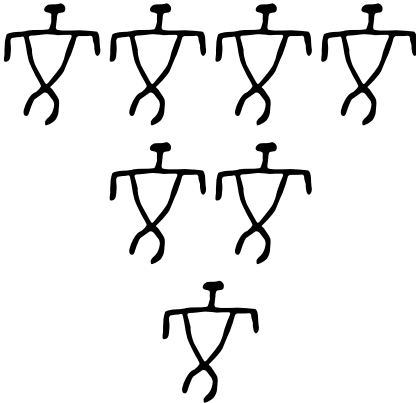


HAWAII FAMILY HISTORY UPDATE

We are asking this next set of questions in order to update our records. The questions refer to the health of your blood relatives, including your parents, full brothers and sisters, children, and extended relatives such as aunts, uncles, cousins, etc. Please do not include family members who were adopted or are unrelated to you by birth. This information will help us to keep your family tree accurate.



Research with Families Today...
to Help Future Generations

Thank you so much for taking the time to complete this form.

HEALTH HISTORY OF YOUR **PARENTS**

FR ID# _____

1a. What is your mother's first name?	1b. When was she born?	1c. Is she still living?	1d. If no, when did she pass away?	1e. Was she ever diagnosed with cancer?	1f. What type(s) of cancer did she have?	1g. How old was she when diagnosed with this cancer?
<p>_____</p> <p>Name</p>	<p>___/___/___</p> <p>Date of birth</p> <p>OR</p> <p>_____</p> <p>Current age (years)</p>	<p><input type="checkbox"/> Yes (go to 1e)</p> <p><input type="checkbox"/> No →</p>	<p>___/___/___</p> <p>Date of death</p> <p>OR</p> <p>_____</p> <p>Age at death</p>	<p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No (go to 2a)</p> <p><input type="checkbox"/> Don't know (go to 2a)</p>	<p>1st _____ →</p> <p>2nd _____ →</p> <p>3rd _____ →</p> <p>4th _____ →</p>	<p>1st ___ or _____</p> <p>Age Yr of diagnosis</p> <p>2nd ___ or _____</p> <p>Age Yr of diagnosis</p> <p>3rd ___ or _____</p> <p>Age Yr of diagnosis</p> <p>4th ___ or _____</p> <p>Age Yr of diagnosis</p>
2a. What is your father's first name?	2b. When was he born?	2c. Is he still living?	2d. If no, when did he pass away?	2e. Was he ever diagnosed with cancer?	2f. What type(s) of cancer did he have?	2g. How old was he when diagnosed with this cancer?
<p>_____</p> <p>Name</p>	<p>___/___/___</p> <p>Date of birth</p> <p>OR</p> <p>_____</p> <p>Current age (years)</p>	<p><input type="checkbox"/> Yes (go to 2e)</p> <p><input type="checkbox"/> No →</p>	<p>___/___/___</p> <p>Date of death</p> <p>OR</p> <p>_____</p> <p>Age at death</p>	<p><input type="checkbox"/> Yes →</p> <p><input type="checkbox"/> No (go to 3)</p> <p><input type="checkbox"/> Don't know (go to 3)</p>	<p>1st _____ →</p> <p>2nd _____ →</p> <p>3rd _____ →</p> <p>4th _____ →</p>	<p>1st ___ or _____</p> <p>Age Yr of diagnosis</p> <p>2nd ___ or _____</p> <p>Age Yr of diagnosis</p> <p>3rd ___ or _____</p> <p>Age Yr of diagnosis</p> <p>4th ___ or _____</p> <p>Age Yr of diagnosis</p>

FR ID# _____

HEALTH HISTORY OF YOUR SIBLINGS

3. Do you have any **full** brothers or sisters? Please include any who have died. →

- Yes →
- No (go to **children form**)
- Don't know (go to **children form**)

Starting with your oldest full brother or sister...(EXCLUDE ADOPTED, STEP-, OR HALF-SIBLINGS.)

