develop freckles as a child?
   - ☐ Yes
   - ☐ No

2. Did you develop freckles in areas of sunburns?
   - ☐ Yes
   - ☐ No

3. Do you have moles?
   - ☐ Yes
   - ☐ No

   3.a. **If yes**, how many moles do you have?

   - ☐ Less than 20
   - ☐ Greater than 20 but less than 100
   - ☐ Greater than 100
   - ☐ Do not know

4. Have you worked outdoors for at least 3 years consecutively?
   - ☐ Yes
   - ☐ No

   4.a. If yes, what was your job(s)?

Farmer	☐ Yes	☐ No	**If yes**, for how many years_____
Landscaper	☐ Yes	☐ No	**If yes**, for how many years_____
Mailman	☐ Yes	☐ No	**If yes**, for how many years_____
House painter (exterior)	☐ Yes	☐ No	**If yes**, for how many years_____
Lifeguard	☐ Yes	☐ No	**If yes**, for how many years_____
Nuclear industry worker	☐ Yes	☐ No	**If yes**, for how many years_____

   Other professions that require being exposed to the sun for **at least** 5 hours a day:

   Please specify _____For how many years_____

5. Did you take vacations to sunny climate spots when you were a child (up to age 12) or a teenager (ages 13 to 18)?
   - ☐ Yes
   - ☐ No

   5.a. **If yes**, how often did you travel as a child (up to age 12)?
   - ☐ Frequently (once a year)
   - ☐ Occasionally (once every five years)
   - ☐ Rarely (once as a child)

   5.b. **If yes**, how often did you travel as a teenager (from age 13 to 18)?

- ☐ Frequently (once a year)
- ☐ Occasionally (once every five years)
- ☐ Rarely (once as a child)

6. Did you spend your **summers** as a child (up to age 12) or as a teenager (ages 13 to 18) outdoors?
   - ☐ Yes
   - ☐ No

   6.a. **If yes**, how often as a child (up to age 12)?
   - ☐ Frequently (everyday)
   - ☐ Occasionally (once a week)
   - ☐ Rarely (once a month)

   6.b. **If yes**, how often as a teenager (from age 13 to 18)?
   - ☐ Frequently (everyday)
   - ☐ Occasionally (once a week)
   - ☐ Rarely (once a month)

7. Did you play outdoor sports(e.g., baseball,soccer, etc.) in the summer s a child (up to age 18)?
   - ☐ Frequently (everyday)
   - ☐ Occasionally (once a week)
   - ☐ Rarely (once a month)
   - ☐ Never

8. What activities did you do in the summer as a **child** (up to age 12)?

	Frequently (every day)	Occasionally (once a week)	Rarely (once a month)	Never
Fishing	☐	☐	☐	☐
Hiking	☐	☐	☐	☐
Riding Bike	☐	☐	☐	☐
Swimming	☐	☐	☐	☐
Surfing	☐	☐	☐	☐

Specify others_____

9. What activities did you do in the summer as a **teenager** (ages 13-18)

	Frequently (every day)	Occasionally (once a week)	Rarely (once a month)	Never
Fishing	☐	☐	☐	☐
Hiking	☐	☐	☐	☐
Riding Bike	☐	☐	☐	☐
Swimming	☐	☐	☐	☐
Surfing	☐	☐	☐	☐

Specify others_____

10. Do you remember being badly sunburnt as a child (up to age 12) or a teenager (ages 13-18)? (Blistering or sunburn lasting more than 48 hours)

☐ Yes
☐ No

10.a. **If yes**, how many times as a **child**? _____

10.b. **If yes**, how many times as a **teenager**? _____

11. Are you currently older than 60 years of age?
    ☐ Yes
    ☐ No

    11.a. **If yes**, on average since you have turned 60, how many hours during daylight do you spend outdoors in the summer on the:

    Weekdays (in hours)_____ **Weekends** (in hours)_____

12. When you are outdoors in the sun during the summer how often do you wear the following?

	Frequently	Occasionally	Rarely	Never
Hat	☐	☐	☐	☐
Shorts	☐	☐	☐	☐
Trousers	☐	☐	☐	☐
Short sleeved shirts	☐	☐	☐	☐
Long sleeved shirts	☐	☐	☐	☐
Sunscreen	☐	☐	☐	☐

13. Extent of Sunbathing/Lying /Sitting in the Sun at following ages:

Age	Frequently	Occasionally	Rarely	Never
60+	☐	☐	☐	☐
40-59	☐	☐	☐	☐
20-39	☐	☐	☐	☐
0-19	☐	☐	☐	☐

14. What Sun Protection Factor (SPF) Sunscreen do you usually use when sunbathing?___

15. Do you go to tanning salons?
    ☐ Yes
    ☐ No

    15.a. **If yes**, how many tanning sessions would you have per year?_____