Ontario
Familial Colorectal Cancer Registry

Follow-up Questionnaire

We last heard from you when you completed a Follow-up Personal History Questionnaire (Follow-up PHQ) for this study about five years ago. We would now like to update some of the information you provided and ask some additional questions including your family history.

If you wish to talk to someone about this questionnaire, you may call (416) 217-1310 or 1-866-225-2728 or email OFCCR@cancercare.on.ca

FAMILY HISTORY SECTION

If you don't know an answer, please write "Don't know" or "DK" in the space for the answer.

If you are not sure of a date, please make the best guess you can, and put a question mark beside it.

If there is not enough space to list all your relatives, please write on the inside of the front cover, or the outside of the back cover.

Please list your parents, children, brothers and sisters on the following pages, referring to records or asking other family members for information when you need to.

Please answer any questions you can about your biological (blood) relatives, including any children you may have.

If you were adopted, please check this box: ☐

Please write in your answers where space is provided, or please insert the check mark inside the circle. ✓

I. Your Mother

1.a **Mother's Full name** (First/middle/last) _____

Date of birth (day/month/year) ____/_____/____ ***OR*** **Age** _____

Mother's Maiden name _____

Any previous married name(s) _____

1.b Is your mother alive?

- ○ no → *please provide details below*
- ○ don't know → *please go to question 1.c*
- ○ yes → *please go to question 1.c*

Cause of death | **Date of death** (day/month/year) | ***OR*** | **Age at death**

_____ ____/_____/____ _____

1.c Has your mother *ever* had any cancers or tumours?

Please list all cancers/tumours including any leukemia or lymphoma. If there was more than one cancer or tumour, please list them all. If the cancer started in one place and spread elsewhere, please indicate where it started.

- ○ no → *please go to question 2.a*
- ○ don't know → *please go to question 2.a*
- ○ yes → *please provide details below*

Type of cancer or tumour | **Date of diagnosis** (day/month/year) | ***OR*** | **Age at diagnosis**

_____ ____/_____/____ _____

_____ ____/_____/____ _____

_____ ____/_____/____ _____

II. Your Father

2.a **Father's Full name** (First/middle/last) _____

Date of birth (day/month/year) ____/_____/____ ***OR*** **Age** _____

2.b Is your father alive?

- ○ no → *please provide details below*
- ○ don't know → *please go to question 2.c*
- ○ yes → *please go to question 2.c*

Cause of death _____

Date of death (day/month/year) ____/_____/____ ***OR*** **Age at death** _____

2.c Has your father ever had any cancers or tumours?

Please list all cancers including any leukemia or lymphoma. If there was more than one cancer or tumour, please list them all. If the cancer started in one place and spread elsewhere, please indicate where it started.

- ○ no → *please go to question 3.a*
- ○ don't know → *please go to question 3.a*
- ○ yes → *please provide details below*

Type of cancer or tumour

Date of diagnosis (day/month/year) ____/_____/____ ***OR*** **Age at diagnosis** _____

_____ ____/_____/____ _____

_____ ____/_____/____ _____

III. Your Children

If you don't know an answer, please write "Don't know" or "DK" in the space for the answer.
If you are not sure of a date, please make your best guess and put a question mark beside it.

3.a How many children have you had? _____ *If none, please go to question 4.a*

- *Please list them all, living and deceased (write on the inside front cover or the outside of the back cover if necessary).*
- *If any have changed their last names, through marriage or otherwise, please list the last names they use now.*
- *If you adopted any of your children, please write "adopted" beside their names.*
- *If some of your children had different fathers or mothers, please note that fact beside their names.*

Full name (First/middle/last)	**Sex** (Circle)	**Date of birth** (day/month/year)	***OR***	**Age**
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____
_____	M F	___/___/____		_____

3.b Are all your children alive?

