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PHASE III RISK FACTOR QUESTIONNAIRE FOR COLORECTAL CANCER FAMILY REGISTRY UNIVERSITY OF SOUTHERN CALIFORNIA CONSORTIUM

Interviewer: _____

Date of Interview:

_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year
Start time: _____ am/pm	Start time: _____ am/pm	Start time: _____ am/pm
Stop time: _____ am/pm	Stop time: _____ am/pm	Stop time: _____ am/pm

Language:

ENGLISH

SPANISH

ARY: _____

Edited on: ____/____/____ Initials

Data entry 1: ____/____/____ Initials

Data entry 2: ____/____/____ Initials

A. PARTICIPANT INFORMATION

A1. Are you male or female?

[DOESN'T NEED TO BE ASKED UNLESS NOT SELF-EVIDENT.]

- MALE
 FEMALE

A2. What is your age?

|_|_|_| YEARS OF AGE

- DON'T KNOW

A3. What is your date of birth?

MONTH: |_|_|_| DON'T KNOW

DAY: |_|_|_| DON'T KNOW

YEAR: |_|_|_|_|_|_|_|_| DON'T KNOW

A4. Are you a twin or triplet, or other multiple birth sibling?

- YES, A TWIN →
- YES, OTHER MULTIPLE (TRIPLET, QUADRUPLLET, ETC.) →
- NO (GO TO A5)
- DON'T KNOW (GO TO A5)

A4a. Do you have a genetically identical sister or brother?

[PROBE: Non-identical twins, or fraternal twins, are no more alike than ordinary brothers and sisters. Genetically identical twins, on the other hand, look so much alike that close family members or teachers often mistake one for the other, especially during their childhood.]

- YES
 NO
 DON'T KNOW

A5. Are you...?

[READ ALL RESPONSES.]

- Currently married or living as married
 Separated
 Divorced
 Widowed
 Single or never married
 DON'T KNOW

B. MEDICAL HISTORY

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

MEDICAL TEST	TIME OF FIRST TEST	REASONS FOR FIRST TEST	NO. OF SEPARATE TESTS	TIME OF LAST TEST
<p>B1. Have you ever had a test for blood in your stool called a smear test or a Hemoccult™ (fecal occult)? <i>[PROBE: This test is frequently part of a routine physical exam and usually done at home.]</i></p> <p><input type="checkbox"/> YES → <input type="checkbox"/> NO (GO TO B2) <input type="checkbox"/> DON'T KNOW (GO TO B2)</p>	<p>B1a. When did you FIRST have this test?</p> <p>____ AGE OR ____ YEAR OR ____ years ago <input type="checkbox"/> DON'T KNOW</p>	<p>B1b. What were the reasons for your first test. . . ? (MARK ALL THAT APPLY)</p> <p><input type="checkbox"/> to investigate a new problem <input type="checkbox"/> family history of colorectal cancer <input type="checkbox"/> routine/yearly exam or checkup <input type="checkbox"/> follow-up of a previous problem <input type="checkbox"/> follow-up of fecal blood test (FOBT) <input type="checkbox"/> Other: _____ <input type="checkbox"/> DON'T KNOW</p>	<p>B1c. How many separate tests have you had?</p> <p>TOTAL NUMBER OF TESTS: ____ (IF 1, GO TO B2) <input type="checkbox"/> DON'T KNOW</p>	<p>B1d. When did you LAST have this test?</p> <p>____ AGE OR ____ YEAR OR ____ years ago <input type="checkbox"/> DON'T KNOW</p>

