



# SJLIFE

## Home Survey

**Control**

Finding cures. Saving children.

The questions in this booklet relate to:

**Name**

Person completing this questionnaire is:

**percomp** **text**

Your relationship:

1  Self 2  Parent 3  Other: **percode** **coded**  
**relation**

Today's date:   /   /       
**m m d d y y y y**  
**datecomp**

**Our mailing address is:**  
St. Jude Children's Research Hospital  
Department of Epidemiology  
Mail Stop 735  
262 Danny Thomas Place  
Memphis, TN 38105-3678

**Toll-free phone number:**  
1-800-775-2167

**e-mail:**  
SJLIFE@stjude.org

SJLIFEID

Please! Do not mark below this line

MRN

Survey #319

3432563972

11/12/2021 09:48:29 AM

## INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen. Do not use a felt-tip or roller-ball pen. These may cause smudging.
2. When marking boxes, make an x inside the box (see examples below).
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided:

CORRECT

INCORRECT

Grape

GRADE

### MARKING EXAMPLES

Below are some examples of how to fill out this questionnaire. Please look these over before you begin.

#### EXAMPLE 1

1. During the past month, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

No     Yes

	<div style="background-color: #e0ffe0; padding: 2px; margin-bottom: 5px;">Not sure</div> <div style="text-align: center;">Yes</div>	<div style="border: 1px solid black; padding: 5px; display: inline-block;">If yes, age at first use</div> <div style="text-align: center; margin: 5px 0;">↓</div> <div style="text-align: center; margin: 5px 0;">years</div> <div style="border: 1px solid black; width: 40px; height: 25px; margin: 5px auto;"></div>
	<div style="background-color: #e0ffe0; padding: 2px; margin-bottom: 5px;">No</div>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input checked="" type="checkbox"/> </div> <div style="text-align: center;"> <input type="checkbox"/> </div> <div style="text-align: center;"> <input type="checkbox"/> </div> </div>
	<div style="background-color: #e0ffe0; padding: 2px; margin-bottom: 5px;">No</div>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <input type="checkbox"/> </div> <div style="text-align: center;"> <input checked="" type="checkbox"/> </div> <div style="text-align: center;"> <input type="checkbox"/> </div> </div>
		<div style="border: 1px solid black; width: 40px; height: 25px; display: flex; justify-content: space-around; align-items: center; margin: 5px auto;"> <span style="font-size: 1.2em;">3</span> <span style="font-size: 1.2em;">4</span> </div>

#### EXAMPLE 2

2. Have you ever taken. . .

- a. BIRTH CONTROL PILLS such as Demulen, Lo-Ovral, Loestrin, Norinyl, Norplant, Ortho-Novum, Ovral, Triphasil-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

- b. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES, such as Zocor, Pravachol, Lipitor, Colestid (colestipol), Tricor, Lescol, Lopid (gemfibrozil), Mevacor, niacin, or Lorelco-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

*MEVACOR*

#### EXAMPLE 3

3. When was this condition diagnosed?

04

1995

Month (mm)

Year (yyyy)

Please! Do not mark below this line

A1. What is your date of birth? **d\_birth**

		/			/				
m	m		d	d		y	y	y	y

A2. What is your sex? **sex**

- 1  Male
- 2  Female

A3. To the nearest inch, what is your current height without shoes?

	feet, and			inches
heightft		heightin		

A4. To the nearest pound, what is your current weight without shoes? **weight**

			pounds
--	--	--	--------

A4a. Since this time last year, have you lost more than 10 pounds unintentionally (not due to dieting or exercise)? **wgtloss**

- 1  Yes
- 2  No
- 3  Not sure

A5. To which one of the following groups do you belong? **race**

- 1  White
- 2  Black
- 3  American Indian or Alaskan Native
- 4  Asian
- 5  Pacific Islander
- 6  Other

Specify

raceoth coded

A5a. Are you Hispanic? **racehsp**

- 2  No
- 1  Yes

A6. Are you a twin or born of a multiple birth? **twin**

- 2  No [Go to Question A7.](#)
- 1  Yes

A6a. If yes, which type of multiple are you? **twin\_typ**

- 1  Identical twin
- 2  Fraternal (non-identical) twin, same sex
- 3  Fraternal (non-identical) twin, opposite sex
- 4  Not sure what type of twin, same sex
- 5  More than twin

Specify

twin\_sp coded

A7. Were you adopted? **adopted**

- 2  No
- 1  Yes

A8. How many full brothers and sisters (living or dead) do/did you have? Include only those brothers and sisters who have the same birth (biological) mother and father as you. **n\_sibls**

--	--

A9. Concerning your current residence, do you: **res** (Mark all that apply)

- Own your residence **res\_own**
- Rent **res\_rent**
- Live with parents **res\_par**
- Other **res\_oth**

Specify

res\_sp coded

# Medical Care

The next questions are about health care received during the last two years.

**B1. During the last two years, which of the following healthcare providers (excluding dentists) did you see or talk to for medical care? This includes routine and sick care. *mdcr* (Mark all that apply)**

- None **→ Go to Question B7, next page.** *mdcr\_none*
- Primary care clinician in the community (e.g., family physician, general internist, pediatrician, nurse practitioner, physician's assistant) *mdcr\_prim*
- Clinician at a cancer center (e.g., oncologist, nurse practitioner or physician's assistant, other cancer specialist) *mdcr\_cactr*
- Other Medical specialist (e.g., endocrinologist, cardiologist, surgeon) *mdcr\_spec*
- Psychiatrist *mdcr\_psymd*
- Psychologist or counselor *mdcr\_psy*
- Physical or occupational therapist *mdcr\_ptot*
- Other *mdcr\_othprov*

**If Other, please specify.**

*dothprov1-10*    *text*

**B2. During this last two years, where did you receive your health care? *hlcr* (Mark all that apply)**

- Doctor's office *hlcr\_droff*
- Oncology (cancer) center or clinic *hlcr\_oncclin*
- Other type of clinic *hlcr\_othclin*
- Hospital *hlcr\_hosp*
- Emergency Room or Urgent Care Center *hlcr\_er*
- Long-term follow-up clinic *hlcr\_fuclin*
- Other *hlcr\_oth*

**Specify**

*no entry*

**B3. During this last two years, how many times did you see a physician? *visphys***

- 1  0 times **→ Go to Question B5a.**
- 2  1 - 2 times      5  7 - 10 times
- 3  3 - 4 times      6  11 - 20 times
- 4  5 - 6 times      7  More than 20 times

**B4. If you have been diagnosed with a cancer, leukemia, tumor, or similar illness, how many of the visits to the physician indicated in question B3 (during the past 2 years) were related to this previous illness? *cvisphs***

- 1  0 visits
- 2  1 - 2 visits
- 3  3 - 4 visits
- 4  5 - 6 visits
- 5  7 - 10 visits
- 6  11 - 20 visits
- 7  More than 20 visits

**B5. During this 2 year period, how often did you telephone a doctor's office, regarding an illness or a medical condition you may have had? *teldoc***

- 1  0 times
- 2  1 - 2 times
- 3  3 - 4 times
- 4  5 - 6 times
- 5  7 - 10 times
- 6  11 - 20 times
- 7  More than 20 times

**B6. During this 2 year period, how many times were you admitted to any hospital?**

*n\_hspadm*

Please! Do not mark below this line

**B6a.** During the past 12 months, how many times have you gone to a **HOSPITAL EMERGENCY ROOM** about your own health (This includes emergency room visits that resulted in a hospital admission)?

times **ervisit**

**B7.** Have you ever been diagnosed with cancer?

- 2  No **→ Go to Question B8i, next page.**  
1  Yes **cadx**

**B8.** When was your most recent routine check-up where a doctor examined you and did tests to see if you had any health problems from your cancer or your cancer treatment? **chkup**

- 1  Less than 1 year ago  
2  1-2 years ago  
3  More than 2 years but less than 5 years ago  
4  5 or more years ago  
5  Never **→ Go to Question B8d.**

**B8a.** Where was this check-up? (*Mark only one*) **chkuploc**

- 1  At a cancer survivor clinic  
2  At a cancer center, but not in a cancer survivor clinic  
3  At my primary care doctor's office  
4  Other

*If Other, please specify.*

**chkupoth**

text

**B8b.** At this check-up, did your doctor give you advice about what to do to reduce risks or discuss medical screening tests? **chkupadv**

- 2  No  
1  Yes  
3  Not sure

**B8c.** At this check-up, did your doctor order medical screening tests? **chkuptest**

- 2  No  
1  Yes  
3  Not sure

**B8d.** When was the last time that you had a medical visit with a cancer specialist (oncologist)? **oncologist**

- 1  Less than 1 year ago  
2  1-2 years ago  
3  More than 2 years but less than 5 years ago  
4  5 or more years ago  
5  Don't know

**B8e.** When was the last time you had a visit to a special clinic for cancer survivors? **survclin**

- 1  Less than 1 year ago  
2  1-2 years ago  
3  More than 2 years but less than 5 years ago  
4  5 or more years ago  
5  Never  
6  Don't know

**B8f.** When do you plan to have your next visit with a doctor in order to examine you for any health problems from your cancer or your cancer treatment? **nxtchkup**

- 1  Less than 1 year from now  
2  1-2 years from now  
3  3-4 years from now  
4  5 or more years from now  
5  Never  
6  Don't know

**B8g. Do you currently have a cancer survivorship care plan and/or a summary of treatment for your cancer (records from your cancer doctor that have details about your cancer treatment and medical tests you should have to check for future health problems)?** *survplan*

- 2  No 1  Yes 3  Not sure

**B8h. Does your local or primary care doctor have a copy of your cancer survivorship care plan and/or a summary of your treatment for your cancer?**

- 1  I don't have a primary care doctor *plancopy*  
 2  I have a primary care doctor but he/she does not have a copy of my cancer survivorship care plan and/or a summary of my treatment for my cancer  
 3  Yes  
 4  Not sure

**B8i. How often do you carefully check your whole body (including the skin on your back and back of your legs) for any sign of skin cancer?** *skinck*

- 1  Once a month  
 2  Every few months  
 3  Every 6 months  
 4  Every year  
 5  Never

**B8j. In the past 12 months, has your regular healthcare provider carefully examined your whole body for any sign of skin cancer?** *skinckdr*

- 2  No 1  Yes 3  Not sure

**B9. Please indicate all medicines/drugs you took *regularly* during the last two years.**

- We are only asking about medicines/drugs which you took consistently for more than one month, or for 30 days or more in a year.