- ○ no → *please provide details below*
- ○ don't know → *please go to question 3.c*
- ○ yes → *please go to question 3.c*

Names of any children who have died	**Cause of death**	**Date of death** (day/month/year)	***OR***	**Age at death**
_____	_____	____/____/_____		_____
_____	_____	____/____/_____		_____
_____	_____	____/____/_____		_____
_____	_____	____/____/_____		_____

3.c Have any of your children *ever* had any cancers or tumours?
Please list all cancers including any leukemia or lymphoma. If there was more than one cancer or tumour, please list them all. If the cancer started in one place and spread elsewhere, please indicate where it started.

- ○ no → *please go to question 4.a*
- ○ don't know → *please go to question 4.a*
- ○ yes → *please provide details below.*

Names of any children who have had cancer	**Type of cancer or tumour**	**Date of diagnosis** (day/month/year)	***OR***	**Age at diagnosis**
_____	_____	____/____/_____		_____
_____	_____	____/____/_____		_____
_____	_____	____/____/_____		_____
_____	_____	____/____/_____		_____
_____	_____	____/____/_____		_____

IV. Your Brothers and Sisters

If you don't know an answer, please write "Don't know" or "DK" in the space for the answer. If you are not sure of a date, please make your best guess and put a question mark beside it.

4.a How many brothers and sisters do you have (living and deceased)? _____ *If none, please go to the Personal History Section, Page 8.*

- *Please list them all, living and deceased (write on the inside front cover or the outside of the back cover if necessary).*
- *If any have changed their last names, through marriage or otherwise, please list the last names they use now.*
- *If any of your brothers or sisters were adopted, please write "adopted" beside their names.*
- *If some are your half-brothers or half-sisters, please write "half-brother" or "half-sister" beside their names, and whether they had the same mother or same father as yourself.*
- *Please do not list any step-brothers or step-sisters (children from your step-mother's or step-father's previous marriage).*

Full name (First/middle/last)	**Sex** (Circle)	**Date of birth** (day/month/year)	***OR***	**Age**
_____	M F	_____/_____/_____		_____
_____	M F	_____/_____/_____		_____
_____	M F	_____/_____/_____		_____
_____	M F	_____/_____/_____		_____
_____	M F	_____/_____/_____		_____
_____	M F	_____/_____/_____		_____
_____	M F	_____/_____/_____		_____
_____	M F	_____/_____/_____		_____
_____	M F	_____/_____/_____		_____

4.b Are all your brothers and sisters alive?

- ○ no → *please provide details below*
- ○ don't know → *please go to question 4.c*
- ○ yes → *please go to question 4.c*

Names of any brothers and sisters who have died	**Cause of death**	**Date of death** (day/month/year)	***OR***	**Age at death**
_____	_____	____/____/____		_____
_____	_____	____/____/____		_____
_____	_____	____/____/____		_____
_____	_____	____/____/____		_____

4.c Have any of your brothers or sisters *ever* had any cancers or tumours?

Please list all cancers/tumours including any leukemia or lymphoma.
If anyone had more than one cancer or tumour, please list them all.
If the cancer started in one place and spread elsewhere, please indicate where it started.

- ○ no → *please go to Personal History Section, page 8*
- ○ don't know → *please go to Personal History Section, page 8*
- ○ yes → *please provide details below*

Names of any brothers or sisters who have had cancer	**Type of cancer or tumour**	**Date of diagnosis** (day/month/year)	***OR***	**Age at diagnosis**
_____	_____	____/_____/_____		_____
_____	_____	____/_____/_____		_____
_____	_____	____/_____/_____		_____

PERSONAL HISTORY SECTION

We last heard from you when you completed a ***Follow-up Personal History Questionnaire (follow-up PHQ)*** *for this study about five years ago. We would now like to update some of the information you already provided. We would also like to ask for some additional information.*

For the following sections please refer to the date you completed your follow-up PHQ wherever indicated. This date appears on the yellow sticker attached to the upper left corner of this questionnaire.

Please also complete the consent forms at the end of the questionnaire.

What date are you filling out this questionnaire?

__ __ _____ __ __ __ __
day month year

What is the date of your birth?