3a. How many **full brothers** do you have? _____

3b. How many **full sisters** do you have? _____

3c. Is your oldest sibling a brother or sister?	3e. When was he/she born?	3f. Is he/she a twin?	3g. Is he/she still living?	3h. If no, when did he/she pass away?	3i. Was he/she ever diagnosed with cancer?	3j. What type(s) of cancer did he/she have?	3k. How old was he/she when diagnosed with this cancer?
Sibling #1 <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know	_____/_____/_____ Date of birth OR _____ Current age (years)	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →	_____/_____/_____ Date of death OR _____ Age at death	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)	1 st _____ → 2 nd _____ → 3 rd _____ → 4 th _____ →	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis 3 rd ____ or ____ Age Yr of diagnosis 4 th ____ or ____ Age Yr of diagnosis
Sibling #2 <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know	_____/_____/_____ Date of birth OR _____ Current age (years)	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →	_____/_____/_____ Date of death OR _____ Age at death	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)	1 st _____ → 2 nd _____ → 3 rd _____ → 4 th _____ →	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis 3 rd ____ or ____ Age Yr of diagnosis 4 th ____ or ____ Age Yr of diagnosis

3. SIBLINGS CONTINUED...

3c. Is your next sibling a brother or sister?	3e. When was he/she born?	3f. Is he/she a twin?	3g. Is he/she still living?	3h. If no, when did he/she pass away?	3i. Was he/she ever diagnosed with cancer?	3j. What type(s) of cancer did he/she have?	3k. How old was he/she when diagnosed with this cancer?
<p>Sibling #3</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p style="text-align: center;">Name</p>	<p>____/____/____ Date of birth</p> <p style="text-align: center;">OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p style="text-align: center;">OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
<p>Sibling #4</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p style="text-align: center;">Name</p>	<p>____/____/____ Date of birth</p> <p style="text-align: center;">OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p style="text-align: center;">OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>

3. SIBLINGS CONTINUED...

3c. Is your next sibling a brother or sister?	3e. When was he/she born?	3f. Is he/she a twin?	3g. Is he/she still living?	3h. If no, when did he/she pass away?	3i. Was he/she ever diagnosed with cancer?	3j. What type(s) of cancer did he/she have?	3k. How old was he/she when diagnosed with this cancer?
<p>Sibling #5</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p>Name</p>	<p>____/____/____ Date of birth</p> <p>OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p>OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
<p>Sibling #6</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p>Name</p>	<p>____/____/____ Date of birth</p> <p>OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p>OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>

3. SIBLINGS CONTINUED...

3c. Is your next sibling a brother or sister?	3e. When was he/she born?	3f. Is he/she a twin?	3g. Is he/she still living?	3h. If no, when did he/she pass away?	3i. Was he/she ever diagnosed with cancer?	3j. What type(s) of cancer did he/she have?	3k. How old was he/she when diagnosed with this cancer?
Sibling #7 <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know <hr/> 3d. What is his/her first name? <hr/>	_____ Date of birth OR _____ Current age (years)	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →	_____ Date of death OR _____ Age at death	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)	1 st _____ → 2 nd _____ → 3 rd _____ → 4 th _____ →	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis 3 rd ____ or ____ Age Yr of diagnosis 4 th ____ or ____ Age Yr of diagnosis
Sibling #8 <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know <hr/> 3d. What is his/her first name? <hr/>	_____ Date of birth OR _____ Current age (years)	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →	_____ Date of death OR _____ Age at death	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)	1 st _____ → 2 nd _____ → 3 rd _____ → 4 th _____ →	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis 3 rd ____ or ____ Age Yr of diagnosis 4 th ____ or ____ Age Yr of diagnosis

3. SIBLINGS CONTINUED...

3c. Is your next sibling a brother or sister?	3e. When was he/she born?	3f. Is he/she a twin?	3g. Is he/she still living?	3h. If no, when did he/she pass away?	3i. Was he/she ever diagnosed with cancer?	3j. What type(s) of cancer did he/she have?	3k. How old was he/she when diagnosed with this cancer?
<p>Sibling #9</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p style="text-align: center;">Name</p>	<p>____/____/____ Date of birth</p> <p style="text-align: center;">OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p style="text-align: center;">OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
<p>Sibling #10</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p style="text-align: center;">Name</p>	<p>____/____/____ Date of birth</p> <p style="text-align: center;">OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p style="text-align: center;">OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>

3. SIBLINGS CONTINUED...

3c. Is your next sibling a brother or sister?	3e. When was he/she born?	3f. Is he/she a twin?	3g. Is he/she still living?	3h. If no, when did he/she pass away?	3i. Was he/she ever diagnosed with cancer?	3j. What type(s) of cancer did he/she have?	3k. How old was he/she when diagnosed with this cancer?
<p>Sibling #11</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p>Name</p>	<p>____/____/____ Date of birth</p> <p>OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p>OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
<p>Sibling #12</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p>Name</p>	<p>____/____/____ Date of birth</p> <p>OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p>OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>

