

Australasian Colorectal Cancer Family Study

Baseline Questionnaire

This study is part of the Colon Cancer Cooperative Family Registry and is funded by the National Institutes of Health (USA).

Interviewer Instructions

All questions will have a check box choice (please TICK) or a numerical response. Numeric responses are to be written in the boxes. Text fields are to be filled in using block capitals, taking care to keep the letters within the boxes. Legibility is essential.

Some questions have instructions to obtain medical records as per your site procedures

NIH ID Number

- -

Interview Date

/ /

Proband

Yes
 No

Gender

Male
 Female

Mother's ID Number

- -

Father's ID Number

- -

Spouse's ID Number

- -

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A. BACKGROUND INFORMATION

I would like to begin by asking you some questions about your background.

<p>A1. How old are you?</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>	<p>A4. Are you currently</p> <p><input type="checkbox"/> Married <input type="checkbox"/> Never married</p> <p><input type="checkbox"/> Separated <input type="checkbox"/> Widowed</p> <p><input type="checkbox"/> Divorced <input type="checkbox"/> Living As married</p> <p><input type="checkbox"/> Don't Know</p>
<p>A2. What is your date of birth?</p> <p><input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p>A5. What was the highest level of education that you completed?</p> <p><input type="checkbox"/> Primary school (some or all)</p> <p><input type="checkbox"/> Secondary school - year 7 or year 8</p> <p><input type="checkbox"/> Secondary school - year 9 or year 10</p> <p><input type="checkbox"/> Secondary school - year 11 or year 12</p> <p><input type="checkbox"/> Vocational training</p> <p><input type="checkbox"/> University - did not graduate</p> <p><input type="checkbox"/> University - graduated</p> <p><input type="checkbox"/> Don't Know</p>
<p>A3. Are you a twin or a triplet?</p> <p><input type="checkbox"/> Yes, a twin</p> <p><input type="checkbox"/> Yes, other multiple</p> <p><input type="checkbox"/> No → A4</p> <p><input type="checkbox"/> Don't Know → A4</p> <p>Do you have a genetically identical twin or triplet?</p> <p>Non-identical twins are no more alike than ordinary brothers and sisters. Genetically identical twins, on the other hand, look so much alike (that is, they have such a strong resemblance to each other in stature, colouring, features of the face, etc.) that people often mistake one for the other, especially during their childhood.</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know</p> <p>May we pass your name to the Australian Twin Registry?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	

A6. In which country were you, your parents and your grandparents born?

	YOU	YOUR MOTHER	YOUR MOTHER'S MOTHER	YOUR MOTHER'S FATHER	YOUR FATHER	YOUR FATHER'S MOTHER	YOUR FATHER'S FATHER
Australia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bangladesh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canada	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
China	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Croatia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyprus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
England	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Egypt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Germany	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greece	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hungary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
India	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ireland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Italy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Japan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Netherlands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Northern Ireland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New Zealand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Philippines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Russia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scotland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
South Africa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sri Lanka	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vietnam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown, not Australia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Specify _____

A7. For how many years have you lived in Australia?

years

Don't Know

A8. In which suburb or town do you usually live? _____

Postcode:

Don't Know

A9. What is the ethnic background of you, your parents and your grandparents?

(Mark as many as apply) Ethnicity is how you see yourself; it is a mixture of culture, religion, skin colour, language, the origins of yourself and your family. It is not the same as nationality.

	YOU	YOUR MOTHER	YOUR MOTHER'S MOTHER	YOUR MOTHER'S FATHER	YOUR FATHER	YOUR FATHER'S MOTHER	YOUR FATHER'S FATHER
Caucasian/White	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
African American/Black	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latino	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Japanese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Filipino/Malay/Indonesian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Korean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
South East Asian(except Chinese)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
South Asian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Native American, Inuit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maori	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Micronesian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Australian Aboriginal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Melanesian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caribbean Black	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Central/South American	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black African	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
North African	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Middle Eastern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Specify _____

A10. In which religion were you, your parents and your grandparents born?

Religion and ethnicity sometimes affect disease risk. Scientists have found that some genetic traits are sometimes more or less common among people of different ethnic backgrounds. We would like to know if this is true for genes associated with colorectal cancer.

	YOU	YOUR MOTHER	YOUR MOTHER'S MOTHER	YOUR MOTHER'S FATHER	YOUR FATHER	YOUR FATHER'S MOTHER	YOUR FATHER'S FATHER
Protestant/Anglican	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eastern Orthodox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catholic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muslim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buddhist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hindu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latter Day Saints/Mormon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seventh Day Adventist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sephardic Jewish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ashkenazi Jewish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other or uncertain Jewish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Specify _____

B. MEDICAL HISTORY

B1. Medical Tests

Now I'm going to ask you some questions about medical tests you may have had.

B1a.

Have you ever had a test for blood in your stool, called a faecal occult blood test or FOBT, such as Hemoccult? This is a test using treated cards to detect blood in faeces? It is also called a smear or stool test. FOBT is typically done at home using a kit containing 3 treated cards.

- Yes —————>
- No *go to barium enema*
- Don't Know *go to barium enema*

What were the reasons for your first test?
(Mark all that apply)

- To investigate a new problem
- Family history of colorectal cancer
- Routine physical examination or check up
- Follow up of previous problem
- Follow up of FOBT result
- Other _____

What was your age when you first had this test?

years

- Don't know

How many separate tests have you had?

tests

- Don't know

If more than one test, what was your age when you last had this test?

years

- Don't know

B1d.

Have you ever had a barium enema? A barium enema is an x-ray examination of your colon. X-rays of the colon are taken following a barium enema. Preparation involves fluids, laxatives, and an enema to cleanse the bowel.

- Yes —————>
- No *go to sigmoidoscopy*
- Don't Know *go to sigmoidoscopy*

What were the reasons for your first test?
(Mark all that apply)

- To investigate a new problem
- Family history of colorectal cancer
- Routine physical examination or check up
- Follow up of previous problem
- Follow up of FOBT result
- Other _____

What was your age when you first had this test?

years

- Don't know

How many separate tests have you had?

tests

- Don't know

If more than one test, what was your age when you last had this test?

years

- Don't know

B1b.

Have you ever had a sigmoidoscopy? This is an examination limited to the lower colon and rectum and is usually done in a doctor's rooms without medication to relax you or make you sleepy. Preparation involves enemas and sometimes drinking fluids or taking pills to cleanse the bowel.

- Yes —————→
- No *go to colonoscopy*
- Don't Know *go to colonoscopy*

What was your age when you first had this test?

- years
- Don't know

How many separate tests have you had?

- tests
- Don't know

If more than one test, what was your age when you last had this test?

- years
- Don't know

What were the reasons for your first test? (Mark all that apply)

- To investigate a new problem
- Family history of colorectal cancer
- Routine physical examination or check up
- Follow up of previous problem
- Follow up of FOBT result
- Other _____

B1c.