__ __ _____ __ __ __ __
day month year

I. Bowel Screening and Health

1. **A test for blood in your stool is called a smear test or a hemoccult test or fecal occult blood test (FOBT).** This test is done by using specially treated cards and frequently done as part of a routine physical examination. It is generally done at home using a kit. **Since you last completed the follow-up PHQ,** have you had a test for blood in your stool, called a smear test or a hemoccult test?
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

- ❍ yes
- ❍ no ⟶ *please go to question 2*
- ❍ don't know ⟶ *please go to question 2*

1.a **Since you last completed the follow-up PHQ**, how many times have you had this test?

___ ___ number of tests
❍ don't know

1.b When was **your most recent** test?

- ❍ age at **most recent** test: __ __ *or*
- ❍ year of **most recent** test: __ __ __ __ *or*
- ❍ I had the **most recent** test __ __ years ago
- ❍ don't know

1.c What were the reasons for **your most recent** test? (*Please tick all that apply)*

- ❍ to investigate a new problem
- ❍ family history of colorectal cancer
- ❍ routine exam or check-up
- ❍ follow-up of a previous problem
- ❍ other: _____
- ❍ don't know

2. A **barium enema (BE)** is an x-ray examination of your colon. In this procedure, a special solution, and usually air, is pumped into the colon or bowel through the rectum, so these organs can be seen on the x-ray.

Since you last completed the follow-up PHQ, have you had a **barium enema/x-ray test**?
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

- ❍ yes
- ❍ no ⟶ *please go to question 3*
- ❍ don't know ⟶ *please go to question 3*

2.a **Since you last completed the follow-up PHQ,** how many times have you had a barium enema?

_____ number of barium enemas
- ❍ don't know

2.b **Since you last completed the follow-up PHQ,** when did you have **your most recent** barium enema?

- ❍ age at **most recent** test: __ __ *or*
- ❍ year of **most recent** test: __ __ __ __ *or*
- ❍ I had the **most recent** test __ __ years ago
- ❍ don't know

2.c **Since you last completed the follow-up PHQ,** what were the reasons for **your most recent** barium enema? (*please tick all that apply)*

- ❍ to investigate a new problem
- ❍ family history of colorectal cancer
- ❍ routine exam or check-up
- ❍ follow-up of a previous problem
- ❍ follow-up of hemoccult or fecal occult blood test (FOBT)
- ❍ other: _____
- ❍ don't know

3. Endoscopy involves looking inside the bowel using a lighted instrument. There are two endoscopic procedures to examine the large bowel. A **sigmoidoscopy examines the lower bowel and rectum** and is usually done in a doctor's office. Preparation involves enemas and sometimes drinking fluid or taking pills to cleanse the bowel. In a ***colonoscopy, the entire large bowel is examined, using a long flexible instrument***. You are generally given medication to relax you or make you sleepy. In preparing for the colonoscopy, you may have an enema or taken ¼ to 1 gallon of liquid preparation, such as Golytely, Oral Fleets, Fleet PhospaSoda, Colyte, Magnesium Citrate or Klean-Prep the day before the procedure to completely empty your bowels.

Since you last completed the follow-up PHQ, have you had a **sigmoidoscopy**?
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

- ❍ yes
- ❍ no ⟶ *please go to question* 4
- ❍ don't know ⟶ *please go to question* 4

3.a **Since you last completed the follow-up PHQ**, how many times have you had a sigmoidoscopy?

_____ number of tests

❍ don't know

3.b **Since you last completed the follow-up PHQ**, when did you have **your most recent** sigmoidoscopy?

❍ age at **most recent** test: __ __ *or*

❍ year of **most recent** test: __ __ __ __ *or*

❍ I had the **most recent** test __ __ years ago

❍ don't know

3.c What were the reasons for **your most recent** sigmoidoscopy? (*Please tick all that apply)*

❍ to investigate a new problem

❍ family history of colorectal cancer

❍ routine exam or check-up

❍ follow-up of a previous problem

❍ follow-up of hemoccult or fecal occult blood test (FOBT)

❍ other: _____

❍ don't know

4. **Since you last completed the PHQ,** have you had a **colonoscopy**?