3. SIBLINGS CONTINUED...

3c. Is your next sibling a brother or sister?	3e. When was he/she born?	3f. Is he/she a twin?	3g. Is he/she still living?	3h. If no, when did he/she pass away?	3i. Was he/she ever diagnosed with cancer?	3j. What type(s) of cancer did he/she have?	3k. How old was he/she when diagnosed with this cancer?
<p>Sibling #13</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p style="text-align: center;">Name</p>	<p>____/____/____ Date of birth</p> <p style="text-align: center;">OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p style="text-align: center;">OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
<p>Sibling #14</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p style="text-align: center;">Name</p>	<p>____/____/____ Date of birth</p> <p style="text-align: center;">OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p style="text-align: center;">OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>

3. SIBLINGS CONTINUED...

3c. Is your next sibling a brother or sister?	3e. When was he/she born?	3f. Is he/she a twin?	3g. Is he/she still living?	3h. If no, when did he/she pass away?	3i. Was he/she ever diagnosed with cancer?	3j. What type(s) of cancer did he/she have?	3k. How old was he/she when diagnosed with this cancer?
<p>Sibling #15</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p>Name</p>	<p>____/____/____ Date of birth</p> <p>OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p>OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
<p>Sibling #16</p> <p><input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Don't know</p> <p>3d. What is his/her first name?</p> <p>_____</p> <p>Name</p>	<p>____/____/____ Date of birth</p> <p>OR</p> <p>_____ Current age (years)</p>	<p><input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know →</p> <p>IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know</p> <p>First name of his/her twin _____</p>	<p><input type="checkbox"/> Yes (go to 3i) <input type="checkbox"/> No →</p>	<p>____/____/____ Date of death</p> <p>OR</p> <p>_____ Age at death</p>	<p><input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next sibling) <input type="checkbox"/> Don't know (go to next sibling)</p>	<p>1st _____ → 2nd _____ → 3rd _____ → 4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>

HEALTH HISTORY OF YOUR CHILDREN

4. Do you have any **children** who are 18 years or older? Please include any who have died. \longrightarrow

Starting with your oldest son or daughter...(EXCLUDE ADOPTED OR STEP-CHILDREN,)

- Yes \longrightarrow
- No (go to **extended family form**)
- Don't know (go to **extended family form**)

4a. How many **sons** do you have? _____

4b. How many **daughters** do you have? _____

4c. Is your first child a son or a daughter?	4e. When was he/she born?	4f. Is he/she a twin?	4g. Is he/she still living?	4h. If no, when did he/she pass away?	4i. Was he/she ever diagnosed with cancer?	4j. What type(s) of cancer did he/she have?	4k. How old was he/she when diagnosed with this cancer?
Child #1 <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	_____/_____/_____ Date of birth OR ____-____-_____ Current age (years)	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No \longrightarrow <input type="checkbox"/> Don't know \longrightarrow IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No \longrightarrow	_____/_____/_____ Date of death OR ____-____-_____ Age at death	<input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	1 st _____ \longrightarrow 2 nd _____ \longrightarrow 3 rd _____ \longrightarrow 4 th _____ \longrightarrow	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis 3 rd ____ or ____ Age Yr of diagnosis 4 th ____ or ____ Age Yr of diagnosis
Child #2 <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	_____/_____/_____ Date of birth OR ____-____-_____ Current age (years)	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No \longrightarrow <input type="checkbox"/> Don't know \longrightarrow IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No \longrightarrow	_____/_____/_____ Date of death OR ____-____-_____ Age at death	<input type="checkbox"/> Yes \longrightarrow <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	1 st _____ \longrightarrow 2 nd _____ \longrightarrow 3 rd _____ \longrightarrow 4 th _____ \longrightarrow	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis 3 rd ____ or ____ Age Yr of diagnosis 4 th ____ or ____ Age Yr of diagnosis

4. CHILDREN CONTINUED...

4c. Is your next child a son or a daughter?	4e. When was he/she born?	4f. Is he/she a twin?	4g. Is he/she still living?	4h. If no, when did he/she pass away?	4i. Was he/she ever diagnosed with cancer?	4j. What type(s) of cancer did he/she have?	4k. How old was he/she when diagnosed with this cancer?
<p>Child #3</p> <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	<p>____/____/____ Date of birth</p> <p>OR</p> <p>____-____-____ Current age (years)</p>	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No →	<p>____/____/____ Date of death</p> <p>OR</p> <p>____-____-____ Age at death</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	<p>1st _____ →</p> <p>2nd _____ →</p> <p>3rd _____ →</p> <p>4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
<p>4d. What is his/her first name?</p>							
<p>_____ Name</p>							
<p>Child #4</p> <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	<p>____/____/____ Date of birth</p> <p>OR</p> <p>____-____-____ Current age (years)</p>	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No →	<p>____/____/____ Date of death</p> <p>OR</p> <p>____-____-____ Age at death</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	<p>1st _____ →</p> <p>2nd _____ →</p> <p>3rd _____ →</p> <p>4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
<p>4d. What is his/her first name?</p>							
<p>_____ Name</p>							