MEDICAL TEST	TIME OF FIRST TEST	REASONS FOR FIRST TEST	NO. OF SEPARATE TESTS	TIME OF LAST TEST
<p>Bb1. Have you ever had a barium enema? <i>[PROBE: A barium enema is an x-ray examination of your colon. In this procedure, an x-ray of the colon is taken following a barium enema. Preparation involves fluids, laxatives and an enema to cleanse the bowel.]</i></p> <p><input type="checkbox"/> YES → <input type="checkbox"/> NO (GO TO B2) <input type="checkbox"/> DON'T KNOW (GO TO B2)</p>	<p>Bb1a. When did you FIRST have a barium enema?</p> <p>____ AGE OR ____ YEAR OR ____ years ago <input type="checkbox"/> DON'T KNOW</p>	<p>Bb1b. What were the reasons for your first barium enema. . . ? (MARK ALL THAT APPLY)</p> <p><input type="checkbox"/> to investigate a new problem <input type="checkbox"/> family history of colorectal cancer <input type="checkbox"/> routine/yearly exam or checkup <input type="checkbox"/> follow-up of a previous problem <input type="checkbox"/> follow-up of fecal blood test (FOBT) <input type="checkbox"/> Other: _____ <input type="checkbox"/> DON'T KNOW</p>	<p>Bb1c. How many separate tests have you had?</p> <p>TOTAL NUMBER OF TESTS: ____ (IF 1, GO TO B2) <input type="checkbox"/> DON'T KNOW</p>	<p>Bb1d. When did you LAST have this test?</p> <p>____ AGE OR ____ YEAR OR ____ years ago <input type="checkbox"/> DON'T KNOW</p>

The next questions pertain to four medical procedures: sigmoidoscopy, colonoscopy, CT colonograph, and polypectomy. A sigmoidoscopy examines the lower part of the bowel and may be done in a doctor's office, whereas a colonoscopy examines the entire large bowel and is usually done under sedation by a specialist. A polypectomy is a procedure to remove a polyp. This procedure may be done during a sigmoidoscopy or colonoscopy, or during bowel surgery.

MEDICAL TEST	TIME OF FIRST TEST	REASONS FOR FIRST TEST	NO. OF SEPARATE TESTS	TIME OF LAST TEST
<p>B2. Have you ever had a sigmoidoscopy?</p> <p><i>[PROBE: Sigmoidoscopy involves looking inside the lower bowel and rectum with a lighted instrument. This examination is usually done in a doctor's office without sedation.]</i></p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO B3)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO B3)</p>	<p>B2a. When did you FIRST have this test?</p> <p>___ ___ AGE</p> <p>OR</p> <p>_____ ___ YEAR</p> <p>OR</p> <p>___ ___ YEARS AGO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B2b. What were the reasons for your first sigmoidoscopy. . . ? (MARK ALL THAT APPLY)</p> <p><input type="checkbox"/> to investigate a new problem</p> <p><input type="checkbox"/> family history of colorectal cancer</p> <p><input type="checkbox"/> routine/yearly exam or checkup</p> <p><input type="checkbox"/> follow-up of a previous problem</p> <p><input type="checkbox"/> follow-up of fecal blood test (FOBT)</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B2c. How many separate tests have you had?</p> <p>TOTAL NUMBER OF TESTS: ___ </p> <p>(IF 1, GO TO B3)</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B2d. When did you LAST have this test?</p> <p>___ ___ AGE</p> <p>OR</p> <p>_____ ___ YEAR</p> <p>OR</p> <p>___ ___ YEARS AGO</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B3. Have you ever had a colonoscopy?</p> <p><i>[PROBE: Colonoscopy is an examination of the entire large bowel using a long flexible instrument. This examination is usually done under sedation.]</i></p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO B4)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO B4)</p>	<p>B3a. When did you FIRST have this test?</p> <p>___ ___ AGE</p> <p>OR</p> <p>_____ ___ YEAR</p> <p>OR</p> <p>___ ___ YEARS AGO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B3b. What were the reasons for your first colonoscopy. . . ? (MARK ALL THAT APPLY)</p> <p><input type="checkbox"/> to investigate a new problem</p> <p><input type="checkbox"/> family history of colorectal cancer</p> <p><input type="checkbox"/> routine/yearly exam or checkup</p> <p><input type="checkbox"/> follow-up of a previous problem</p> <p><input type="checkbox"/> follow-up of fecal blood test (FOBT)</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B3c. How many separate tests have you had?</p> <p>TOTAL NUMBER OF TESTS: ___ </p> <p>(IF 1, GO TO B4)</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B3d. When did you LAST have this test?</p> <p>___ ___ AGE</p> <p>OR</p> <p>_____ ___ YEAR</p> <p>OR</p> <p>___ ___ YEARS AGO</p> <p><input type="checkbox"/> DON'T KNOW</p>