- Please list only drugs prescribed by a doctor and filled by a pharmacist. Include pills, syrups, injections, patches, or creams.

- Please do NOT include medicines/drugs that you bought without a prescription (over-the-counter drugs).

1. BIRTH CONTROL MEDICATIONS such as Demulen, Lo-Ovral, Loestrin, Norinyl, Norplant, Ortho-Novum, Ovral, Triphasil, Depo Provera -----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

*bcpillc1-4*  
*coded*

3 Not sure  
 1 Yes  
 2 No

*bcpill*

If yes, age at first use

years

*abcpill*

If yes, are you currently taking?

1 Yes  
 2 No

*bcpill2*

2. ESTROGENS OR PROGESTERONES (FEMALE HORMONES) such as Estrace, Estraderm, Premarin, Provera, Medroxyprogesterone, Vivelle-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

*estproc1-6*  
*coded*

*estprog*

*aestprog*

*estprog2*

3. TESTOSTERONES (MALE HORMONES) such as Androgel, Delatesteral, Testosterone cypionate, Testosterone enanthate-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

*testosc1-5*  
*coded*

*testot*

*atestos*

*testos2*

Please! Do not mark below this line

**B9. (Cont) Please indicate all medicines/drugs you took *regularly* during the last two years.**

- We are only asking about medicines/drugs which you took consistently for more than one month, or for 30 days or more in a year.

- Please list only drugs prescribed by a doctor and filled by a pharmacist. Include pills, syrups, injections, patches, or creams.

- Please do NOT include medicines/drugs that you bought without a prescription (over-the-counter drugs).

If yes, age at first use

If yes, are you currently taking?

4. PILLS OR INSULIN FOR DIABETES such as Glucophage (metformin), Glucotrol (glipizide), Glynase (glyburide), Prandin, Amaryl, Avandia, Actos, or insulin injections (such as Humulin, Novolin, Lantus)-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**diabdr1-7**  
coded

3 Not sure  
1 Yes  
2 No

diadrug

years

adiabdr

1 Yes  
2 No

diabdr2

5. MEDICATIONS FOR HIGH BLOOD PRESSURE OR HYPERTENSION such as hydrochlorothiazide (HCTZ), Dyazide (triamterene/HCTZ), Tenormin (atenolol), Lopressor (metoprolol), Zestril or Prinivil (lisinopril), Vasotec (enalapril), Cozaar, Hyzaar, Diovan, or others-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**hrtdrug1-5**  
coded

hrtdrug

ahrtdrug

hrtdrug2

6. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES such as Lovastatin, Zocor (simvastatin), Pravachol (pravastatin), Crestor, Lipitor, Zetia, Tricor, Vytorin, gemfibrozil-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**chodrg1-6**  
coded

chodrg

achodrg

chodrg2

7. MEDICATIONS FOR HEART CONDITIONS, INCLUDING ANGINA, CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE, OR IRREGULAR HEART BEAT-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**hrtcon1-6**  
coded

hrtcon

ahrtcon

hrtcon2

8. THYROID MEDICATIONS such as Synthroid (levothyroxine or L-thyroxine), Levothroid, or others-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**thydrug1-4**  
coded

thydrug

athydrug

thydrug2

Please! Do not mark below this line

**B9. (Cont) Please indicate all medicines/drugs you took *regularly* during the last two years.**

- We are only asking about medicines/drugs which you took consistently for more than one month, or for 30 days or more in a year.

- Please list only drugs prescribed by a doctor and filled by a pharmacist. Include pills, syrups, injections, patches, or creams.

- Please do NOT include medicines/drugs that you bought without a prescription (over-the-counter drugs).

9. MEDICATIONS FOR DEPRESSION such as Prozac (fluoxetine), Serzone, Celexa, Zoloft, Wellbutrin, Effexor, Desyrel (trazodone), or Vivactil-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**depressc1-8**  
coded

3 Not sure  
1 Yes  
2 No

If yes, age at first use

years

**adepress**

If yes, are you currently taking?

**Yes**

2 No

**depress2**

10. MEDICATIONS FOR TREATMENT OF LOW BONE MINERAL DENSITY (OSTEOPOROSIS/OSTEOPENIA) such as Fosamax (alendronate), Boniva (ibandronate), Actonel (risedronate), or Evista (raloxifene)-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**lobmddr1-5**  
coded

**lobmd**

**alobmd**

**lobmd2**

11. MEDICATIONS TO CORRECT LOW BLOOD LEVELS OF POTASSIUM, MAGNESIUM, PHOSPHOROUS, OR BICARBONATE such as KCl, KPhos, NeutraPhos, or Bicitra-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**loeled1-5**  
coded

**lowk**

**alowk**

**lowk2**

12. MEDICATIONS FOR ATTENTION OR MEMORY PROBLEMS such as Ritalin, Adderall, Concerta, Strattera, Aricept (donepezil), or Provigil (modafinil)-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name

**attenc1-6**  
coded

**atten**

**aatten**

**atten2**

13. OTHER PRESCRIBED DRUGS-----

If yes, specify the name of the drug(s) or indicate you do not know the specific name **and** specify the reason the drug was prescribed.

**opdrugr1-18**  
**opdrugc1-18**  
coded

**othdrug**

**aopdrug**

**opdrug2**

Please! Do not mark below this line



**B10. Please list all over the counter medications (NOT prescribed by a doctor) which you took *regularly* during the last two years.**

**We are only asking about medications which you took consistently for more than one month, or for 30 days or more in a year. Include pills, syrups, injections, patches, or creams.**

otcmed1-13

text

**B11. Please list all supplements which you took *regularly* during the last two years.**

**We are only asking about medicines which you took consistently for more than one month, or for 30 days or more in a year. Include pills, syrups, injections, patches, or creams.**

suppl1-12

text

*Continue on next page.*

# Medical Conditions

The next series of questions relate to medical conditions that have ever occurred in your lifetime.

Please indicate, by marking the box (either "No", "Yes", or "Not sure") if a doctor or other health care professional has told you that you have or have had any of the following conditions. In addition, please give your approximate age when the condition first occurred. (If more than one occurrence, please give age at first occurrence.)

Because we need definite responses, it is very important to mark an answer for each question, even if you have never had that condition. **Please do not leave any questions blank (unmarked).**

## DENTAL HEALTH

Questions C1 to C19 are about your general dental health and any dental care you may have received.

In addition to the above instructions, if you answered either "Yes" response to any of the items below, please also mark "Yes" or "No" to whether you have received this care in the last 2 years.

Have you ever . . .

		4 Not sure	
		3 Yes, but the condition is no longer present	
		2 No	
		1 Yes, and the condition is still present	
C1. Had one or more missing teeth because they did not develop? . . . . .	mistth	<input type="checkbox"/>	<input type="checkbox"/>
C2. Had a lack of or decreased amount of enamel on surface of teeth (hypoplasia)? . . . . .	enamel	<input type="checkbox"/>	<input type="checkbox"/>
C3. Had abnormal shaped (small or malformed) teeth? . . . . .	abnth	<input type="checkbox"/>	<input type="checkbox"/>
C4. Had abnormal root development? . . . . .	abnrt	<input type="checkbox"/>	<input type="checkbox"/>
C5. Had difficulty in producing saliva (dry mouth) that required treatment such as artificial saliva? . . . . .	drymth	<input type="checkbox"/>	<input type="checkbox"/>
C6. Had severe gingivitis or gum disease requiring surgery or deep cleaning? . . . . .	gumdis	<input type="checkbox"/>	<input type="checkbox"/>
C7. Had root canal therapy? . . . . .	rtcanl	2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Not Sure	
C8. Had more than 5 cavities? . . . . .	cavities	2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Not Sure	
C9. Lost 6 or more teeth due to decay or gum disease? . . . . .	lost6th	2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Not Sure	
C10. Worn a dental bridge (for missing or removed teeth)? . . . . .	dntbrg	<input type="checkbox"/>	<input type="checkbox"/>
C11. Worn removable dentures (complete or partial upper or lower or both)? . . . . .	dentur	<input type="checkbox"/>	<input type="checkbox"/>
C12. Worn a prosthesis to lift your palate to improve the quality of your voice? . . . . .	dntpros	<input type="checkbox"/>	<input type="checkbox"/>
C13. Had other dental treatment or surgery? . . . . .	othdntx	2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Not Sure	
<div style="border: 1px solid black; padding: 5px;"> <p><i>If yes, explain type of procedure.</i></p> <p>dothdntx1-5    text</p> </div>			
C14. Had any other dental problems? . . . . .	othdnpr	<input type="checkbox"/>	<input type="checkbox"/>
<div style="border: 1px solid black; padding: 5px;"> <p><i>If yes, explain type of procedure.</i></p> <p>dothdnpr1-3    text</p> </div>			

If yes, age at first occurrence

years

a_mistth	<input type="text"/>	<input type="text"/>
a_enamel	<input type="text"/>	<input type="text"/>
a_abnth	<input type="text"/>	<input type="text"/>
a_abnrt	<input type="text"/>	<input type="text"/>
a_drymth	<input type="text"/>	<input type="text"/>
a_gumdis	<input type="text"/>	<input type="text"/>
a_rtcanl	<input type="text"/>	<input type="text"/>
a_dntbrg	<input type="text"/>	<input type="text"/>
a_dentur	<input type="text"/>	<input type="text"/>
a_dntpros	<input type="text"/>	<input type="text"/>
a_othdntx	<input type="text"/>	<input type="text"/>
a_othdnpr	<input type="text"/>	<input type="text"/>

Have you received care for this in the last two years?