Have you ever had a colonoscopy? In a colonoscopy, the entire large bowel is examined and a medication is usually given intravenously to relax you or make you sleepy. Preparation involves drinking fluids or taking pills to cleanse the bowel.

- Yes —————→
- No *go to VC*
- Don't Know *go to VC*

What was your age when you first had this test?

- years
- Don't know

How many separate tests have you had?

- tests
- Don't know

If more than one test, what was your age when you last had this test?

- years
- Don't know

What were the reasons for your first test? (Mark all that apply)

- To investigate a new problem
- Family history of colorectal cancer
- Routine physical examination or check up
- Follow up of previous problem
- Follow up of FOBT result
- Other _____

B1e.

Have you ever had a CT colonograph or virtual colonoscopy (VC)? A CT colonograph is a procedure done using x-rays with you lying on a table that is slid through a large circular scanner or tunnel. Typically a tube is inserted to inflate the rectum with air. Preparation may include drinking fluid or taking laxatives to cleanse the bowel. You are not given medications to relax you or make you sleep. This procedure may also be referred to as a Virtual Colonoscopy (VC).

- Yes —————→
- No *go to B2.*
- Don't Know *go to B2.*

What was your age when you first had this test?

- years
- Don't know

How many separate tests have you had?

- tests
- Don't know

If more than one test, what was your age when you last had this test?

- years
- Don't know

What were the reasons for your first test? (Mark all that apply)

- To investigate a new problem
- Family history of colorectal cancer
- Routine physical examination or check up
- Follow up of previous problem
- Follow up of FOBT result
- Other _____

B2. Medical History: Polyps

Now I'd like to ask you some questions about your polyp history.

B2a. Has a doctor ever told you that you had polyps in your large bowel or colon or rectum?

Yes —————>

No go to B3

Don't Know go to B3

How old were you when you were first told that you had polyps?

years

Don't Know

Have you been told that you had polyps more than once?

Yes —————>

No go to B2b.

Don't Know go to B3.

How old were you when you were last told that you had polyps?

years

Don't Know

B2b. Do you know if your polyps were benign, adenomatous (pre-cancerous), or something else? (Mark all that apply) Include all the separate times you were told you had polyps

Benign

Adenomatous (sometimes called pre-cancerous)

Other (specify) _____

Don't Know

B2c. Did you have the polyps removed (by a procedure called polypectomy)? This can be done during a sigmoidoscopy/flexisigmoidoscopy or colonoscopy.

Yes

No go to B3.

Don't Know go to B3.

How old were you when you first had polyps removed?

years

Don't Know

Have you had polyps removed more than once?

Yes

No go to B3.

Don't Know go to B3.

How old were you when you last had polyps removed?

years

Don't Know

How many separate polypectomies have you had?

Procedures

Don't Know

INTERVIEWER INSTRUCTIONS; For ALL reports of polypectomies – (Complete Form K) obtain as many details as possible on the names of the treating gastroenterologist or doctor/s and, name/s and location/s of clinic/s or hospital/s where the procedure/s were performed. Request reports as per your site procedure.

B3. Medical History of the Bowel

Has a doctor ever told you that you had	Age at which your doctor <u>first</u> told you that you had the condition
<p>B3a. Familial Adenomatous Polyposis, known also by its initials as FAP? This is an inherited condition in which numerous polyps line the inside of the bowel.</p> <p><input type="checkbox"/> Yes _____ →</p> <p><input type="checkbox"/> No go to B3b.</p> <p><input type="checkbox"/> Don't Know go to B3b.</p>	<p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>B3b. Crohn's Disease? This is where inflammation extends into deeper layers of the large bowel or colon wall. It may also affect other part of the digestive tract including mouth, oesophagus, stomach and small intestine and is often referred to as an "Auto immune inflammatory disease".</p> <p><input type="checkbox"/> Yes _____ →</p> <p><input type="checkbox"/> No go to B3c.</p> <p><input type="checkbox"/> Don't Know go to B3c.</p>	<p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>B3c. Ulcerative Colitis? This is where there is inflammation and ulceration of the lining of the large bowel or colon or rectum – not the same as a stomach ulcer.</p> <p><input type="checkbox"/> Yes _____ →</p> <p><input type="checkbox"/> No go to B3d.</p> <p><input type="checkbox"/> Don't Know go to B3d.</p>	<p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>B3d. Irritable bowel syndrome? Also known as IBS. This is a disorder of the large bowel or colon that leads to cramping, gassiness, bloating, alternating diarrhoea and constipation.</p> <p><input type="checkbox"/> Yes _____ →</p> <p><input type="checkbox"/> No go to B3e.</p> <p><input type="checkbox"/> Don't Know go to B3e.</p>	<p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>B3e. Diverticular disease? This may also be called diverticulosis or diverticulitis. It is a condition in which the large bowel or colon may become infected, leading to pain and chronic bowel problems</p> <p><input type="checkbox"/> Yes _____ →</p> <p><input type="checkbox"/> No go to B3f.</p> <p><input type="checkbox"/> Don't Know go to B3f.</p>	<p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>

B3f.

Have you ever had any of your large bowel or colon removed?

- Yes →
 No go to B3g.
 Don't Know go to B3g.

Was it completely removed, or was only part of it removed

- Completely removed →
 Partly removed →
 Don't Know

What was your age when you had all your bowel removed or first had part of your bowel removed?

- years
 Don't Know

Have you had more than one surgery to remove part of your bowel or colon?

- Yes →
 No go to B3g.
 Don't Know go to B3g.

What was your age when you last had part of your bowel removed?

- years
 Don't Know

Where and when did this surgery take place?

*INTERVIEWER INSTRUCTION:
 For ALL separate surgeries on the bowel where a CRC was removed (complete Form F), obtain as many details as possible on the name of the surgeon and other treating doctors; and the name and location of the hospital/s where the surgery was performed. Request at minimum all histopathology reports in relation to a surgery for CRC as per your site procedure. Requesting other medical records is optional.*

B3g.

Have you had your gallbladder removed?

- Yes →
 No go to B3h.
 Don't Know go to B3h.

What was your age when you had your gallbladder removed?

- years
 Don't Know

B3h.

Has a doctor ever told you that you had diabetes? Also known as diabetes mellitus. Do not include diabetes which you had only during pregnancy (gestational diabetes).

- Yes →
 No go to B3i.
 Don't Know go to B3i.

How old were you when this was diagnosed?

- years
 Don't Know

Have you ever taken medication to control your diabetes?

- Yes
 Pills → go to B3h.1
 Insulin injections → go to B3h.2
 Both → complete both B3h.1 & B3h.2
 Don't Know
 No go to B3i.
 Don't Know go to B3i.