4. CHILDREN CONTINUED...

4c. Is your next child a son or a daughter?	4e. When was he/she born?	4f. Is he/she a twin?	4g. Is he/she still living?	4h. If no, when did he/she pass away?	4i. Was he/she ever diagnosed with cancer?	4j. What type(s) of cancer did he/she have?	4k. How old was he/she when diagnosed with this cancer?
<p>Child #5</p> <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	<p>____/____/____ Date of birth</p> <p>OR</p> <p>____-____-____ Current age (years)</p>	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No →	<p>____/____/____ Date of death</p> <p>OR</p> <p>____-____-____ Age at death</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	<p>1st _____ →</p> <p>2nd _____ →</p> <p>3rd _____ →</p> <p>4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
4d. What is his/her first name?							
Name							
<p>Child #6</p> <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	<p>____/____/____ Date of birth</p> <p>OR</p> <p>____-____-____ Current age (years)</p>	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No →	<p>____/____/____ Date of death</p> <p>OR</p> <p>____-____-____ Age at death</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	<p>1st _____ →</p> <p>2nd _____ →</p> <p>3rd _____ →</p> <p>4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
4d. What is his/her first name?							
Name							

4. CHILDREN CONTINUED...

4c. Is your next child a son or a daughter?	4e. When was he/she born?	4f. Is he/she a twin?	4g. Is he/she still living?	4h. If no, when did he/she pass away?	4i. Was he/she ever diagnosed with cancer?	4j. What type(s) of cancer did he/she have?	4k. How old was he/she when diagnosed with this cancer?
Child #7 <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	____/____/____ Date of birth	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No →	____/____/____ Date of death	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	1 st ____ → 2 nd ____ → 3 rd ____ → 4 th ____ →	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis 3 rd ____ or ____ Age Yr of diagnosis 4 th ____ or ____ Age Yr of diagnosis
4d. What is his/her first name?	OR			OR			
_____ Name	_____ Current age (years)	First name of his/her twin _____		_____ Age at death			
Child #8 <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	____/____/____ Date of birth	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No →	____/____/____ Date of death	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	1 st ____ → 2 nd ____ → 3 rd ____ → 4 th ____ →	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis 3 rd ____ or ____ Age Yr of diagnosis 4 th ____ or ____ Age Yr of diagnosis
4d. What is his/her first name?	OR			OR			
_____ Name	_____ Current age (years)	First name of his/her twin _____		_____ Age at death			

4. CHILDREN CONTINUED...

4c. Is your next child a son or a daughter?	4e. When was he/she born?	4f. Is he/she a twin?	4g. Is he/she still living?	4h. If no, when did he/she pass away?	4i. Was he/she ever diagnosed with cancer?	4j. What type(s) of cancer did he/she have?	4k. How old was he/she when diagnosed with this cancer?
<p>Child #9</p> <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	<p>____/____/____ Date of birth</p> <p>OR</p> <p>____-____-____ Current age (years)</p>	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No →	<p>____/____/____ Date of death</p> <p>OR</p> <p>____-____-____ Age at death</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	<p>1st _____ →</p> <p>2nd _____ →</p> <p>3rd _____ →</p> <p>4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
4d. What is his/her first name?							
Name _____							
<p>Child #10</p> <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Don't know	<p>____/____/____ Date of birth</p> <p>OR</p> <p>____-____-____ Current age (years)</p>	<input type="checkbox"/> Yes (see below) <input type="checkbox"/> No → <input type="checkbox"/> Don't know → IF YES, what type? <input type="checkbox"/> Identical? (Monozygous) <input type="checkbox"/> Fraternal? (Dizygous) <input type="checkbox"/> Don't know First name of his/her twin _____	<input type="checkbox"/> Yes (go to 4i) <input type="checkbox"/> No →	<p>____/____/____ Date of death</p> <p>OR</p> <p>____-____-____ Age at death</p>	<input type="checkbox"/> Yes → <input type="checkbox"/> No (go to next child) <input type="checkbox"/> Don't know (go to next child)	<p>1st _____ →</p> <p>2nd _____ →</p> <p>3rd _____ →</p> <p>4th _____ →</p>	<p>1st ____ or ____ Age Yr of diagnosis</p> <p>2nd ____ or ____ Age Yr of diagnosis</p> <p>3rd ____ or ____ Age Yr of diagnosis</p> <p>4th ____ or ____ Age Yr of diagnosis</p>
4d. What is his/her first name?							
Name _____							

HEALTH HISTORY OF YOUR EXTENDED FAMILY

5. Do you have any grandparents, uncles, aunties, cousins, nieces, nephews, or grandchildren who have ever had cancer? → Yes (go to 5a)
 No (**stop**)
 Don't know (**stop**)

Please include only your **blood** relatives and also include any who have died.