2 No	<input type="checkbox"/>	<input type="checkbox"/>
1 Yes	<input type="checkbox"/>	<input type="checkbox"/>
c_mistth	<input type="checkbox"/>	<input type="checkbox"/>
c_enamel	<input type="checkbox"/>	<input type="checkbox"/>
c_abnth	<input type="checkbox"/>	<input type="checkbox"/>
c_abnrt	<input type="checkbox"/>	<input type="checkbox"/>
c_drymth	<input type="checkbox"/>	<input type="checkbox"/>
c_gumdis	<input type="checkbox"/>	<input type="checkbox"/>
c_rtcanl	<input type="checkbox"/>	<input type="checkbox"/>
c_dntbrg	<input type="checkbox"/>	<input type="checkbox"/>
c_dentur	<input type="checkbox"/>	<input type="checkbox"/>
c_dntpros	<input type="checkbox"/>	<input type="checkbox"/>
c_othdntx	<input type="checkbox"/>	<input type="checkbox"/>
c_othdnpr	<input type="checkbox"/>	<input type="checkbox"/>

Please! Do not mark below this line

C15. Have you ever had dental braces? **dntbrace**

2  No 1  Yes 3  Don't know

C16. Do you currently have dental insurance? **dntins**

2  No 1  Yes 3  Don't know

C17. Have you visited the dentist or a dental clinic within the past year for any reason? **dntvisit**

2  No 1  Yes 3  Don't know

C18. Have you had your teeth cleaned by the dentist or dental hygienist within the past year? **teethcln**

2  No 1  Yes 3  Don't know

C19. Do you have problems finding a dentist to help with your dental care because of your previous cancer or similar illness? **finddnt**

2  No 1  Yes 3  Don't know

## HEARING/VISION/SPEECH

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	3 Yes, but the condition is no longer present	2 No	1 Yes, and the condition is still present	4 Not sure	If yes, age at first occurrence
					years
D1. Hearing loss requiring a hearing aid? <b>hear</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_hear</b>
D2. Deafness in both ears not completely corrected by hearing aid? <b>deaf1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_deaf1</b>
D3. Deafness in only one ear not completely corrected by hearing aid? <b>deaf2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_deaf2</b>
D4. Tinnitus or ringing in the ears? <b>tinn</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_tinn</b>
D5. Persistent dizziness or vertigo? <b>dizzy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_dizzy</b>
D6. Hearing loss, not requiring a hearing aid? <b>hearlos</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_hearlos</b>
D7. Any other hearing problems? <b>othhpr</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_othhpr</b>

**If yes, describe the other hearing problem(s). List the age at first occurrence for each problem separately.**

**dothhpr1-3** coded

**aothhpr1-3**

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	3 Yes, but the condition is no longer present	2 No	1 Yes, and the condition is still present	4 Not sure	If yes, age at first occurrence
					years
D8. Legally blind in only one eye? <b>oneeye</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_oneeye</b>
<b>If yes, do you have any sight in this eye? <b>onesight</b></b>					
	2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes			
D9. Legally blind in both eyes? <b>twoeye</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_twoeye</b>
<b>If yes, do you have any sight? <b>twosight</b></b>					
	2 <input type="checkbox"/> No	1 <input type="checkbox"/> Yes			
D10. Cataracts? <b>catar</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_catar</b>
D11. Glaucoma (excess pressure in the eyeball)? <b>glauc</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_glauc</b>
D12. Problems with double vision? <b>dblvis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_dblvis</b>
D13. A detached retina or any other condition of the retina? <b>retina</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_retina</b>
<b>If yes, describe the other condition(s). List the age at first occurrence for each problem separately.</b>					
<b>dretina1-3</b> coded					
<b>aretina1-3</b>					
D14. Crossed or turned eyes (strabismus)? <b>croseye</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_croseye</b>
D15. Lazy eye (amblyopia)? <b>lazyeye</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_lazyeye</b>
D16. Any other trouble seeing with one or both eyes even when wearing glasses? <b>othsee</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_othsee</b>
D17. Very dry eyes requiring eye drops or ointment? <b>dryeyes</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_dryeye</b>
D18. Any other eye problems? <b>otheye</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <b>a_otheye</b>
<b>If yes, describe the other eye problem(s). List the age at first occurrence for each problem separately.</b>					
<b>dotheye1-4</b> coded					
<b>aotheye1-4</b>					

Please! Do not mark below this line

# HORMONAL SYSTEMS

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

Remember, it is very important that you mark an answer for each of the following questions, even if you have never had that condition.

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	3 Yes, but the condition is no longer present	2 No	4 Not sure	1 Yes, and the condition is still present	If yes, age at first occurrence
					years
D19. Stammering or stuttering? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_stammr
D20. Any other speech defects? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_othspk

If yes, describe the other speech defect(s). List the age at first occurrence for each problem separately.

dothspk1-3 coded  
aothspk1-3

D21. Abnormal sense of taste? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_abtast
D22. Loss of taste lasting for 3 months or more? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_tastlos
D23. Loss of smell lasting for 3 months or more? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_smellos

## URINARY SYSTEM

E1. Kidney stones? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_kidstn
E2. REPEATED (more than 3 in any 12 month period) kidney or bladder infections? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_kidinf
E3. Dialysis? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_dialys
E4. Blood in your urine? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_urblood
E5. Protein in your urine? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_urprot
E6. Urinary incontinence? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_incont
E7. Any other kind of kidney, bladder or urinary tract disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_othkud

If yes, describe the other disorder(s). List the age at first occurrence for each disorder separately.

dothkud1-4 coded  
aothkud1-4

# HORMONAL SYSTEMS

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	3 Yes, but the condition is no longer present	2 No	4 Not sure	1 Yes, and the condition is still present	If yes, age at first occurrence
					years
F1. An overactive thyroid gland (hyperthyroid)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_ovthy
F2. An underactive thyroid gland (hypothyroid)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_unthy
F3. Thyroid nodules? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_thynod
F4. Swollen or enlarged thyroid gland? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_thyenl
F5. Diabetes that can be controlled with diet? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_diabd
F6. Diabetes controlled with pills or tablets? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_diabp
F7. Diabetes controlled with insulin shots? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_diabi
F8. Deficiency of growth hormone? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_ghdef
F9. Have you received injections of growth hormone (such as Nutropin, Genotropin, Humatrope, Norditropin, Saizen)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_injghr
<p>If yes, do you currently take injections of growth hormone?</p> <p>2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes injghr_c</p>					
F10. Osteoporosis or osteopenia (thin, brittle, or fragile bones)? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_ostpor
F11. Have you ever broken a bone? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_bknbon
<p>If yes, describe <u>all</u> occurrences of broken bone(s). List the age for each individual occurrence.</p> <p>bknbon1-16 coded abknbon1-16</p>					
F12. Any other hormonal problems? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_othhor

If yes, describe the other hormonal problem(s). List the age at first occurrence for each problem separately.

dothhor1-4 coded  
aothhor1-4

Please! Do not mark below this line

Remember, it is very important that you mark an answer for each of the following questions, even if you have never had that condition.

Males → Go to Question G1.

F13. **FEMALES** - Have you had a menstrual period naturally, that is, without needing hormones or medication?

No  Yes If yes, age at first occurrence:

If no, → Go to Question F15.

F14. **FEMALES** - At what age did you last have a menstrual period naturally, without needing hormones or medication to induce menstruation?

years and   months old

F15. **FEMALES** - Which one of the following statements best describes you? (Select only one) **pdesc**

- 1  a. I am having regular periods and I am not taking birth control pills or female hormones (example: Premarin, estrogen)
- 2  b. I am having regular periods but I am using birth control pills to prevent a pregnancy
- 3  c. My menstrual periods are irregular and I am taking birth control pills or female hormones to regulate my periods
- 8  d. My menstrual periods are irregular but I am not using birth control pills or female hormones to regulate my periods
- 4  e. I am currently pregnant
- 5  f. I am not having menstrual periods naturally but I am taking birth control pills or female hormones
- 6  g. I am not having menstrual periods naturally and I am not taking birth control pills or female hormones
- 7  h. Other

If Other, please describe.

pother text

If you selected a, b, c, d or e → Go to Question G1.