B3h.1

How often did you take pills to control your diabetes?

- day
 week
 Don't Know

Were you taking them two years ago?

- Yes
 No
 Don't Know

How long, in total, have you taken pills to control your diabetes?

- months
 years
 Don't Know

B3h.2

How often did you have insulin injections to control your diabetes?

- day
 week
 Don't Know

Were you having them two years ago?

- Yes
 No
 Don't Know

How long, in total, have you had insulin to control your diabetes?

- months
 years
 Don't Know

B3i.

Has a doctor ever told you that you had high cholesterol?

- Yes →
 No go to B3j.
 Don't Know go to B3j.

How often did you take this medication?

- day
 week
 Don't Know

How old were you when this was diagnosed

- Years
 Don't Know

Were you taking it two years ago?

- Yes
 No
 Don't Know

Have you ever taken medication to control your high cholesterol?

- Yes →
 No go to B3j.
 Don't Know go to B3j.

How long, in total, have you taken this medication?

- months
 years
 Don't Know

B3j.

Has a doctor ever told you that you had high triglycerides? Triglycerides are a type of fat in your blood.

- Yes →
 No go to B4.
 Don't Know go to B4.

How often did you take this medication?

- day
 week
 Don't Know

How old were you when this was diagnosed

- Years
 Don't Know

Were you taking it two years ago?

- Yes
 No
 Don't Know

Have you ever taken medication to control your high triglycerides?

- Yes →
 No go to B4.
 Don't Know go to B4.

How long, in total, have you taken this medication?

- months
 years
 Don't Know

B4. Cancer History

Has a doctor ever told you that you had cancer, leukaemia or a malignant tumour? This may seem obvious, but for scientific reasons I need to ask this question for everyone.

- Yes
 No go to B5.
 Don't Know go to B5.

INTERVIEWER INSTRUCTION:

1. Cancer question is asked for ALL participants – complete details
2. Chemotherapy & Radio-therapy questions are asked for reports of CRC only
3. Obtain doctor/hospital details on chemo/radio therapy for reports of incident cases of CRC only. Incident refers to a primary CRC diagnosed within 5 years of this interview date. Complete FORM G.
4. Request pathology and/or operation reports for diagnosis of cancers that are within protocol as per your site procedure.

First Cancer Diagnosis

What type of cancer was your first cancer?

_____ →

if CRC reported – ask chemotherapy/radiotherapy questions

What was your age when your doctor first told you, you had your first cancer?

years

Don't know

Were you treated with radiation therapy (radiotherapy) for your first cancer?

Yes →

No

Don't Know

Age first treated with radiation therapy for your first cancer?

years

Don't know

Were you treated with chemotherapy for your first cancer?

Yes →

No

Don't Know

Age first treated with chemotherapy for your first cancer?

years

Don't Know

Second Cancer Diagnosis

What type of cancer was your second cancer?

_____ →

if CRC reported – ask chemotherapy/radiotherapy questions

What was your age when your doctor first told you, you had your second cancer?

years

Don't know

Were you treated with radiation therapy (radiotherapy) for your second cancer?

Yes →

No

Don't Know

Age first treated with radiation therapy for your second cancer?

years

Don't Know

Were you treated with chemotherapy for your second cancer?

Yes →

No

Don't Know

Age first treated with chemotherapy for your second cancer?

years

Don't Know

Third Cancer Diagnosis

What type of cancer was your third cancer?

_____ →

if CRC reported – ask chemotherapy/radiotherapy questions

What was your age when your doctor first told you, you had your third cancer?

years

Don't know

Were you treated with radiation therapy (radiotherapy) for your third cancer?

Yes _____ →

No

Don't Know

Age first treated with radiation therapy for your third cancer?

years

Don't Know

Were you treated with chemotherapy for your third cancer?

Yes _____ →

No

Don't Know

Age first treated with chemotherapy for your third cancer?

years

Don't Know

Fourth Cancer Diagnosis

What type of cancer was your fourth cancer?

_____ →

if CRC reported – ask chemotherapy/radiotherapy questions

What was your age when your doctor first told you, you had your fourth cancer?

years

Don't know

Were you treated with radiation therapy (radiotherapy) for your fourth cancer?

Yes _____ →

No

Don't Know

Age first treated with radiation therapy for your fourth cancer?

years

Don't Know

Were you treated with chemotherapy for your fourth cancer?

Yes _____ →

No

Don't Know

Age first treated with chemotherapy for your fourth cancer?

years

Don't Know

B5. Medication

Now I'd like to ask you some questions about medication you may have taken.

	Have you ever taken any of the following medications <u>at least twice a week for a month or longer?</u>	How often did you take it, when you were taking it at least twice a week for a month or longer?	Were you taking it at least twice a week for a month or longer <u>two years ago?</u>	How long, in total, have you taken this medication for at least twice a week for a month or longer?
B5a	Aspirin (such as Aspro, Disprin, Codral Forte, Ecotrin, Cartiprin or Cartia) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No \longrightarrow go to B5b. <input type="checkbox"/> Don't Know go to B5b.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know
B5b	Paracetamol (such as Panadol, Panamax, Panadeine, Tylenol, Codral) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No go to B5c. <input type="checkbox"/> Don't Know go to B5c.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know
B5c	Pain killing anti-inflammatory medication (such as Naprosyn, Orudis, Voltaren, Brufen, Feldene, Indocid) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No go to B5d. <input type="checkbox"/> Don't Know go to B5d.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know
B5d	Bulk forming Laxatives (such as Metamucil, Normacol, Psyllium, Granocol) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No go to B5e. <input type="checkbox"/> Don't Know go to B5e.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know
B5e	Other Laxatives (such as Castor Oil, Coloxyl, Senokot, Durolox, Laxettes, Agarol) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No go to B5f. <input type="checkbox"/> Don't Know go to B5f.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know
B5f	Calcium containing Antacids (such as Tums, Gaviscon, Mylanta, Dexsal, Mucaine, Gastrogel) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No go to B5g. <input type="checkbox"/> Don't Know go to B5g.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know

B5. Medication continued...

	Have you ever taken any of the following medications <u>at least twice a week for a month or longer?</u>	How often did you take it, when you were taking it at least twice a week for a month or longer?	Were you taking it at least twice a week for a month or longer <u>two years ago?</u>	How long, in total, have you taken this medication for at least twice a week for a month or longer?
B5g	Calcium Supplements (such as Sandocal, Calvita, Caltrate) <input type="checkbox"/> Yes → <input type="checkbox"/> No go to B5h. <input type="checkbox"/> Don't Know go to B5h.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know
B5h	Multivitamin pills or tablets (such as Myadec, Centrum, Pluravit, Swisse, Bioglan) <input type="checkbox"/> Yes → <input type="checkbox"/> No go to B5i. <input type="checkbox"/> Don't Know go to B5i.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know
B5i	Folic Acid or Folate supplements (such as Folic Acid, Fefol) <input type="checkbox"/> Yes → <input type="checkbox"/> No go to C1. <input type="checkbox"/> Don't Know go to C1.	<input type="text"/> <input type="text"/> <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> Don't know

C. MENSTRUATION, REPRODUCTIVE HISTORY AND MENOPAUSE

This next series of questions are about menstruation and pregnancy.