5a. What is his/her first name?	5b. What is his/her relationship to you?	5c. What is his/her current age or birth year?	5d. Is he/she still living?	5e. If no, when did he/she pass away?	5f. What type(s) of cancer did he/she have?	5g. How old was he/she when diagnosed with this cancer?
Example: <u>Mary</u> Name	<u>Cousin, my mother's sister's daughter</u> relationship	___/___/___ Date of birth OR <u>068</u> Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input checked="" type="checkbox"/> No →	<u>09 / ? / 1988</u> Date of death OR ___ ___ ___ Age at death	1 st <u>Rectum</u> → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ___ or <u>1996</u> Age Yr of diagnosis 2 nd ___ or _____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)
Relative #1 _____ Name	_____ relationship	___/___/___ Date of birth OR ___ ___ ___ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	___/___/___ Date of death OR ___ ___ ___ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ___ or _____ Age Yr of diagnosis 2 nd ___ or _____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)
Relative #2 _____ Name	_____ relationship	___/___/___ Date of birth OR ___ ___ ___ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	___/___/___ Date of death OR ___ ___ ___ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ___ or _____ Age Yr of diagnosis 2 nd ___ or _____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)

FR ID# _____

5. EXTENDED FAMILY CONTINUED...

5a. What is his/her first name?	5b. What is his/her relationship to you?	5c. What is his/her current age or birth year?	5d. Is he/she still living?	5e. If no, when did he/she pass away?	5f. What type(s) of cancer did he/she have?	5g. How old was he/she when diagnosed with this cancer?
Relative #3 _____ Name	_____ relationship	____/____/____ Date of birth OR ____-____-____ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	____/____/____ Date of death OR ____-____-____ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ____ or _____ Age Yr of diagnosis 2 nd ____ or _____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)
Relative #4 _____ Name	_____ relationship	____/____/____ Date of birth OR ____-____-____ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	____/____/____ Date of death OR ____-____-____ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ____ or _____ Age Yr of diagnosis 2 nd ____ or _____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)
Relative #5 _____ Name	_____ relationship	____/____/____ Date of birth OR ____-____-____ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	____/____/____ Date of death OR ____-____-____ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ____ or _____ Age Yr of diagnosis 2 nd ____ or _____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)
Relative #6 _____ Name	_____ relationship	____/____/____ Date of birth OR ____-____-____ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	____/____/____ Date of death OR ____-____-____ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ____ or _____ Age Yr of diagnosis 2 nd ____ or _____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)

5. EXTENDED FAMILY CONTINUED...

5a. What is his/her first name?	5b. What is his/her relationship to you?	5c. What is his/her current age or birth year?	5d. Is he/she still living?	5e. If no, when did he/she pass away?	5f. What type(s) of cancer did he/she have?	5g. How old was he/she when diagnosed with this cancer?
Relative #7 _____ Name	_____ relationship	____/____/____ Date of birth OR ____-____-____ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	____/____/____ Date of death OR ____-____-____ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)
Relative #8 _____ Name	_____ relationship	____/____/____ Date of birth OR ____-____-____ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	____/____/____ Date of death OR ____-____-____ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)
Relative #9 _____ Name	_____ relationship	____/____/____ Date of birth OR ____-____-____ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	____/____/____ Date of death OR ____-____-____ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)
Relative #10 _____ Name	_____ relationship	____/____/____ Date of birth OR ____-____-____ Current Age (years)	<input type="checkbox"/> Yes (go to 5f) <input type="checkbox"/> No →	____/____/____ Date of death OR ____-____-____ Age at death	1 st _____ → 2 nd _____ → <input type="checkbox"/> Don't know (go to next relative)	1 st ____ or ____ Age Yr of diagnosis 2 nd ____ or ____ Age Yr of diagnosis <input type="checkbox"/> Don't know (go to next relative)

Thank you so much for taking the time to complete this form. The information that you have provided in your follow-up forms will help us to better understand the role that genetics and environment play in the development of cancer in Hawaii families. It is our hope that the information collected from individuals like yourself and others participating in Family Registry sites across the world can be used to help scientists develop better methods to detect and treat cancer.

THE HAWAII FAMILY REGISTRY