If you selected f, g, or h → Go to Question F16.

F16. **FEMALES** - What caused your menstrual periods to stop? (Select only one) **pstopwhy**

- 1  Normal or early menopause
- 2  Surgery (example: a hysterectomy)
- 3  Pregnancy
- 9  Don't know
- 4  Other

If Other, please describe.

pstopdes textcode

## HEART AND CIRCULATORY SYSTEM

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	1	2	3	4	
	Yes, and the condition is still present	No	Yes, but the condition is no longer present	Not sure	If yes, age at first occurrence
G1. Congestive heart failure or cardiomyopathy (weak heart muscle)? <b>conghf</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/> <input type="text"/> <b>a_conghf</b>
G2. A myocardial infarction (heart attack)? <b>htatt</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <b>a_htatt</b>
G3. Irregular heartbeat or palpitations, (Arrhythmia) requiring medication or follow-up by a doctor? <b>arrytm</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <b>a_arrytm</b>
G4. Coronary heart disease? <b>coronh</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <b>a_coronh</b>

If yes, describe the type of problem(s). List the age at first occurrence for each problem separately.

coronh1-3 coded  
acoronh1-3

G5. Hypertension (high blood pressure) requiring medication? **hytmed**

**a\_hytmed**

If yes, do you currently take hypertension medication?

2  No 1  Yes **hytmed2**

It is very important that you mark an answer for each of the following questions, even if you have never had that condition.

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	1 Yes, and the condition is still present	2 No	3 Yes, but the condition is no longer present	4 Not sure	If yes, age at first occurrence
G6. Angina pectoris (chest pains due to lack of oxygen to the heart requiring medication such as nitroglycerin)? <i>angina</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_angina</i>
G7. Pericarditis or fluid around the heart? <i>percis</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_percis</i>
G8. Pericardial constriction (scarring or tightness of the sac around the heart)? <i>percon</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_percon</i>
G9. Stiff or leaking heart valves? <i>sivalv</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_sivalv</i>
G10. Blood clot in head, lung, arm, leg, or pelvis? <i>bclot</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_bclot</i>
G11. Does exercise cause severe chest pain, shortness of breath, or irregular heart beat? <i>exerpn</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_exerpn</i>
G12. High cholesterol (or triglyceride) requiring prescription medication? <i>trigdr1</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_trigdr1</i>
<p><b>If yes, do you currently take medication for this?</b>            2 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes <i>trigdr2</i></p>					
G13. Any other heart or circulatory problems? <i>othhrt</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_othhrt</i>

**If yes, describe the other problem(s). List the age at first occurrence for each problem separately.**

*dothhrt1-5*  
*aothhrt1-5* coded

G14. Has anyone in your immediate family (biological mother, father, brothers, sisters) had a heart attack before the age of 55? *fmi55*

2  No 1  Yes 3  Unsure

## RESPIRATORY SYSTEM

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	1 Yes, and the condition is still present	2 No	3 Yes, but the condition is no longer present	4 Not sure	If yes, age at first occurrence
H1. Asthma? <i>asthma</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_asthma</i>
H2. Chronic cough or shortness of breath for more than one month? <i>ccough</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_ccough</i>
H3. Have you had a need for extra oxygen? <i>evoxy</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_evoxy</i>
H4. Pneumonia, 3 or more times in the past 2 years? <i>pneum3</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_pneum3</i>
H5. Emphysema or other chronic obstructive pulmonary disease (COPD) <i>emphma</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_emphma</i>
H6. Lung fibrosis or "scarring" of the lung? <i>lngfib</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_lngfib</i>
H7. Problems with breathing while at rest that lasted for more than 3 months? <i>brhprb</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_brhprb</i>
H8. Any other breathing or lung problems? <i>othres</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <i>a_othres</i>

**If yes, describe the other problem(s). List the age at first occurrence for each problem separately.**

*dothres1-3* coded  
*aothres1-3*

*Continue on next page.*

It is very important that you mark an answer for each of the following questions, even if you have never had that condition.

## DIGESTIVE SYSTEM

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	3 Yes, but the condition is no longer present	1 Yes, and the condition is still present	2 No	4 Not sure	If yes, age at first occurrence
11. Hepatitis? . . . . . <b>hepats</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
<b>If yes, what type(s)? (Mark all that apply)</b>					
<input type="checkbox"/> Hepatitis A <b>hepatyp_a</b>					<b>hepatyp</b> <input type="text"/>
<input type="checkbox"/> Hepatitis B <b>hepatyp_b</b>					<input type="text"/>
<input type="checkbox"/> Hepatitis C <b>hepatyp_c</b>					<input type="text"/>
<input type="checkbox"/> Don't know <b>hepatyp_dk</b>					<input type="text"/>
<input type="checkbox"/> Other <b>hepatyp_ot</b>					<input type="text"/>
12. Cirrhosis of the liver? . . . <b>cirliv</b> . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
13. Any other liver trouble?. <b>othliv</b> . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>

**If yes, describe the liver problem(s). List the age at first occurrence for each problem separately.**

**dothliv1-4** coded  
**aothliv1-4**

14. Intestinal (colon) polyps? <b>polyps</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
15. Fatty liver? . . . . . <b>faliv</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
16. Esophageal strictures (narrowing of the esophagus)? . . . . . <b>esophs</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
17. Rectal or anal fistula? . . . <b>recfis</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
18. Rectal or anal stricture (narrowing or scarring)? <b>recstr</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
19. Stricture (narrowing or scarring) of the small or large intestine? . . . . . <b>intestr</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
110. Any other stomach or digestive trouble? . . . . . <b>othdig</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>

**If yes, describe the other problem(s). List the age at first occurrence for each problem separately.**

**dothdig1-6** coded  
**aothdig1-6**

## SURGICAL PROCEDURES

Please indicate if you have ever had any of the following surgical procedures done.

	3 Not sure	1 Yes	2 No	If yes, age at first occurrence
J1. Amputation of an arm, leg, hand, foot? . . . . . <b>amputn</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>

**If yes, specify (example: left hand, right foot). List the age for each amputation separately.**

**damputn1-3** coded  
**aamputn1-3**

J2. Scoliosis surgery (insertion of rods or other methods to straighten the spine)? . . . <b>sclsis</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
J3. Other surgery of spinal cord or spine? . . . . . <b>othspn</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>

**If yes, specify all surgeries of the spinal cord or spine. List the age at which each surgery occurred.**

**dothspn1-5** coded  
**aothspn1-5**

J4. Leg lengthening or shortening procedures? . . . <b>lensht</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
J5. Joint replacement? . . . . . <b>jntrep</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>

**If yes, specify all joint replacements. List the age at which each joint replacement occurred.**

**djntrep1-5** coded  
**ajntrep1-5**

J6. Other bone surgery? . . . . . <b>othbon</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
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**If yes, specify all other bone surgeries. List the age at which each bone surgery occurred.**

**dothbon1-4** coded  
**aothbon1-4**

J7. Coronary artery bypass surgery? . . . . . <b>bypass</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years <input type="text"/>
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Please! Do not mark below this line

It is very important that you mark an answer for each of the following questions, even if you have never had that procedure.

Please indicate if you have ever had any of the following surgical procedures done.

	3 Not sure	1 Yes	2 No	If yes, age at first occurrence
				years
J8. Pericardiectomy (stripping of the sac around the heart)? <i>prcdmy</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_prcdmy
J9. Heart catheterization ("heart cath")? <i>htcath</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_htcath
J10. Angioplasty (enlarging a heart vessel using a balloon) or stent placement to keep vessel open? <i>angpty</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_angpty
J11. Surgery for heart valve replacement? <i>valverp</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_valverp
J12. Surgery for pacemaker? <i>pacem</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_pacem
J13. Other heart surgery? <i>othht</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_othht

If yes, specify all other heart surgeries. List the age at which each heart surgery occurred.

*dothht1-3* coded  
*aothht1-3*

	3 Not sure	1 Yes	2 No	If yes, age at first occurrence
				years
J14. Surgery to repair a fistula (an abnormal connection between the intestine or rectum and other structures)? <i>fistul</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_fistul
J15. Surgery for intestinal obstruction (blocked intestines)? <i>intobs</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_intobs
J16. Colostomy or ileostomy (stool going into a bag)? <i>colsty</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_colsty
J17. Removal of part or all of the colon <i>colsty_col</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_colon
J18. Removal of part or all of the rectum <i>colsty_rec</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_rectum
J19. Biopsy or removal of lump in thyroid gland? <i>biothy</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_biothy
J20. Removal of part or all of the thyroid gland? <i>remthy</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_remthy
J21. Removal of the spleen? <i>remspl</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_remspl
J22. Bladder, ureter, or kidney surgery? <i>bladsur</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_bladsur
J23. Removal of all or part of a kidney? <i>remkidn</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_remkidn
J24. Liver or gall bladder surgery? <i>livsur</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_livsur
J25. Ventriculoperitoneal (VP) shunt (tube from the brain to the abdomen under the skin) that removes excess spinal fluid? <i>vpshunt</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_vpshunt
J26. Breast biopsy? <i>brstbio</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_brstbio
J27. Breast-conserving or breast-sparing surgery (lumpectomy)? <i>lumpsur</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_lumpsur
J28. Mastectomy or removal of a breast? <i>mastec</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a_mastec

*brstspe*

If yes, was one or both breasts removed?