C1. Menstruation

How old were you when you had your first menstrual period?

years

Don't Know

Never had a menstrual period

C2. Pregnancies

<p>C2a. Have you ever been pregnant?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No go to C3. <input type="checkbox"/> Don't Know go to C3.	<p>C2b. How many times have you been pregnant? Include all pregnancies: miscarriages, still births, tubal pregnancies and abortions. <u>If currently pregnant exclude your current pregnancy</u></p> <input type="text"/> <input type="text"/> number of pregnancies, if 0 go to C3. <input type="checkbox"/> Don't Know
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C2. Pregnancies continued...

<p>C2c. How many times were you pregnant with more than one baby? Twins, triplets, etc.</p> <p><input type="text"/> <input type="text"/> number of pregnancies with multiples</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Don't Know</p>	<p>C2d. How many of your pregnancies lasted 6 months or longer?</p> <p><input type="text"/> <input type="text"/> number of pregnancies, <i>if 0 go to C3.</i></p> <p><input type="checkbox"/> Don't Know</p>	
<p>C2e. How many of your pregnancies resulted in live births?</p> <p><input type="text"/> <input type="text"/> number of pregnancies, <i>if 0 go to C3.</i></p> <p><input type="checkbox"/> Don't Know</p>	<p>C2f. How old were you at your <u>first</u> live birth?*</p> <p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't know</p>	
<p><i>* INTERVIEWER INSTRUCTION: If not already recorded, ask for name, vital status, date of birth (and if applicable date of death) of all children for the pedigree</i></p>		<p>C2g. How old were you at your <u>last</u> live birth?*</p> <p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't know</p>

C3. Contraceptive Use

<p>C3a. Have you ever used birth control pills or other hormonal contraceptives (implants or injections) for at least one year?</p> <p><input type="checkbox"/> Yes \longrightarrow</p> <p><input type="checkbox"/> No \longrightarrow go to C4.</p> <p><input type="checkbox"/> Don't Know \longrightarrow go to C4.</p>	<p>C3b. How old were you when you first used birth control pills or other hormonal contraceptives?</p> <p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>C3c. Were you still using birth control pills or other hormonal contraceptives two years ago?</p> <p><input type="checkbox"/> Yes \longrightarrow</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know</p>	<p>C3d. In total, how long did you take birth control pills or other hormonal contraceptives?</p> <p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>

C4. Menopause

If the answer to question C.1 was "Never had a menstrual period" go to section C5.

<p>C4a. Have you had a menstrual period in the last 12 months? Only menstrual bleeding is of interest here. Do not include bleeding that results from hormone replacement therapy (HRT), or progesterones, progestins, or withdrawal bleeding.</p> <p><input type="checkbox"/> Yes → go to C4d.</p> <p><input type="checkbox"/> No →</p> <p><input type="checkbox"/> Don't Know go to C4d.</p>	<p>C4b. Have your menstrual periods stopped permanently or only temporarily due to pregnancy, breastfeeding or other conditions?</p> <p><input type="checkbox"/> Stopped temporarily → go to C4d.</p> <p><input type="checkbox"/> Stopped permanently ↓</p> <p>How old were you when your periods stopped permanently?</p> <p><input type="text"/> <input type="text"/> Years <input type="checkbox"/> Don't Know</p>
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<p>C4c. Why did your menstrual periods stop?</p> <p><input type="checkbox"/> Natural menopause</p> <p><input type="checkbox"/> Gynaecological surgery</p> <p><input type="checkbox"/> Radiation or chemotherapy →</p> <p><input type="checkbox"/> Other, Specify _____ →</p> <p><input type="checkbox"/> Don't Know</p>	<p>How old were you when you <u>first</u> had radiation or chemotherapy?</p> <p><input type="text"/> <input type="text"/> Years <input type="checkbox"/> Don't Know</p> <p>How old were you when you <u>first</u> had (other)?</p> <p><input type="text"/> <input type="text"/> Years <input type="checkbox"/> Don't Know</p>
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<p>C4d. Have you ever had any gynaecological surgery? (Surgery on your uterus or ovaries)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No go to C5.</p> <p><input type="checkbox"/> Don't Know go to C5.</p>	<p><i>INTERVIEWER INSTRUCTION: For ALL separate surgeries on the uterus/ovaries where a cancer was removed, obtain as many details as possible on the name of the surgeon and other treating doctors; and the name and location of the hospital/s where the was surgery was performed. Request at minimum all histopathology reports in relation to a surgery for uterine/ovarian cancer as per your site procedure. Requesting other medical records is optional.</i></p>
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Which of the following surgery did you have and at what age?

Hysterectomy (uterus/womb removed)	One ovary removed in whole or part without hysterectomy	Both ovaries removed without hysterectomy	Other surgery
<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Hysterectomy only</p> <p><input type="checkbox"/> With one or part ovary</p> <p><input type="checkbox"/> With both ovaries</p> <p><input type="checkbox"/> Don't Know</p> <p><input type="checkbox"/> No →</p> <p><input type="checkbox"/> Don't Know →</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No →</p> <p><input type="checkbox"/> Don't Know →</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No →</p> <p><input type="checkbox"/> Don't Know →</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No go to C5.</p> <p><input type="checkbox"/> Don't Know go to C5.</p> <p>Specify: _____</p>
<p>How old were you when you had this surgery?</p> <p><input type="text"/> <input type="text"/> Years</p> <p><input type="checkbox"/> Don't Know</p>	<p>How old were you when you had this surgery?</p> <p><input type="text"/> <input type="text"/> Years</p> <p><input type="checkbox"/> Don't Know</p>	<p>How old were you when you had this surgery?</p> <p><input type="text"/> <input type="text"/> Years</p> <p><input type="checkbox"/> Don't Know</p>	<p>How old were you when you had this surgery?</p> <p><input type="text"/> <input type="text"/> Years</p> <p><input type="checkbox"/> Don't Know</p>

C5. Hormone Replacement Therapy

Doctors prescribe hormone replacement therapy for many reasons including menopausal symptoms, surgical removal of the ovaries, osteoporosis, and heart disease prevention.

C5a. Have you ever used a pill, patch or implant form of hormone replacement therapy? Menopausal symptoms include hot flushes, sweating and depression. Please do not include hormone therapy that was prescribed for birth control; hormone therapy delivered by injections, vaginal creams or vaginal suppositories.

Yes

No go to C5d.