Please refer to the yellow sticker for the date when you completed the follow-up PHQ

❍ yes

❍ no ⟶ *please go to question* 5

❍ don't know ⟶ *please go to question* 5

4.a **Since you last completed the follow-up PHQ**, how many times have you had a colonoscopy?

_____ number of tests

❍ don't know

4.b **Since you last completed the follow-up PHQ**, when did you have **your most recent** colonoscopy?

❍ age at **most recent** test: __ __ *or*

❍ year of **most recent** test: __ __ __ __ *or*

❍ I had the **most recent** test __ __ years ago

❍ don't know

4.c What were the reasons for **your most recent** colonoscopy? (*Please tick all that apply)*

❍ to investigate a new problem

❍ family history of colorectal cancer

❍ routine exam or check-up

❍ follow-up of a previous problem

❍ follow-up of hemoccult or fecal occult blood test (FOBT)

❍ other: _____

❍ don't know

5. A **CT colonograph or virtual colonoscopy** is a procedure without sedation and is done using X-rays taken in a CT scanner. The exam takes 20-30 minutes usually. No scope is used. Instead the test is done with you laying on a table that slides through a large tunnel called a CT scanner. Preparation involves drinking fluids or taking pills to cleanse the bowel.
Since you last completed the follow-up PHQ, have you had a virtual colonoscopy or colonograph?
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

- ❍ yes
- ❍ no
- ❍ don't know

6. **Since you last completed the follow-up PHQ**, has a doctor told you that you had **polyps** in your large bowel or colon or rectum? *Please think about <u>all</u> polyps that were found in any of the procedures you had since you last completed the follow-up PHQ.*
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

- ❍ yes
- ❍ no ⟶ *please go to question 7*
- ❍ don't know ⟶ *please go to question 7*

6.a Were any of these polyps removed?

- ❍ yes
- ❍ no ⟶ *please go to question 7*
- ❍ don't know ⟶ *please go to question 7*

6.b On how many separate occasions were these polyps removed?

_____ number of times polyps were removed

- ❍ don't know

Please provide details of **ALL** polyp(s) that were removed ***since you last completed the follow-up PHQ***

Polyp(s) removed the **first time**	Polyp(s) removed the **second time**	Polyp(s) removed the **third time**	Polyp(s) removed the **fourth time**
age polyp removed ____ or year polyp removed ____ or polyp was removed _____ years ago	age polyp removed ____ or year polyp removed ____ or polyp was removed _____ years ago	age polyp removed ____ or year polyp removed ____ or polyp was removed _____ years ago	age polyp removed ____ or year polyp removed ____ or polyp was removed _____ years ago
	❍ no, polyp was not removed the second time	❍ no, polyp was not removed the third time	❍ no, polyp was not removed the fourth time
❍ don't know	❍ don't know	❍ don't know	❍ don't know

7. **Since you last completed the PHQ**, have you had any surgery to remove any part of your large bowel or colon? Please do **not** include any surgeries where **only polyp(s)** were removed.
Please refer to the yellow sticker for the date when you completed the follow-up PHQ.

- ❍ yes
- ❍ no ⟶ *please go to question* 8
- ❍ don't know ⟶ *please go to question* 8

7a. **Since you last completed the follow-up PHQ,** how many times have you had this surgery?

___ ___ number of times you had this surgery
❍ don't know

7b. **Since you last completed the follow-up PHQ (*please refer to the yellow sticker for the date of completing the PHQ),*** when was the

	First time you had this surgery?	**Second** time you had this surgery?
	age at surgery ____ or year of surgery _____ or I had surgery _____ years ago ❍ don't know	age at surgery ____ or year of surgery _____ or I had surgery _____ years ago ❍ don't know
Your colon was removed	❍ partially ❍ completely ❍ don't know	❍ partially ❍ completely ❍ don't know
Reason for this surgery was	❍ benign or malignant tumour ❍ diverticulitis ❍ inflammatory bowel disease, such as Ulcerative colitis or Crohn's disease ❍ other, specify_____ ❍ don't know	❍ benign or malignant tumour ❍ diverticulitis ❍ inflammatory bowel disease, such as Ulcerative colitis or Crohn's disease ❍ other, specify_____ ❍ don't know
Name of surgeon:		
Place of surgery: (Hospital/Clinic)		
Town/City:		
Province/State:		
Country:		
❍ don't know		

8. **Since you last completed the follow-up PHQ**, has a doctor told you that you had **any type of cancer**?
Please refer to the yellow sticker for the date when you completed the follow-up PHQ.