1  Left Only 2  Right Only 3  Both

Please! Do not mark below this line



It is very important that you mark an answer for each of the following questions, even if you have never had that procedure.

Please indicate if you have ever had any of the following surgical procedures done.

3 Not sure	1 Yes	2 No	If yes, age at first occurrence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	years
			a_lungsur

J29. Any lung surgery? . . . . . lungsur

If yes, specify all other lung surgeries. List the age at which each lung surgery occurred.

dlngsur1-4 coded  
alngsur1-4

- J30. Periodontal (gum) surgery? . . . . . gumsur 

a_gumsur
----------
- J31. Heart transplant? . . . . . hrtrtn 

a_hrtrtn
----------
- J32. Lung transplant? . . . . . lngtrn 

a_lngtrn
----------
- J33. Kidney transplant? . . . . . kidtrn 

a_kidtrn
----------
- J34. Liver transplant? . . . . . trasliv 

a_trasliv
-----------
- J35. Bone marrow transplant? . . . . . bmrtrn 

a_bmrtrn
----------
- J36. Other organ transplant? . . . . . othtrn 

a_othtrn
----------

If yes, specify all other organ transplants. List the age for each individual transplant.

dothtrn1-3 coded  
aothtrn1-3

- J37. Cataract surgery? . . . . . catsrg 

--	--	--
- J38. Removal of one ovary? reoneov 

--	--	--
- J39. Removal of both ovaries? . . . . . retwoov 

--	--	--
- J40. Removal of uterus? . . . . . reutrs 

--	--	--
- J41. Surgery of the vagina? vagsrg 

--	--	--
- J42. Removal of one testis? reonete 

--	--	--
- J43. Removal of both testes? retwote 

--	--	--
- J44. Removal of part or all of the prostate gland (prostatectomy) 

--	--	--
- J45. Any other surgery? . . . . . othsg 

--	--	--

Males → Go to Question J42.

Females → Go to Question J45.

If yes, age at first occurrence
years
a_catsrg

a_reoneov
a_retwoov
a_reutrs
a_vagsrg

a_reonete
a_retwote
a_repros
a_othsg

If yes, specify all other surgeries. List the age at which each other surgery occurred.

dothsg1-24 coded  
aothsh1-24

Continue on next page.

# BRAIN AND NERVOUS SYSTEM

Have you ever been told by a doctor or other health care professional that you have, or have had. . .

	<b>4 Not sure</b>								
	<b>3 Yes, but the condition is no longer present</b>								
	<b>1 Yes, and the condition is still present</b>								
		<b>2 No</b>							

K1. Problems with learning or memory? . . . . . **prbmem**

If yes, age at first occurrence  
years  
   
**a\_prbmem**

**If yes and still present**, please rate the severity of these problems:

**1**  **Mild**; does not interfere with my work, school, or general life. I did not need special help in school.

**2**  **Moderate**; interferes with my work, school, or general life, but I am capable of independent living. I used special help in school.

**3**  **Severe**; I am significantly impaired in my school or work performance or in my general life.

**4**  **Disabling**; I am unable to perform daily activities such as taking care of myself; I require full-time help or I am living in an institution for people with disabling conditions.

K2. Epilepsy, repeated seizures, convulsions, or blackouts? . . .

**a\_eplpsy**

**If yes, describe this problem(s). List the age at first occurrence for each problem separately.**

**deplpsy1-6**      **coded**  
**aeplpsy1-6**

**If yes, are you currently taking medication for this?**

**2**  No **1**  Yes **eplpsy2**

**If yes, name of medications**

**meplpsy1-6**      **coded**

Date of last seizure

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
M	M		D	D		Y	Y	Y	Y

**seizdt**

	<b>4 Not sure</b>								
	<b>3 Yes, but the condition is no longer present</b>								
	<b>1 Yes, and the condition is still present</b>								
		<b>2 No</b>							

K3. Migraine? . . . . . **migrne**

K4. Other severe headaches? . . .

K5. Other repeated headaches? . .

If yes, age at first occurrence  
years  
   
**a\_migrne**  
**a\_hdache**  
**a\_rhache**

**If yes, list medications required to control migraine or other severe headaches.**

**mhdache1-8**      **coded**  
**ahdache1-8**

K6. Problems with balance, equilibrium, or ability to reach for or manipulate objects? . . .

**a\_balnce**

**If yes and still present**, please rate the severity of these problems:

**1**  **Mild**; does not affect walking or my daily routine.

**2**  **Moderate**; it is bothersome and affects my walking but I am able to do my daily routine.

**3**  **Severe**; this problem significantly affects my walking and my daily routine.

**4**  **Disabling**; I require a wheelchair or cannot walk because of this problem.

K7. Tremors or problems with movements? . . . . . **tremor**

K8. Problems chewing or swallowing solids or liquids? . .

K9. Decreased sense of touch or feeling in hands, fingers, arms or legs? . . . . . **touch**

K10. Prolonged pain in arms or legs. . . . . **armlegpn**

K11. Prolonged pain in back. . . . . **backpn**

K12. Abnormal sensation in arms, legs or back? . . . . . **absens**

K13. Weakness or inability to move arm(s)? . . . . . **movarm**

Please! Do not mark below this line

Just a reminder - it is very important that you mark an answer for each of the following questions, even if you have never had that condition.

Have you **ever** been told by a doctor or other health care professional that you have, or have had. . .

	4	Not sure					
3	Yes, but the condition is no longer present						
1	Yes, and the condition is still present						
		2	No				

If yes, age at first occurrence

years

K14. Weakness or inability to move leg(s)? . . . . . **movleg**     a\_ **movleg**

K15. Paralysis of any kind? . . . . . **parlys**     a\_ **parlys**

**If yes, describe the paralysis. List the age at first occurrence for each episode of paralysis separately.**

**dparlys1-5** coded

**aparlys1-5**

K16. Stroke? . . . . . **srk1**

**If no → Go to K18.**

a\_ **srk1**

**If yes, as a result of the stroke . . .**

a. Did the symptoms last more than 24 hours?  
 2  No 1  Yes **srkday**

**Did the stroke affect:**

b. Speech. . . . . **srkspch**

c. Balance and coordination.      
 Only one side of the body . **srkbal**      
 Both sides of the body . . . **srkbal1**      
**srkbal2**

d. Did you lose consciousness?  
 2  No 1  Yes **srkcons**

e. Did you experience sensory loss (vision, taste, smell)?      
 Only one side of the body **strsens**      
 Both sides of the body . . . **srksens1**      
**srksens2**

f. Did you have weakness or inability to move arm(s)? .      
 Only one side of the body **srkmar**      
 Both sides of the body . . . **srkmar1**      
**srkmar2**

g. Did you have weakness or inability to move leg(s)? .      
 Only one side of the body **srkmlg**      
 Both sides of the body . . . **srkmlg1**      
**srkmlg2**

	4	Not sure					
3	Yes, but the condition is no longer present						
1	Yes, and the condition is still present						
		2	No				

h. Did you have paralysis of any kind? . . . . . **srkpar**

Only one side of the body .

Both sides of the body . . . **srkpar1**      
**srkpar2**

**If yes, describe the paralysis. List the age at first occurrence for each episode of paralysis separately.**

**dsrkpar1-7** coded

**asrkpar1-7**

K17. In your lifetime, how many strokes have you had? . . . . . **srknum**

If yes, age at first occurrence

years

K18. Any other brain or nervous system problems? **othbns**     a\_ **othbns**

**If yes, describe the other problem(s). List the age at first occurrence for each problem separately.**

**dbnspro1-7** coded

**abnspro1-7**

K19. Do you have any driving restrictions because of brain or nervous system problems (such as seizures)? **drrestr**

2  No

1  Yes, but I am able to drive

4  Yes, I am unable to drive

3  Unsure

K20. Do you have any work restrictions because of brain or nervous system problems (such as seizures)? **wkrestr**

2  No

1  Yes, but I am able to work

4  Yes, I am unable to work

3  Unsure

Please! Do not mark below this line

# CANCER, LEUKEMIA, OR TUMORS

L1. At any time were you diagnosed with cancer, leukemia, tumor, or similar illness? **cancer1c**