Don't Know go to C5d.

Were you still having periods when you first took these hormones?

Yes

No

Don't Know

C5b. First, I will ask about oestrogen-only therapy, and then about oestrogen given in combination with progesterone. After that, I will ask about tamoxifen, raloxifene and other anti-oestrogens.

Were you prescribed an oestrogen-only pill or patch? (such as Premarin, Climara, Dermetril, Estigyn, Estraderm, Femtran, Menorest, Ogen, Ovestin, Prognova)

Yes

No go to C5c.

Don't Know go to C5c.

How old were you when you first took oestrogen-only medication?

Years

Don't Know

Were you still taking oestrogen-only medication two years ago?

Yes

No

Don't Know

In total, how long have you taken oestrogen-only medication?

months

years

Don't Know

C5c. Progesterone, one common brand is Provera, is frequently prescribed by doctors along with oestrogen. Have you ever taken progesterone along with oestrogen for menopause or other reasons? Such as Divina, Estracombi, Estrapak, Kliogest, Menoprem, Provelle

Yes

No go to C5d.

Don't Know go to C5d.

How old were you when you first took progesterone along with oestrogen medication?

Years

Don't Know

Were you still taking progesterone along with oestrogen two years ago?

Yes

No

Don't Know

In total, how long have you taken progesterone along with oestrogen medication?

months

years

Don't Know

C5. Hormone Replacement Therapy continued...

C5d.

Have you ever taken tamoxifen, raloxifene or other anti-oestrogen medication? such as Tamoxen, Genox, Nolvadex, Noxiton, Tamosin)

Yes _____ →

No → go to D1.

Possibly → I have participated in a clinical trial for tamoxifen, raloxifene or other anti-oestrogen medication

Don't Know

Did you take tamoxifen or raloxifene, or do you know what the other anti-oestrogen was? (mark all that apply)

Tamoxifen

Raloxifene

Other _____

Don't Know

How old were you when you first took tamoxifen, raloxifene or other anti-oestrogen medication?

Don't Know

Were you still taking them two years ago?

Yes

No → go to D1.

Possibly →

I have participated in a clinical trial for tamoxifen, raloxifene or other anti-oestrogen medication

Don't Know

In total, how long have you taken them?

months
 years

Don't Know

D. DIET

In this next section, the questions ask how often you ate certain foods about two years ago. Would you please tell me how often per day, per week or per month you ate the following foods.

D1. Fruit

About two years ago, on average how often did you eat a piece or serving of fruit?

A serving of fruit is:

1 medium fresh fruit

1/2 cup of chopped, or cooked, or canned fruit

1/4 cup of dried fruit

6 ounces (200 mls or 1 glass) of fruit juice

portions/servings

per day

per week

per month

Did not eat fruit go to D2.

Don't Know

D2. Vegetables

About two years ago, on average how often did you eat a serving of vegetables?

A serving of vegetables is:

1 cup raw leafy vegetables

1/2 cup of other vegetables, cooked or chopped raw

6 ounces (200 mls or 1 glass) of vegetable juice

portions/servings

per day

per week

per month

Did not eat vegetables go to D3a.

Don't Know

D3. Red Meat

D3a. About two years ago, on average how many servings of red meat (not chicken or fish) did you eat?

A serving of red meat is 2-3 ounces (60-100 grams); about the size of a deck of cards.

Red meat includes beef, steak, mince, lamb, hamburger, pork, bacon, sausages and veal

portions/servings

per day

per week

per month

Did not eat red meat *go to D4a.*

Don't Know

D3b. About two years ago, on average how many servings of red meat did you eat that were cooked by pan-frying or fryer pan, grilling or barbequing?

portions/servings

per day

per week

per month

Did not eat red meat cooked this way *go to D4a.*

Don't Know

D3c. About two years ago, on average when you ate red meat cooked by these methods, which of the following best describes its outside appearance?

Lightly browned

Medium browned

Heavily browned/blackened

Don't Know

About two years ago, on average when you ate red meat cooked by these methods, which of the following best describes its inside appearance?

Red or rare

Pink or medium

Brown or well done

Don't Know

D4. Chicken

D4a. About two years ago, on average how often did you eat a serving of chicken?

A serving of chicken is: 2-3 ounces (60-100gms) of chicken meat, 1 drumstick, 1 thigh, half a breast, 2 wings or 3 nuggets

portions/servings

per day

per week

per month

Did not eat chicken *go to E1.*

Don't Know

D4b. About two years ago, on average how many servings of chicken did you eat that were cooked by pan-frying or fryer pan, grilling or barbequing?

portions/servings

per day

per week

per month

Did not eat chicken cooked this way *go to E1.*

Don't Know

D4c. About two years ago, on average when you ate chicken cooked by these methods, which of the following best describes its outside appearance?

Lightly browned

Medium browned

Heavily browned/blackened

Don't Know

E. PHYSICAL ACTIVITY

The next section contains questions about your participation in a variety of physical activities during three periods of your life.

E1. Early Adult years

Skip to section F1 if the participant is aged less than 20 years and 3 months.

Think back to the period when you were in your 20s. I would like to know if you participated regularly in any of the following activities. By "regularly", I mean at least 30 minutes a week for a minimum of 3 months in a row.

	For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?
<p>E1a. Did you ever walk regularly?</p> <p><input type="checkbox"/> Yes \longrightarrow</p> <p><input type="checkbox"/> No <i>go to E1b.</i></p> <p><input type="checkbox"/> Don't Know <i>go to E1b.</i></p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>
<p>E1b Did you ever Jog regularly? (jogging is running slower than a kilometre in 6 minutes or a mile in 10 minutes)</p> <p><input type="checkbox"/> Yes \longrightarrow</p> <p><input type="checkbox"/> No <i>go to E1c.</i></p> <p><input type="checkbox"/> Don't Know <i>go to E1c</i></p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>
<p>E1c Did you ever run regularly? (ie running faster than a kilometre in 6 minutes or a mile in 10 minutes)</p> <p><input type="checkbox"/> Yes \longrightarrow</p> <p><input type="checkbox"/> No <i>go to E1d.</i></p> <p><input type="checkbox"/> Don't Know <i>go to E1d.</i></p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>
<p>E1d. Did you ever cycle regularly? (this includes a stationary bike)</p> <p><input type="checkbox"/> Yes \longrightarrow</p> <p><input type="checkbox"/> No <i>go to E1e</i></p> <p><input type="checkbox"/> Don't Know <i>go to E1e.</i></p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>
<p>E1e. Did you ever swim regularly? (laps in a pool or ocean)</p> <p><input type="checkbox"/> Yes \longrightarrow</p> <p><input type="checkbox"/> No <i>go to E1f.</i></p> <p><input type="checkbox"/> Don't Know <i>go to E1f.</i></p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>