- ❍ yes
- ❍ no ⟶ *please go to question 9*
- ❍ don't know ⟶ *please go to question 9*

8a. What type of cancer was it?

_____Cancer

❍ don't know

Please provide details for ***ALL*** cancer(s) you may have had **since you last completed the follow-up PHQ.**

Type of cancer	**When was this cancer diagnosed?**	**Did you receive any chemotherapy and/or radiation therapy for this cancer?**
1. _____ _____ _____ _____	age at diagnosis ____ or year of diagnosis _____ or I was diagnosed ____years ago ❍ don't know	❍ yes, I received chemotherapy ❍ yes, I received radiation therapy ❍ yes, I received chemotherapy and radiation therapy ❍ no, I did not receive chemotherapy or radiation therapy ❍ don't know
2. _____ _____ _____ _____	age at diagnosis ____ or year of diagnosis _____ or I was diagnosed ____years ago ❍ no, did not have cancer the second time ❍ don't know	❍ yes, I received chemotherapy ❍ yes, I received radiation therapy ❍ yes, I received chemotherapy and radiation therapy ❍ no, I did not receive chemotherapy or radiation therapy ❍ don't know
3. _____ _____ _____ _____	age at diagnosis ____ or year of diagnosis _____ or I was diagnosed ____years ago ❍ no, did not have cancer the third time ❍ don't know	❍ yes, I received chemotherapy ❍ yes, I received radiation therapy ❍ yes, I received chemotherapy and radiation therapy ❍ no, I did not receive chemotherapy or radiation therapy ❍ don't know
4. _____ _____ _____ _____	age at diagnosis ____ or year of diagnosis _____ or I was diagnosed ____years ago ❍ no, did not have cancer the fourth time ❍ don't know	❍ yes, I received chemotherapy ❍ yes, I received radiation therapy ❍ yes, I received chemotherapy and radiation therapy ❍ no, I did not receive chemotherapy or radiation therapy ❍ don't know

II. Medications

9. Since you last completed the follow-up PHQ, have you ever taken any of the following medications regularly (at least twice a week for more than a month)?
please refer to the yellow sticker for date of completing the follow-up PHQ

Medication	Since you last completed the follow-up PHQ, have you taken this medication **regularly**, i.e. at least twice a week for more than a month? Please select only **one** for each medication	Since you last completed the follow-up PHQ, **how often** did you usually take it when you were taking it **regularly**, i.e. at least twice a week for more than a month? Please **do not leave blank** Please select only **one**	Since you last completed the follow-up PHQ, **how long in total** have you taken this medication **regularly**? *If you started and stopped and then started again, please count only the time you were taking this medication.* Please **do not leave blank** Please select only **one**
ASPIRIN (such as Anacin, Bufferin, Bayer, Excedrin, etc.)	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
ACETAMINOPHEN (such as Tylenol, Anacin-3, Panadol, etc.)	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
COX 2 Inhibitor NSAIDS (such as Celebrex, Vioxx, Mobicox)	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
CHOLESTEROL lowering drugs (statins such as Lipitor, Mevacor, Altocor or Pravachol or Crestor. Please include only prescription drugs)	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
POLYETHYLENE glycol laxative (such as MiraLax, GlycoLax or GoLYTELY, etc.)	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know