2  No **→ Go to Question M1, page 22.**

1  Yes **↓**

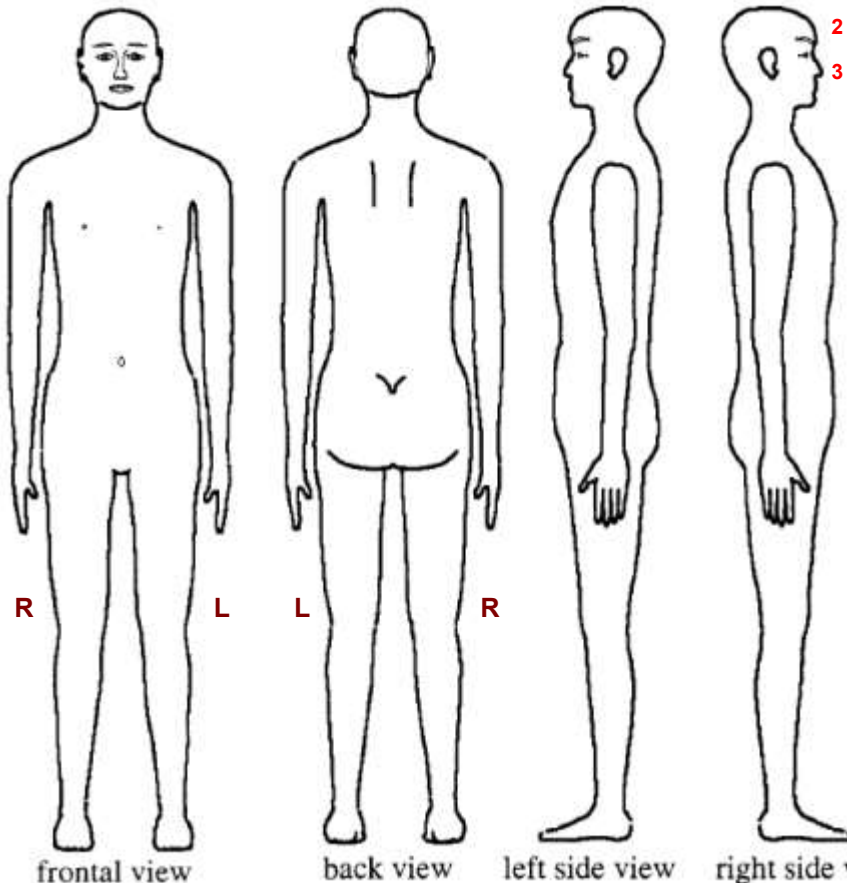
L2. What was the name of this disease? If more than one, write the first one.

**cond1c** text

L3. Where was it located? (Example: right upper arm, left ear)

**loc1c\_1-9** text

If the condition in item L2 above was a skin cancer or solid tumor (not a leukemia), please mark an "X" at the location(s) of your cancer(s). We are interested in the most exact location(s) you can provide so please be as specific as possible.



L4. Did you have treatment for this disease? **txcond1c**

2  No **→ Skip L4a and go to Question L5.**

1  Yes **→ L4a. What treatments did you receive? (Mark all that apply) tx1c**

- Chemotherapy **tx1c\_chemo**
- Radiation therapy **tx1c\_rt**
- Surgery **tx1c\_surg**

L5. Where was this diagnosed?

L6. Was this a: **recuon1c**

- 2  Cancer, leukemia, tumor, or similar illness
- 3  Don't know

Date of Diagnosis:

--	--	--	--	--	--

Month (mm)  
**mocon1c**

Year (yyyy)  
**yrcon1c**

Please use this space to provide any additional details on tumor location.

**locdet1c**  
text

Please! Do not mark below this line

L7. Have you had any additional cancers, leukemias, tumors, or similar illnesses? (Include any relapse of your original diagnosis).

- 2  No **→ Go to Question M1, next page.** cancer2c  
 1  Yes **↓**

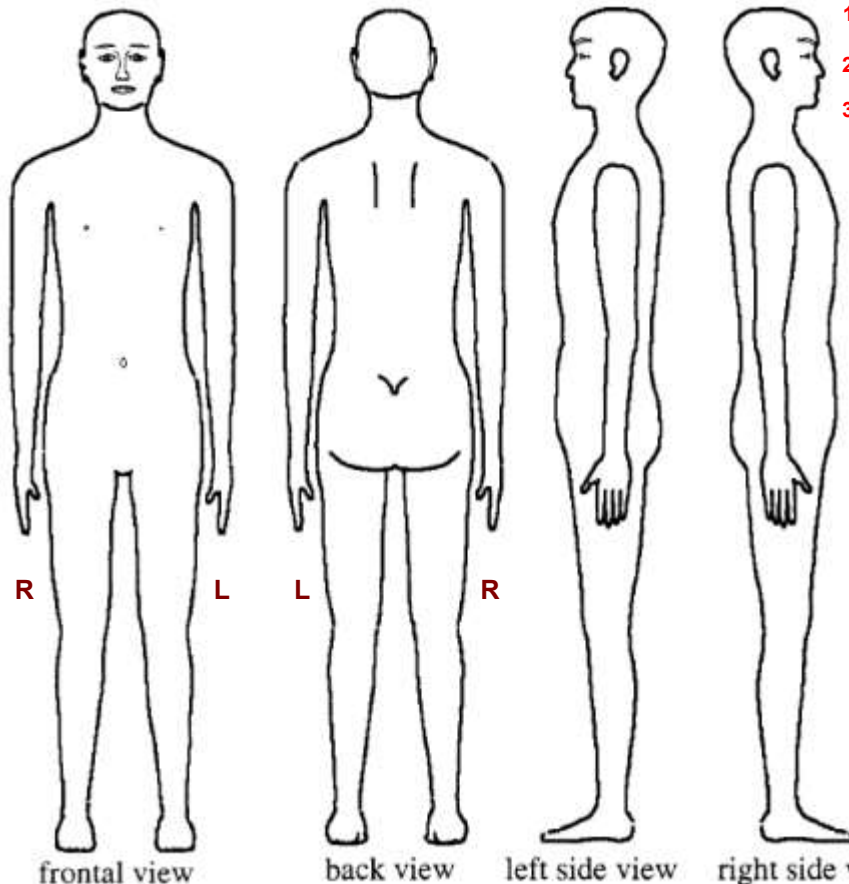
L8. What was the name of this disease?

cond2c text

L9. Where was it located? (Example: right upper arm, left ear)

loc2c\_1-4 text

If the condition in item L8 above was a skin cancer or solid tumor (not a leukemia), please mark an "X" at the location(s) of your cancer(s). We are interested in the most exact location(s) you can provide so please be as specific as possible.



L10. Did you have treatment for this disease? txcond2c

- 2  No **→ Skip L10a and go to Question L11.**

1  Yes **L10a. What treatments did you receive? (Mark all that apply) tx2c**

- Chemotherapy tx2c\_chemo  
 Radiation therapy tx2c\_rt  
 Surgery tx2c\_surg

L11. Where was this diagnosed?

Four empty rectangular boxes for text input.

L12. Was this a: recucon2c

- 1  Recurrence of original diagnosis  
 2  New cancer, leukemia, tumor, or similar illness  
 3  Don't know

Date of Recurrence or New Diagnosis:

Month (mm)      Year (yyyy)

mocon2c      yrcon2c

Please use this space to provide any additional details on tumor location.

locdet2c text

**Please use a separate sheet of paper for additional cancers**

Please! Do not mark below this line

## OFFSPRING/PREGNANCY HISTORY

M1. Have you ever been sexually active (had sexual intercourse)? **evsexac**

2  No → Go to Question N1, page 24.

1  Yes ↓

M2. Are you currently sexually active? **nowsexac**

2  No

1  Yes

M3. Have you or your partner had:

(Mark all that apply) **vasctub**

A vasectomy → At what age?

**vasctub\_vasc**

**a\_vasctmy**

--	--

A tubal ligation → At what age?

**vasctub\_tub**

--	--

**a\_tublign**

M4. Was there ever a period in your life when you and a partner tried for one year or more to become pregnant, without success? **trypreg**

2  No

1  Yes

M5. Have you and a partner ever become pregnant?

2  No → Go to Question N1, page 24. **everpreg**

1  Yes

M6. Including live births, stillbirths, miscarriages, and abortions, how many times have you become pregnant or had a woman become pregnant by you? **n\_preg**

--	--

 times

Continue on next page.

**Female**

M7. Have you ever had any pregnancies? **pregyn\_f**

- 2  No → Go to Question N1.  
 1  Yes ↓

M8. Are you currently pregnant? **pregnow\_f**

- 2  No  
 1  Yes

Continue to Question M11 below.

**Male**

M9. Has a woman ever been pregnant by you? **pregyn\_m**

- 2  No → Go to Question N1.  
 1  Yes ↓

M10. Is she currently pregnant? **pregnow\_m**

- 2  No  
 1  Yes

Continue to Question M11 below.

M11. Please fill in the following information for each of your pregnancies, or each time a woman has become pregnant by you, regardless of the outcome.

Pregnancy outcome

	5 Currently pregnant							
	4 Medical abortion							
	3 Miscarriage							
	2 Stillbirth							
	1 Live birth							
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Your age at start of pregnancy	Partner's age at start of pregnancy	Weeks pregnancy lasted
Pregnancy 1. .... <b>pregout1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="a_preg1"/>	<input type="text" value="a_ppreg1"/>	<input type="text" value="wkspreg1"/>
Pregnancy 2. .... <b>pregout2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="a_preg2"/>	<input type="text" value="a_ppreg2"/>	<input type="text" value="wkspreg2"/>
Pregnancy 3. .... <b>pregout3</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="a_preg3"/>	<input type="text" value="a_ppreg3"/>	<input type="text" value="wkspreg3"/>
Pregnancy 4. .... <b>pregout4</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="a_preg4"/>	<input type="text" value="a_ppreg4"/>	<input type="text" value="wkspreg4"/>
Pregnancy 5. .... <b>pregout5</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="a_preg5"/>	<input type="text" value="a_ppreg5"/>	<input type="text" value="wkspreg5"/>
Pregnancy 6. .... <b>pregout6</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="a_preg6"/>	<input type="text" value="a_ppreg6"/>	<input type="text" value="wkspreg6"/>
Pregnancy 7. .... <b>pregout7</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="a_preg7"/>	<input type="text" value="a_ppreg7"/>	<input type="text" value="wkspreg7"/>
Pregnancy 8. .... <b>pregout8-10</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="a_preg8-10"/>	<input type="text" value="a_ppreg8-10"/>	<input type="text" value="wkspreg8-10"/>