E1. Early Adult Years continued Must be at least 30 minutes a week for a minimum of 3 months in a row.	For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?			
E1f. Did you ever play tennis, racquetball, badminton or squash regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E1g.</i> <input type="checkbox"/> Don't Know <i>go to E1g.</i>	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know			
E1g. Did you ever do aerobics, vigorous dance, calisthenics or use a rowing machine regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E1h.</i> <input type="checkbox"/> Don't Know <i>go to E1h.</i>	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know			
E1h. Did you ever play football, basketball, rugby or netball regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E1i.</i> <input type="checkbox"/> Don't Know <i>go to E1i.</i>	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know			
E1i. Did you ever do any strenuous tasks in or around the house regularly? (like mowing lawns with a non-power mower, scrubbing floors vigorously) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E1j.</i> <input type="checkbox"/> Don't Know <i>go to E1j.</i>	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know			
E1j. Did you ever participate regularly in any other strenuous physical activities? (strenuous activities means something that really increased your heart rate, made you hot, and caused you to sweat such as skiing, skating, hockey, scuba diving, surfing and other activities) <input type="checkbox"/> Yes <input type="checkbox"/> No \longrightarrow <i>go to E1k.</i> <input type="checkbox"/> Don't Know \longrightarrow <i>go to E1k.</i>						
Activity1 _____ <table style="width:100%; border:none;"> <tr> <td style="width:33%; border:none;"> For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know </td> <td style="width:33%; border:none;"> For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know </td> <td style="width:33%; border:none;"> For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know </td> </tr> </table>				For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know				

E1j. Early Adult years continued – other strenuous physical activities? such as skiing, skating, hockey, scuba diving, surfing and other activities

Activity2 _____		
For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
Activity3 _____		
For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
Activity4 _____		
For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
E1k. In your 20s, what was your usual occupation? ("Usual" is the longest held activity including any paid or unpaid employment, such as being a student, home duties, or unemployed.) _____		

If the participant is younger than 30years, and 3 months go to F1.

E2. Midlife Years

Think back to the period when you were in your 30s and 40s. I would like to know if you participated regularly in any of the following activities. By "regularly", I mean at least 30 minutes a week for a minimum of 3 months in a row.

	For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?
E2a. Did you ever walk regularly? <input type="checkbox"/> Yes → <input type="checkbox"/> No go to E2b. <input type="checkbox"/> Don't Know go to E2b.	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
E2b. Did you ever Jog regularly? (jogging is running slower than a kilometre in 6 minutes or a mile in 10 minutes) <input type="checkbox"/> Yes → <input type="checkbox"/> No go to E2c. <input type="checkbox"/> Don't Know go to E2c	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know

E2. Midlife Years continued Must be at least 30 minutes a week for a minimum of 3 months in a row.	For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?
E2c. Did you ever run regularly? (ie running faster than a kilometre in 6 minutes or a mile in 10 minutes) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2d.</i> <input type="checkbox"/> Don't Know <i>go to E2d.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know
E2d. Did you ever cycle regularly? (this includes a stationary bike) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2e</i> <input type="checkbox"/> Don't Know <i>go to E2e.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know
E2e. Did you ever swim regularly? (laps in a pool or ocean) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2f.</i> <input type="checkbox"/> Don't Know <i>go to E2f.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know
E2f. Did you ever play tennis, racquetball, badminton or squash regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2g.</i> <input type="checkbox"/> Don't Know <i>go to E2g.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know
E2g. Did you ever do aerobics, vigorous dance, calisthenics or use a rowing machine regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2h.</i> <input type="checkbox"/> Don't Know <i>go to E2h.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know
E2h. Did you ever play football, basketball, rugby or netball regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2i.</i> <input type="checkbox"/> Don't Know <i>go to E2i.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know

E2.	Midlife Years continued Must be at least 30 minutes a week for a minimum of 3 months in a row.	For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?						
E2i.	Did you ever do any strenuous tasks in or around the house regularly? (like mowing lawns with a non-power mower, scrubbing floors vigorously) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2j.</i> <input type="checkbox"/> Don't Know <i>go to E2j.</i>	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know						
E2j. Did you ever participate regularly in any other strenuous physical activities? (strenuous activities means something that really increased your heart rate, made you hot, and caused you to sweat such as skiing, skating, hockey, scuba diving, surfing and other activities) <input type="checkbox"/> Yes <input type="checkbox"/> No \longrightarrow <i>go to E1k.</i> <input type="checkbox"/> Don't Know \longrightarrow <i>go to E1k.</i>										
Activity1 _____ <table border="0" style="width:100%"> <tr> <td style="width:33%">For how many years did you do this activity?</td> <td style="width:33%">For how many months of the year, on average, did you do this activity?</td> <td style="width:33%">For how many hours per week, on average, did you do this activity?</td> </tr> <tr> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> </tr> </table>					For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?								
<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know								
Activity2 _____ <table border="0" style="width:100%"> <tr> <td style="width:33%">For how many years did you do this activity?</td> <td style="width:33%">For how many months of the year, on average, did you do this activity?</td> <td style="width:33%">For how many hours per week, on average, did you do this activity?</td> </tr> <tr> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> </tr> </table>					For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?								
<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know								
Activity3 _____ <table border="0" style="width:100%"> <tr> <td style="width:33%">For how many years did you do this activity?</td> <td style="width:33%">For how many months of the year, on average, did you do this activity?</td> <td style="width:33%">For how many hours per week, on average, did you do this activity?</td> </tr> <tr> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> </tr> </table>					For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?								
<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know								
Activity4 _____ <table border="0" style="width:100%"> <tr> <td style="width:33%">For how many years did you do this activity?</td> <td style="width:33%">For how many months of the year, on average, did you do this activity?</td> <td style="width:33%">For how many hours per week, on average, did you do this activity?</td> </tr> <tr> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> <td><input type="text"/><input type="text"/> <input type="checkbox"/> Don't Know</td> </tr> </table>					For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know
For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?								
<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know								
E2k. In your 30s and 40s,, what was your usual occupation? ("Usual" is the longest held activity including any paid or unpaid employment, such as being a student, home duties, or unemployed.) _____										

If the participant is younger than 50 years, and 3 months go to F1.

E3. Older Ages

Now I will ask you to think about activities you have participated in since you turned 50. By "regularly", I mean at least 30 minutes a week for a minimum of 3 months in a row.