Medication	Since you last completed the follow-up PHQ, have you taken this medication **regularly**, i.e. at least twice a week for more than a month? Please select only **one** for each medication	Since you last completed the follow-up PHQ, **how often** did you usually take it when you were taking it **regularly**, i.e. at least twice a week for more than a month? Please **do not leave blank** Please select only **one**	Since you last completed the follow-up PHQ, **how long in total** have you taken this medication **regularly**? *If you started and stopped and then started again, please count only the time you were taking this medication.* Please **do not leave blank** Please select only **one**
Medications to control diabetes (pills or insulin)	❍ yes (please provide details) ⟶ ❍ no (please go to # 9a) ❍ don't know (please go to # 9a)	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Pills to control Diabetes	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Insulin injections	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Insulin pump	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know

9a. The next set of questions request information about some common vitamins and other supplements. **Since you last completed the follow up PHQ,** have you taken any of the following supplements regularly? (at least twice a week for more than a month)?
please refer to the yellow sticker for date when you completed the follow-up PHQ

Vitamins and other supplements	Since you last completed the follow-up PHQ, have you taken this medication **regularly**, i.e. at least twice a week for more than a month? Please select only **one** for each vitamin or supplement	Since you last completed the follow-up PHQ, **how often** did you usually take it when you were taking it **regularly**, i.e. at least twice a week for more than a month? Please **do not leave blank** Please select only **one**	Since you last completed the follow-up PHQ, **how long in total** have you taken this medication **regularly**? *If you started and stopped and then started again, please count only the time you were taking this medication.* Please **do not leave blank** Please select only **one**
Multivitamin supplements (such as One-A-Day, Centrum, Unicap) not individual vitamins	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Vitamin D only or in combination with calcium supplement (not part of mutivitamin)	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Cod liver oil	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Folic acid or folate pills or tablets	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Calcium pills or tablets (not part of multivitamin preparation)	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Calcium based antacids (such as Tums, Rolaids, Extra-strength Rolaids, Alkamints, Chooze antacid gums)	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know
Selenium pills	❍ yes (please provide details) ⟶ ❍ no ❍ don't know	_____ times per day *or* _____ times per week ❍ don't know	_____ No. of months *or* _____ No. of years ❍ don't know

Men: please go to question 12, page 19; Women: please continue below

III. Female Hormones and Surgery

10. Since you last completed the follow-up PHQ, have you taken **an estrogen pill or used a patch,** alone or in combination with another hormone continuously for at least 6 months?
Please do not include hormone therapy that was prescribed for birth control, infertility or hormonal therapy delivered by injections, vaginal creams or suppositories or herbal or soy products.
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

❍ yes, I used the pill or patch for _____ months _____ years
❍ no
❍ don't know

11. Since you last completed the follow-up PHQ, have you had **any surgery to remove your reproductive organs,** such as uterus (hysterectomy), and/or ovaries?
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

❍ yes
❍ no ⟶ *please go to question 12*
❍ don't know ⟶ *please go to question 12*

Since you last completed the follow-up PHQ,
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

When did you have surgery on your uterus and/or ovaries?	**What type of surgery did you have?**	**Where was this surgery performed?**
age at surgery _____ or year of surgery _____ or I had surgery_____ years ago ❍ don't know	❍ hysterectomy (only the uterus or womb was removed) ❍ hysterectomy with ovary or part of an ovary removed ❍ hysterectomy with both ovaries removed ❍ one ovary removed, completely or partly without hysterectomy ❍ both ovaries removed without hysterectomy ❍ other, specify _____ ❍ don't know	**Name of surgeon** _____ **Hospital/Clinic** _____ **Town/City** _____ **Province/State, Country** _____ , _____ ❍ don't know

IV. Sunlight Exposure

12. Please answer the following questions about your exposure to the sun **since you last completed the follow-up PHQ.** Please include all sun exposure **at work** and **in your leisure time.**
Please refer to the yellow sticker for the date when you completed the follow-up PHQ

	On a typical **weekday** in the summer, **(May–September)**, about how many hours per day did you spend outside in the sun? Please select **one**	On a typical **weekend (Saturday and Sunday)** in the summer, **(May–September)**, about how many hours per day did you spend outside in the sun? Please select **one**	When in the sun, did you wear **sunscreen or protective clothing** such as long sleeves, hats, etc.? Please select **one**	For each section below, please include all place(s) of residence where you have lived for **at least one year.**	
Sunlight Exposure	❍ less than 1 hour ❍ 1 to 2 hours ❍ 3 to 4 hours ❍ more than 4 hours ❍ don't know	❍ less than 1 hour ❍ 1 to 2 hours ❍ 3 to 4 hours ❍ more than 4 hours ❍ don't know	❍ never ❍ sometimes ❍ always ❍ don't know	City/ Country _____ _____ _____ _____	No. of years _____ _____ _____ _____

V. Health Issues

We would now like to know about your current health status.