Please attach a separate sheet of paper, if more than 8 pregnancies

Please! Do not mark below this line

# HEALTH BEHAVIORS

## Alternative Medicine

N1. In this section, we would like to know about any alternative therapy or complementary healing techniques that you have used during the last year. (Mark all that apply)

		2 No	1 Yes	3 Not sure
a. Acupuncture . . . . .	amaccp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Biofeedback . . . . .	ambio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Chiropractor . . . . .	amchir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Crystals/magnets . . . . .	ammag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Nutritional supplements (such as Omega-3 fatty acids) . . . . .	amnusp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Herbal remedies (such as St. John's Wort, Echinacea) . . . . .	amhebr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Homeopathic remedies . . . . .	amhopa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Hypnosis/guided imagery . . . . .	amhyp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Massage/body work . . . . .	ammas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Meditation/relaxation . . . . .	amrelx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Modified diet (gluten-free, vegan) . . . . .	ammodi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Naturopathic treatments . . . . .	amnatu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Spiritual healing/prayer . . . . .	amspir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Therapeutic touch . . . . .	amther	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Vitamins/minerals (not regular multi-vitamin, but high dose C, zinc, etc.) . . . . .	amvit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Yoga/Tai Chi/Qi Gong/special exercise . . . . .	amyoga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Other . . . . .	amoth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If Other, please specify.*

damoth1-4

text

N2. Some people get a general physical examination from a doctor once in a while even though they are feeling well and have not been sick. When was the last time you had a general physical examination when you were not sick? wellexam

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

N3. When was the last time you had an echocardiogram (ultrasound of the heart to look at the heart muscle and heart valves)? echoexam

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

N4. When was the last time you had a test to measure your bone strength or bone mineral density (such as a DEXA, quantitative CT scan, or ultrasound)? dexaexam

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

Please! Do not mark below this line



**N5. How long has it been since you last went to a dentist?** *dentexam*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

**N6. When was the last time you had an MRI of your heart (you were placed inside a scanner, like a long tube)?**

*heartmri*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

**N7. When was the last time you had an MRI of your head or brain?** *headmri*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

**N8. When was the last time you had an ultrasound of the thyroid gland?** *thyus*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

**N9. When was the last time you had an ultrasound of the carotid arteries (blood vessels in the neck)?**

*carotidus*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

**N10. When was the last time you had a skin exam for cancer by a healthcare provider?** *skinexam*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

**N11. When was the last time you had a home blood stool test to determine whether your stool contains blood?** *stooltest*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

**N12. When was the last time you had a sigmoidoscopy or colonoscopy to view the colon for signs of cancer or other problems?** *colonexam*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

Please! Do not mark below this line

**N13.** During the past 12 months, have you had either a flu shot or a flu vaccine that was sprayed in your nose? **fluvac**

- 1  Yes 2  No 3  Don't Know

**N14.** A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot? **pneumovac**

- 1  Yes 2  No 3  Don't Know

**N15a.** Have you ever had zoster (shingles)? **shingles\_yn**

2  No **→ Go to Question N16.**

1  Yes ↓

If yes, indicate number of times and date(s) of occurrence(s).

Times	Month	Year	<b>shingmo3-6</b> <b>shingyr3-6</b>
<input type="text"/>	<b>shingmo1</b>	<b>shingyr1</b>	
<b>shingno</b>	<b>shingmo2</b>	<b>shingyr2</b>	

**Please use a separate sheet of paper for additional dates.**

**N15b.** Do you currently take chronic (for more than 1 month) medications because of shingles?

- 2  No 1  Yes **shmednow**

**N16.** Have you ever been hospitalized for infection?

2  No 1  Yes ↓ **infecthosp**

Note date(s) and sites(s) of infection:

Date of infection	Site of infection (lung, blood, sinus, brain, etc.)
<b>infdte1-8</b>	<b>infeste1-8</b>
	<b>text</b>

**Please use a separate sheet of paper for additional dates and sites.**

**Males → Go to Question N27 next page.**

**N17. FEMALES** - How often do you perform monthly breast self-examinations? **breastex**

- 1  Regularly (once a month)  
2  Occasionally  
3  Rarely or never

**N18. FEMALES** - Have you ever required surgical treatment for an abnormal Pap smear (cone biopsy, laser surgery, loop electrosurgical excision (LEEP), removal of cervix, etc.)? **abpapsmr**

- 2  No 1  Yes

**N19. FEMALES** - When was the last time you had a breast examination by a doctor or a health care professional? **lstbrex**

- 1  Never  
2  Less than 1 year ago  
3  1-2 years ago  
4  More than 2 years ago but less than 5 years ago  
5  5 or more years ago  
6  I don't know if I ever had one  
7  I had one, but I don't recall when

**N20. FEMALES** - Have you ever had a mammogram?

1  Yes 2  No **→ Go to Question N21.**

↓ **mamgrm**

**N20a.** How old were you when you had your first mammogram? . . . . **a\_mamo**

**N20b.** When was the last time you had a mammogram? **lstmamgrm**

- 1  Never  
2  Less than 1 year ago  
3  1-2 years ago  
4  More than 2 years ago but less than 5 years ago  
5  5 or more years ago  
6  I don't know if I ever had one  
7  I had one, but I don't recall when

**N21. FEMALES** - When was the last time you had a breast ultrasound? **breastus**

- 1  Never  
2  Less than 1 year ago  
3  1-2 years ago  
4  More than 2 years ago but less than 5 years ago  
5  5 or more years ago  
6  I don't know if I ever had one  
7  I had one, but I don't recall when

Please! Do not mark below this line

**N22. FEMALES** - When was the last time you had a breast MRI? *breastmri*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

**N23. FEMALES** - There are two different kinds of tests to check for cervical cancer. One is a Pap smear or Pap test and the other is the HPV or human papillomavirus test. Have you ever had a test to check for cervical cancer? *cervicaltest\_yn*

- 1  Yes → Go to Question N24.
- 2  No → Go to Question N27.
- 3  Refused → Go to Question N27.
- 4  Don't know → Go to Question N27.

**N24. FEMALES** - When did you have your most recent test to check for cervical cancer? *cervicaltest\_recent*

- 1  Within the past year (anytime less than 12 months ago)
- 2  Within the past 2 years (1 year but less than 2 years ago)
- 3  Within the past 3 years (2 years but less than 3 years ago)
- 4  Within the past 5 years (3 years but less than 5 years ago)
- 5  Within the past 10 years (5 years but less than 10 year ago)
- 6  10 years ago or more
- 7  Refused
- 8  Don't know

**N25. FEMALES** - At your most recent cervical cancer screening, did you have a Pap test? *paptest*

- 1  Yes
- 2  No
- 3  Refused
- 4  Don't know

**N26. FEMALES** - At your most recent cervical cancer screening, did you have an HPV test? *hpvtest*

- 1  Yes
- 2  No
- 3  Refused
- 4  Don't know

**N27. MALES AND FEMALES-**

HPV is the Human Papillomavirus. The HPV vaccine is a series of 2 or 3 shots, depending on what age the shots are started. Have you ever received the HPV shot or vaccine? *hpvvacfm*

- 1  Yes
- 2  No → Go to Question N30.
- 3  Don't Know → Go to Question N30.

**N28.** How old were you when you received the first dose of the HPV vaccine .....

--	--

*a\_hpvvacfm*

**N29.** How many shots of the HPV vaccine did you receive? *nhpvvacfm*

- 1  1 shot
- 2  2 shots
- 3  3 shots
- 4  Don't Know

**N30.** How likely is it that you will receive the HPV vaccine in the next 12 months?

- 1  Very likely *vaccine\_12mons*
- 2  Somewhat likely
- 3  Not too likely
- 4  Not likely at all
- 5  Refused
- 6  Don't know

**N31. MALES** - When was the last time you had a PSA or blood test to detect prostate cancer? *psatest*

- 1  Never
- 2  Less than 1 year ago
- 3  1-2 years ago
- 4  More than 2 years ago but less than 5 years ago
- 5  5 or more years ago
- 6  I don't know if I ever had one
- 7  I had one, but I don't recall when

Please! Do not mark below this line

# HOSPITALIZATIONS

We are interested in any admissions to the hospital for illness, surgical, or diagnostic procedures, including psychiatric/mental health hospitalization or short stays of 24 hours or less that you may have had in the last 12 months. **DO NOT INCLUDE PREGNANCY RELATED ADMISSIONS or EMERGENCY ROOM VISITS.**

O1. Have you been admitted to a hospital in the last 12 months? **hospadm**

- 2  No → Go to Section P, next page.  
 1  Yes

O2. How many times have you been admitted to a hospital in the last 12 months? **hosadmn**

--	--

O3. What was the reason for the first hospitalization?

ha1reason1-5

coded

O3a. What procedures/surgeries were performed?

ha1proced1-5

coded

O3b. Where were you hospitalized?

Hospital
Address
City, State, Zip code
Doctor's name

O3c. Date of first hospitalization:

Month (mm)		Year (yyyy)			
ha1mo		ha1yr			

O3d. How many days were you hospitalized?

Days		
ha1days		

O4. What was the reason for the second hospitalization?

ha2reason1-4

coded

O4a. What procedures/surgeries were performed?

ha2proced1-6

coded

O4b. Where were you hospitalized?