	For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?
<p>E3a. Did you ever walk regularly?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to E2b.</p> <p><input type="checkbox"/> Don't Know go to E2b.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>
<p>E3b. Did you ever Jog regularly? (jogging is running slower than a kilometer in 6 minutes or a mile in 10 minutes)</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to E2c.</p> <p><input type="checkbox"/> Don't Know go to E2c</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>
<p>E3c. Did you ever run regularly? (ie running faster than a kilometer in 6 minutes or a mile in 10 minutes)</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to E2d.</p> <p><input type="checkbox"/> Don't Know go to E2d.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>
<p>E3d. Did you ever cycle regularly? (this includes a stationary bike)</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to E3e.</p> <p><input type="checkbox"/> Don't Know go to E3e.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>
<p>E3e. Did you ever swim regularly? (laps in a pool or ocean)</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to E2f.</p> <p><input type="checkbox"/> Don't Know go to E2f.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>

E3.	Older Years continued Must be at least 30 minutes a week for a minimum of 3 months in a row.	For how many years did you do this activity?	For how many months of the year, on average, did you do this activity?	For how many hours per week, on average, did you do this activity?			
E3f.	Did you ever play tennis, racquetball, badminton or squash regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2g.</i> <input type="checkbox"/> Don't Know <i>go to E2g.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know			
E3g.	Did you ever do aerobics, vigorous dance, calisthenics or use a rowing machine regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2h.</i> <input type="checkbox"/> Don't Know <i>go to E2h.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know			
E3h.	Did you ever play football, basketball, rugby or netball regularly? <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2i.</i> <input type="checkbox"/> Don't Know <i>go to E2i.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know			
E3i.	Did you ever do any strenuous tasks in or around the house regularly? (like mowing lawns with a non-power mower, scrubbing floors vigorously) <input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No <i>go to E2j.</i> <input type="checkbox"/> Don't Know <i>go to E2j.</i>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know			
E3j. Did you ever participate regularly in any other strenuous physical activities? (strenuous activities means something that really increased your heart rate, made you hot, and caused you to sweat such as skiing, skating, hockey, scuba diving, surfing and other activities) <input type="checkbox"/> Yes <input type="checkbox"/> No \longrightarrow <i>go to E1k.</i> <input type="checkbox"/> Don't Know \longrightarrow <i>go to E1k.</i>							
Activity1 _____ <table style="width:100%; border:none;"> <tr> <td style="width:33%; border:none;"> For how many years did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know </td> <td style="width:33%; border:none;"> For how many months of the year, on average, did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know </td> <td style="width:33%; border:none;"> For how many hours per week, on average, did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know </td> </tr> </table>					For how many years did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know
For how many years did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Don't Know					

E3j. Older years continued – other strenuous physical activities? such as skiing, skating, hockey, scuba diving, surfing and other activities

Activity2 _____			
For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	
Activity3 _____			
For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	
Activity4 _____			
For how many years did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many months of the year, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	For how many hours per week, on average, did you do this activity? <input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	
E3k. In your 50s, what was your usual occupation? ("Usual" is the longest held activity including any paid or unpaid employment, such as being a student, home duties, or unemployed.). _____			

F. ALCOHOL CONSUMPTION

The next set of questions asks about alcohol consumption during three periods of your life.

F1. Early Adult Years

Think back to the period when you were in your 20s. During the period when you were in your 20s, did you ever consume any alcoholic beverages? (Alcoholic beverages include beer, wine, cider, spirits, mixed drinks, or cocktails).

- Yes
- No go to F2.
- Don't Know go to F2.

Now I will ask you questions about specific types of alcoholic beverages.

	In your 20's did you ever drink.....?	How many did you typically drink?	How often did you typically drink.....?	For how many months or years did you typically drink.....?
F1a. Beer – Full Strength <input type="checkbox"/> Yes → <input type="checkbox"/> No go to F1b. <input type="checkbox"/> Don't Know go to F1b.	<input type="text"/> <input type="text"/> <input type="checkbox"/> Don't Know	<input type="checkbox"/> Glasses <input type="checkbox"/> Pots <input type="checkbox"/> Stubbies <input type="checkbox"/> Cans <input type="checkbox"/> Bottles	<input type="checkbox"/> Per Day <input type="checkbox"/> Per Week <input type="checkbox"/> Per Month <input type="checkbox"/> Per Year <input type="checkbox"/> Don't Know	<input type="text"/> <input type="text"/> <input type="checkbox"/> months <input type="text"/> <input type="text"/> <input type="checkbox"/> years <input type="checkbox"/> Don't Know

F1. Early Adult Years continued...

During your 20s, did you ever drink...

<p>F1b. Beer – Low Alcohol (light)</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F1c.</p> <p><input type="checkbox"/> Don't Know go to F1c.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Pots</p> <p><input type="checkbox"/> Stubbies</p> <p><input type="checkbox"/> Cans</p> <p><input type="checkbox"/> Bottles</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>F1c. Wine or Cider</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F1d.</p> <p><input type="checkbox"/> Don't Know go to F1d.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Small Bottles</p> <p><input type="checkbox"/> Bottles</p> <p><input type="checkbox"/> Casks or Flagons</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>F1d. Spirits</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F2.</p> <p><input type="checkbox"/> Don't Know go to F2.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Shots/ Glasses</p> <p><input type="checkbox"/> Cans</p> <p><input type="checkbox"/> Bottles</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>

If participant is younger than 30, go to G.

F2. Midlife Years

Think back to the period when you were in your 30s and 40s. During the period when you were in your 30s and 40s, did you ever consume any alcoholic beverages? (Alcoholic beverages include beer, wine, cider, spirits, mixed drinks, or cocktails).

Yes

No go to F3.

Don't Know go to F3.

Now I will ask you questions about specific beverages.

In your 30s and 40s did you ever drink.....?	How many did you typically drink?		How often did you typically drink.....?	For how many months or years did you typically drink.....?
<p>F2a. Beer – Full Strength</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F2b.</p> <p><input type="checkbox"/> Don't Know go to F2b.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Pots</p> <p><input type="checkbox"/> Stubbies</p> <p><input type="checkbox"/> Cans</p> <p><input type="checkbox"/> Bottles</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>

F2. Midlife Years continued...

During the period when you were in your 30s and 40s, did you ever drink....

<p>F2b. Beer – Low Alcohol (light)</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F2c.</p> <p><input type="checkbox"/> Don't Know go to F2c.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Pots</p> <p><input type="checkbox"/> Stubbies</p> <p><input type="checkbox"/> Cans</p> <p><input type="checkbox"/> Bottles</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>F2c. Wine or Cider</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F2d.</p> <p><input type="checkbox"/> Don't Know go to F2d.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Small Bottles</p> <p><input type="checkbox"/> Bottles</p> <p><input type="checkbox"/> Casks or Flagon</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>F2d. Spirits</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F3.</p> <p><input type="checkbox"/> Don't Know go to F3.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Shots/ Glasses</p> <p><input type="checkbox"/> Cans</p> <p><input type="checkbox"/> Bottles</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>

If participant is younger than 50, go to G.

F3. Older Years

Think back to the period since you turned 50. Since turning 50, have you ever consume any alcoholic beverages ? (Alcoholic beverages include beer, wine, cider, spirits, mixed drinks, or cocktails)

Yes

No go to G.