13. In **general** would you say your health is
❍ excellent ❍ very good ❍ good ❍ fair ❍ poor

14. How much do you currently weigh?
_____pounds ***or***
_____kilograms
❍ don't know

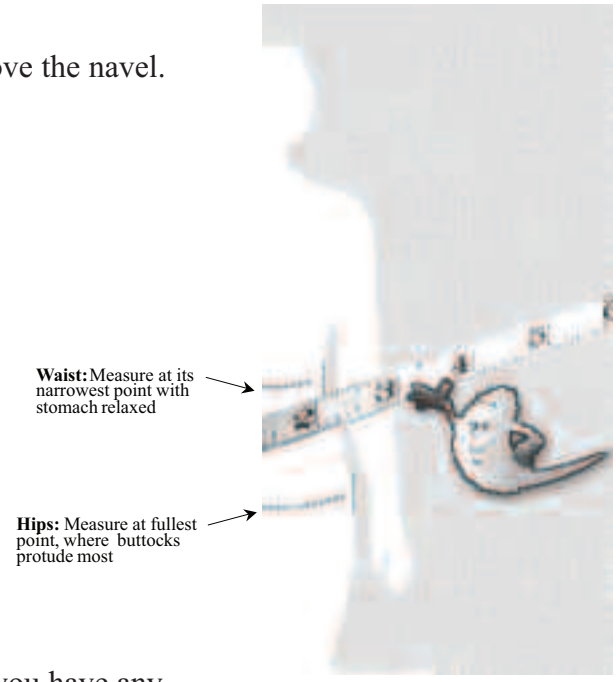
We would like to know your waist and hip measurements. Please take the tape measure provided with this questionnaire and wrap it around your waist and hips. It should be snug but not too tight.

15. Please measure your waist at the smallest point just above the navel.

_____ inches *or*
_____ centimetres

16. Please measure your hips at the widest point.

_____ inches *or*
_____ centimetres



17. Not counting your wisdom teeth, by the age of 16, did you have any permanent teeth that never formed at all, that is permanent teeth were missing?

- ❍ yes, some permanent teeth did not form by age 16
  - ❍ number of permanent teeth that failed to form by age 16 ____
  - ❍ don't know
- ❍ no, all my permanent teeth (except wisdom teeth) were formed by age of 16
- ❍ don't know

VI. Contact Information

18. From time to time we would like to tell you about the progress of the study. Please let us know if there are any changes to your name and address information.

Surname, First Name, Middle Initial: _____

Street#:_____

Town/City:_____

Province/State: _____

Postal Code/ZIP: _____

Country:_____

Tel. (Home): _____ (Work):_____ (Cell):_____

Email:_____

19. We would like to update your current marital status.

- ❍ currently married or living as married
- ❍ separated - *please go to question 21*
- ❍ divorced - *please go to question 21*
- ❍ widowed - *please go to question 21*
- ❍ single or never married - *please go to question 21*
- ❍ don't know - *please go to question 21*

20. If you are married, please provide the name of your spouse

_____	_____	_____	_____
Last Name	First Name	Middle Name	Maiden Name

21. In case we lose contact with you in the future (e.g. change of address/name/phone number etc.) and need to contact you, could we please have the name of someone who is not living with you to whom we might write or call for your new address?