Hospital
Address
City, State, Zip code
Doctor's name

O4c. Date of second hospitalization:

Month (mm)		Year (yyyy)			
ha2mo		ha2yr			

O4d. How many days were you hospitalized?

Days		
ha2days		

**Please use a separate sheet of paper for additional hospitalizations**

ha3reason1-4      ha3mo  
 ha3proced1-4      ha3yr

Please! Do not mark below this line

# GENETIC CONDITIONS

Please mark the appropriate box (either "No", "Yes", or "Not sure") for each of the listed conditions. Indicate "Yes" only if a physician has told you that you were born with, or have the condition.

Because we need definite responses, and questions left blank are difficult to interpret, it is very important that you mark an answer for each of the following questions, even if you have never had that condition. If you have never heard of these conditions, it is unlikely that you have had them.

## P1a. Have you ever been told by a doctor that you have. . .

	2 No	1 Yes	3 Not sure
a. Ataxia telangiectasia. . . . . <b>gcataxtg</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Beckwith-Wiedemann syndrome. . . . . <b>gcbwsynd</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Bilateral acoustic neurofibromatosis (Neurofibromatosis Type 2). . . . . <b>gcnf2</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Bloom's syndrome . . . . . <b>gcbloom</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Down syndrome . . . . . <b>gcdown</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Klinefelter's syndrome. . . . . <b>gckline</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Fanconi's anemia. . . . . <b>gcfanemia</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Multiple exostoses . . . . . <b>gcmexos</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Familial adenomatous polyposis (FAP or Gardner syndrome). . . . . <b>gcfap</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Neurofibromatosis (Type 1). . . . . <b>gcnf1</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Nevoid basal cell carcinoma syndrome. . . . . <b>gcnvbcc</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Turner's syndrome. . . . . <b>gcturner</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Von Hippel-Lindau syndrome. <b>gcvhl</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Wiskott-Aldrich syndrome. . . . . <b>gcwasynd</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Xeroderma pigmentosum. . . . . <b>gcpigment</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Polycystic kidney disease. . . . . <b>gcpkd</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. WAGR syndrome. . . . . <b>gcwagr</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Li-Fraumeni syndrome (p53 gene abnormality). . . . . <b>gcp53</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Any other genetic disorder . . . . . <b>gcoth</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe this disorder.

**dgcoth1-3**  
coded

## P1b. Has anyone in your immediate family (blood relatives only) or your spouse ever had any of the conditions in question P1a? (*Mark all that apply*)

gc	What conditions?
<input type="checkbox"/> Mother <b>gc_mom</b>	<b>dgcmom1-4</b> coded
<input type="checkbox"/> Father <b>gc_dad</b>	<b>dgcdad1-4</b> coded
<input type="checkbox"/> Full brother <b>gc_bro</b>	<b>dgcbro1-4</b> coded
<input type="checkbox"/> Full sister <b>gc_sis</b>	<b>dgcsis1-4</b> coded
<input type="checkbox"/> Son <b>gc_son</b>	<b>dgkson1-4</b> coded
<input type="checkbox"/> Daughter <b>gc_dau</b>	<b>dgcdau1-4</b> coded
<input type="checkbox"/> Spouse <b>gc_spo</b>	<b>dgcspo1-4</b> coded

## CONDITIONS PRESENT AT BIRTH

Because we need definite responses, and questions left blank are difficult to interpret, it is very important that you mark an answer for each of the following questions, even if you have never had that condition. If you have never heard of these conditions, it is unlikely that you have had them.

## P2. Have you ever had genetic counseling for cancer risk? **grcounsel**

- 2  No
- 1  Yes

*Continue on next page.*

Please! Do not mark below this line

**P3a. To the best of your knowledge, were you born with. . .**

	2	1	3
	No	Yes	Not sure
a. Cleft lip or palate. . . . . <b>bdclleft</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Club foot . . . . . <b>bdclub</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Large or multiple birthmarks (any 1 larger than a quarter, or 6 larger than a dime) . . . . . <b>bdmarks</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Deafness or impaired hearing at birth . . . . . <b>bdhear</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Blindness or difficulty seeing at birth . . . . . <b>bdsee</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Eyes different colors or missing an iris (the colored part of the eye) . . . . . <b>bdeye</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Hydrocephalus (excessive water around or within the brain) . . . . . <b>bdhydro</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Spina bifida or other neural tube defect . . . . . <b>bdnt</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Unusually small head (microcephaly) . . . . . <b>bdhead</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Unequal sized limbs (hemihypertrophy) . . . . . <b>bdlimbs</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Extra fingers, deformed chest, shortened limbs or any other skeletal abnormality . . . . . <b>bdskel</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Hole in the heart or other congenital heart defect . . . . . <b>bdheart</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If other defect, please specify.*

**dbdhrt1-5**  
coded

m. Any congenital abnormality of the pancreas, liver, or digestive tract (stomach, intestines). . . . . <b>bddigest</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Any kidney, bladder, or genital abnormalities. . . . . <b>bdurin</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Undescended testes. . . . . <b>bdtestes</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Any other birth defects . . . . . <b>bdoth</b> . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*If other, please specify.*

**dbdoth1-4**  
coded

**P3b. Has anyone in your immediate family (blood relatives only) or your spouse ever had any of the conditions in Question P3a? (Mark all that apply)**

**bd**

**What conditions?**

<input type="checkbox"/> Mother <b>bd_mom</b>	→	<b>dbdmom1-4</b> coded
<input type="checkbox"/> Father <b>bd_dad</b>	→	<b>dbddad1-4</b> coded
<input type="checkbox"/> Full brother <b>bd_bro</b>	→	<b>dbdbro1-4</b> coded
<input type="checkbox"/> Full sister <b>bd_sis</b>	→	<b>dbdsis1-4</b> coded
<input type="checkbox"/> Son <b>bd_son</b>	→	<b>dbdson1-4</b> coded
<input type="checkbox"/> Daughter <b>bd_dau</b>	→	<b>dbddau1-6</b> coded
<input type="checkbox"/> Spouse <b>bd_spo</b>	→	<b>dbdspo1-4</b> coded

**P4. Has anyone in your immediate family (blood relatives only) or your spouse ever had cancer? (Mark all that apply)**

**catypes**

**What types?**

<input type="checkbox"/> Mother <b>catypes_mom</b>	→	<b>dcamom1-4</b> coded
<input type="checkbox"/> Father <b>catypes_dad</b>	→	<b>dcadad1-8</b> coded
<input type="checkbox"/> Full brother <b>catypes_bro</b>	→	<b>dcabro1-4</b> coded
<input type="checkbox"/> Full sister <b>catypes_sis</b>	→	<b>dcasis1-4</b> coded
<input type="checkbox"/> Son <b>catypes_son</b>	→	<b>dcason1-4</b> coded
<input type="checkbox"/> Daughter <b>catypes_dau</b>	→	<b>dcadau1-4</b> coded
<input type="checkbox"/> Spouse <b>catypes_spo</b>	→	<b>dcaspo1-4</b> coded

Please! Do not mark below this line

# CONTACT INFORMATION

1. Do you use a cell phone? **cellyn**

Yes  No **→ Go to question 3.**  
 1                      2

1a. Would you be willing to send/receive study-related texts? **textsyn**

1  Yes  
 2  No  
 3  My phone is not text capable

2. Do you use a "smartphone" that can access the internet or download "apps" (e.g. iPhone, Android, Blackberry, Windows)? **smartyn**

1  Yes  
 2  No

3. Which of the following types of devices do you use to access the internet? **devices** (Mark all that apply)

Computer or laptop **devices\_comp**  
 Tablet (iPad or similar) **devices\_tab**  
 Smartphone **devices\_smrtphn** **text**  
 Other, specify: **devices\_oth** **othdevs\_1-2**  
 I don't access the internet **devices\_noint**

We have your current address and phone as:

**addr**  
**city**  
**state**  
**zipcode**  
**homephone**  
**phonenummer2**

Is this information correct, or are you planning on moving in the next 6 months? **addrstat**

1  Correct 2  Not correct 3  Moving

Do you have an email address we could use to contact you? **emailyn**

2  No 1  Yes

Your Email Address

**email**

Please give us your correct address or location (if different from above):

Address <b>upaddr</b>		
City <b>upcity</b>	State <b>upstate</b>	
Zip Code <b>upzip</b>	Home Phone Number <b>uphomeph</b>	Cell Phone Number <b>upcellph</b>

Please provide the name and address of someone who could give us your new address should you move. We will contact this person only if we are unable to reach you at your home address.

Name <b>cntname</b>	
Address <b>cntaddr</b>	Relationship to you <b>cntrel</b>
City <b>cntcity</b>	State <b>cntst</b>
Zip Code <b>cntzip</b>	Phone Number <b>cntph</b>

Please! Do not mark below this line

For our future planning, what type of information or help do you think should be available to survivors of childhood cancer, leukemia, tumor, or similar illnesses?

comments

text

*Attach additional pages, if necessary.*

**When you have completed this questionnaire please return it to us in the enclosed envelope.**

**Mail to:**

**SJLIFE STUDY**

St. Jude Children's Research Hospital  
Department of Epidemiology  
Mail Stop 735  
262 Danny Thomas Place  
Memphis, TN 38105-3678

**Thank you!**

**Please! Do not mark below this line**