Don't Know go to G.

Now I will ask you questions about specific types of alcoholic beverages.

In your 50's did you ever drink.....?	How many did you typically drink?		How often did you typically drink.....?	For how many months or years did you typically drink.....?
<p>F3a. Beer – Full Strength</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F3b.</p> <p><input type="checkbox"/> Don't Know go to F3b.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Pots</p> <p><input type="checkbox"/> Stubbies</p> <p><input type="checkbox"/> Cans</p> <p><input type="checkbox"/> Bottles</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>

F3. Older Years continued...

Since turning 50, have you ever drunk...

<p>F3b. Beer – Low Alcohol (light)</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F3c.</p> <p><input type="checkbox"/> Don't Know go to F3c.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Pots</p> <p><input type="checkbox"/> Stubbies</p> <p><input type="checkbox"/> Cans</p> <p><input type="checkbox"/> Bottles</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>F3c. Wine or Cider</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to F3d.</p> <p><input type="checkbox"/> Don't Know go to F3d.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Glasses</p> <p><input type="checkbox"/> Small Bottles</p> <p><input type="checkbox"/> Bottles</p> <p><input type="checkbox"/> Casks or Flagon</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>
<p>F3d. Spirits</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to G.</p> <p><input type="checkbox"/> Don't Know go to G.</p>	<p><input type="text"/> <input type="text"/></p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="checkbox"/> Shots/ Glasses</p> <p><input type="checkbox"/> Cans</p> <p><input type="checkbox"/> Bottles</p>	<p><input type="checkbox"/> Per Day</p> <p><input type="checkbox"/> Per Week</p> <p><input type="checkbox"/> Per Month</p> <p><input type="checkbox"/> Per Year</p> <p><input type="checkbox"/> Don't Know</p>	<p><input type="text"/> <input type="text"/> <input type="text"/> months</p> <p><input type="text"/> <input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>

G. SMOKING

Now I'd like to ask you a few questions about your use of tobacco.

G1. Cigarettes

<p>G1a Have you ever smoked a cigarette a day for 3 months or longer?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to G2.</p> <p><input type="checkbox"/> Don't Know go to G2.</p>	<p>G1b At what age did you first start smoking at least one cigarette per day for 3 months or longer?</p> <p><input type="text"/> <input type="text"/> years of age</p> <p><input type="checkbox"/> Don't Know</p>	<p>G1c During periods when you smoked regularly, on average how many cigarettes did you typically smoke in a day?</p> <p><input type="text"/> <input type="text"/> cigarettes per day</p> <p><input type="checkbox"/> Don't Know</p>
<p>G1d About two years ago were you smoking at least one cigarette a day?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know</p>	<p>G1e Do you currently smoke at least one cigarette a day?</p> <p><input type="checkbox"/> Yes go to G1g</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know</p>	<p>G1f When did you last quit smoking regularly? (One cigarette a day for 3 months or longer)</p> <p><input type="text"/> <input type="text"/> years of age</p> <p><input type="checkbox"/> Don't Know</p>
<p>G1g How many years in total did you smoke at least one cigarette per day for 3 months or longer? If you have stopped and started at least once, count only the time when you were smoking</p> <p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>		

G2. Cigars or Pipes

<p>G2a Have you ever smoked at least one cigar or one pipe per month for 3 months or longer?</p> <p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No go to H1.</p> <p><input type="checkbox"/> Don't Know go to H1.</p>	<p>Did you smoke cigars or pipes or both?</p> <p><input type="checkbox"/> Cigars</p> <p><input type="checkbox"/> Pipes</p> <p><input type="checkbox"/> Both</p>	<p>G2b At what age did you first start smoking at least one cigar or one pipe per month for 3 months or longer?</p> <p><input type="text"/> <input type="text"/> years of age</p> <p><input type="checkbox"/> Don't Know</p>
<p>G2c During periods when you smoked regularly, on average how many (cigars or pipes) did you typically smoke in a month?</p> <p><input type="text"/> <input type="text"/> cigars or pipes per month</p> <p><input type="checkbox"/> Don't Know</p>	<p>G2d About two years ago were you smoking at least one cigar or pipe per month?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know</p>	<p>G2e Do you currently smoke at least one (cigar or pipe) per month?</p> <p><input type="checkbox"/> Yes go to G2g</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Don't Know</p>
<p>G2f When did you last quit smoking regularly? (One cigar or one pipe per month for 3 months or longer)</p> <p><input type="text"/> <input type="text"/> years of age</p> <p><input type="checkbox"/> Don't Know</p>		<p>G2g How many years in total did you smoke at least one cigar or one pipe per month for 3 months or longer? (If you have stopped and restarted at least once, count only the time when you were smoking)</p> <p><input type="text"/> <input type="text"/> years</p> <p><input type="checkbox"/> Don't Know</p>

H. HEIGHT AND WEIGHT

The next set of questions are about your height and weight

Height

H1. How tall are you currently without shoes on?

ft AND inches OR cm

Don't Know

H2. How tall were you when you were 20 years old?

ft AND inches OR cm

Don't Know

Weight

H3. What is your current weight?

st AND lbs OR kg

Don't Know

H4. What was your weight two years ago?

st AND lbs OR kg

Don't Know

H5. What was your weight when you were 20 years old?

st AND lbs OR kg

Don't Know

I. OTHER

I1. Have you ever participated in any other genetic or family-based cancer studies other than this study.

Yes (Specify name of the study or clinic) _____

No *go to I2*

Don't Know *go to I2*

I2. Have you had a blood test to look for genes for bowel cancer? You may have had such a test when attending a genetic clinic or service? Do not include blood tests you have had as part of this study.

Yes

No *go to I3*

Don't Know *go to I3*

I2a. Have you received your gene test result?

Yes – Specify result _____ *go to I2b*

No *go to I3*

Don't Know *go to I3*

I2b. (If participant answered YES to having received their genetic test result) May we have your permission to access a copy of your result for the research study?

Yes, what is the name and location of the clinic where you attended for your genetic testing,

No

INTERVIEWER INSTRUCTIONS; Obtain as many details as possible on the name of clinic or hospital where testing was completed. Request reports as per your site procedure.

I3. Have you any comments, or information, that you think we should have asked about?

J. Interviewer's Assessment

J1 Interviewer _____ Interviewer ID _____

J2 How and where was the interview conducted?

Phone

Face to Face

Mail

Other, Specify _____

J3 Was an interpreter used?

Yes

No

J4 Interview Length: _____ minutes

INTERVIEWER INSTRUCTION: GO TO FAMILY HISTORY FORMS AND FOR EVERY FULL PARTICIPANT ASK ABOUT THEIR FIRST DEGREE RELATIVES AND OTHER RELATIVES IF A RELEVANT CANCER IS REPORTED.