Name of relative or friend:_____

Relationship (e.g. sister, friend) _____

Address _____

Town/City_____

Province/State_____

Country_____

Postal Code/ZIP_____

Tel. (Home):_____ (Work):_____ (Cell):_____

Email_____

If you had a sigmoidoscopy and/or colonoscopy in the last five years, please provide consent to access your sigmoidoscopy and/or colonoscopy records.

ONTARIO FAMILIAL COLORECTAL CANCER REGISTRY

CONSENT FOR ACCESS TO COLONOSCOPY AND/OR SIGMOIDOSCOPY REPORTS

The Ontario Familial Colorectal Cancer Registry has been developed so that researchers can learn more about the causes of colon and rectal cancer. As a participant in the registry, you have already provided valuable information about yourself and your family.

At this time we are asking permission to have access to the medical records related to your colonoscopy and sigmoidoscopy procedures. With your agreement, we will be recording such information as type of procedure, completeness of the procedure and details about the type of lesion you may have had. This would allow us, for example, to study these factors and how they relate to your family history. Please provide the date(s) and location(s) of any colonoscopy and/or sigmoidoscopy procedure(s).

By signing this form, you are granting permission to the Ontario Familial Colorectal Cancer Registry to access only your medical records that pertain to your procedure(s) listed below. No other medical records will be obtained. You are allowing us to review these records periodically without a time limit.

☐ I give permission to the Ontario Familial Colorectal Cancer Registry to review my medical records in this manner.

_____ _____ Birth Date: _ _ _ _ _ _ _ _ _ _ _ _

First name *Surname* *DD* *MMM* *YYYY*

I have had the colonoscopy and/or sigmoidoscopy procedures performed at the following clinics/hospitals.

	DATE OF PROCEDURE(S)	LOCATION(S) PROCEDURE(S) PERFORMED (Hospital, laboratory or doctor's office - list all places)
Colonoscopy(s)	_____	_____
	_____	_____
	_____	_____
Sigmoidoscopy(s)	_____	_____
	_____	_____

Signature:_____ Date:_____ OFCCR Id: _____
(To be completed by OFCCR)

Witness: _____ Date: _____

Witness Name: _____

☐ At this time I prefer to decline access to my medical records.

You will be receiving a copy of your signed consent form by mail.

OFCCR: 505 University Avenue, Suite 1800, Toronto, Ontario M5G 1X3
Tel: (416) 217-1310 or 1-866-225-2728 Fax: (416) 217-1339 Email: OFCCR@cancercare.on.ca

If you have had any polyps removed in the last five years, please provide permission to access the polyp records by signing the following form. With your agreement, we will be recording such information as type and size of polyp(s) and other details. This would allow us, for example, to study the nature of polyp(s) and how they relate to your family history.

ONTARIO FAMILIAL COLORECTAL CANCER REGISTRY

Authorization For Release of Medical Information/Tissue

I hereby authorize the Ontario Cancer Registry or the Medical Record and/or Pathology Department at the following locations to release information/tissue pertaining to the diagnosis listed below to Dr. Steven Gallinger, Principal Investigator, Ontario Familial Colorectal Cancer Registry, 505 University Ave.,Toronto, ON. M5G 1X3.

_____ _____ ***Date of birth*** __ ___ ____

First Name ***Surname*** ***DD MMM YYYY***

	Polyps removed for the first time	Polyps removed the second time	Polyps removed the third time	Polyps removed the next time
Name of Physician				
Hospital/Clinic				
City/Town, Province/State				
Country				

Signature :_____ Date:_____

Witness: _____ Date: _____

Witness Name: _____

Re: File # _____
(to be completed by OFCCR)

☐ At this time I prefer to decline access to my medical records.

NOTE: The authorization must contain the original signature of:
a) the patient, and b) the witness to the patient's signature.

You will be receiving a copy of your signed consent form by mail.

OFCCR: 505 University Avenue, Suite 1800, Toronto, Ontario M5G 1X3

Tel: (416) 217-1310 or 1-866-225-2728 Fax: (416) 217-1339 Email: OFCCR@cancercare.on.ca

WE GREATLY APPRECIATE YOUR PARTICIPATION AND THANK YOU FOR YOUR TIME AND EFFORT