A CT colonograph or virtual colonoscopy is a procedure in which you are not given medication to relax you or make you sleep. It is done using x-rays with you lying on a table that is slid through a large circular scanner or a tunnel. Typically a tube is inserted to inflate the rectum with air. Preparation involves drinking fluids or taking pills to cleanse the bowel. Most often no recovery time is needed.

MEDICAL TEST	TIME OF FIRST TEST	REASONS FOR FIRST TEST	NO. OF SEPARATE TESTS	TIME OF LAST TEST
<p>Bb3. Have you ever had a virtual colonoscopy?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO B2)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO B2)</p>	<p>Bb3a. When did you FIRST have a virtual colonoscopy?</p> <p>___ ___ AGE</p> <p>OR</p> <p>_____ ___ YEAR</p> <p>OR</p> <p>___ ___ years ago</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>Bb3b. What were the reasons for your first virtual colonoscopy . . . ? (MARK ALL THAT APPLY)</p> <p><input type="checkbox"/> to investigate a new problem</p> <p><input type="checkbox"/> family history of colorectal cancer</p> <p><input type="checkbox"/> routine/yearly exam or checkup</p> <p><input type="checkbox"/> follow-up of a previous problem</p> <p><input type="checkbox"/> follow-up of fecal blood test (FOBT)</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>Bb3c. How many separate tests have you had?</p> <p>TOTAL NUMBER OF TESTS: ___ </p> <p>(IF 1, GO TO B2)</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>Bb3d. When did you LAST have this test?</p> <p>___ ___ AGE</p> <p>OR</p> <p>_____ ___ YEAR</p> <p>OR</p> <p>___ ___ years ago</p> <p><input type="checkbox"/> DON'T KNOW</p>

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

B4. Has a doctor ever told you that you had a polyp(s) in your large bowel or colon or rectum?

- YES →
- NO (GO TO B5)
- DON'T KNOW (GO TO B5)

B4a. When did your doctor FIRST tell you that you had a polyp?

- AGE: |_|_| OR DON'T KNOW
YEAR: |_|_|_|_| OR
YEARS AGO |_|_|

B4b. Have you been told that you had a polyp more than once?

- YES →
- NO (GO TO B4c)
- DON'T KNOW (GO TO B4c)

B4b(1). When did your doctor LAST tell you that you had a polyp?

- AGE: |_|_| OR
YEAR: |_|_|_|_| OR
YEARS AGO |_|_|
 DON'T KNOW

B4c. Do you know if your polyp(s) was benign, adenomatous (pre-cancerous), or something else?

[PROBE: Include all the separate episodes when you were told you had polyps.]
[PROBE: What did your doctor tell you about your polyp?]

(MARK ALL THAT APPLY)

- BENIGN
- ADENOMATOUS
- MALIGNANT
- OTHER: _____ (SPECIFY)
- DON'T KNOW

B4d. Did you have the polyp(s) removed (by a procedure called a polypectomy)?

[PROBE: This can be done during a sigmoidoscopy, a colonoscopy, or during bowel surgery.]

- YES →
- NO (GO TO B5)
- DON'T KNOW (GO TO B5)

B4d(1). When did you FIRST have the polyp(s) removed?

- AGE: |_|_| OR
YEAR: |_|_|_|_| OR
YEARS AGO |_|_|
 DON'T KNOW

B4d(2). Have you had a polyp removed more than once?


- YES
- NO (GO TO B5)
- DON'T KNOW (GO TO B5)

B4d(3). When did you LAST have a polyp(s) removed?

- AGE: |_|_| OR
YEAR: |_|_|_|_| OR
YEARS AGO |_|_|
 DON'T KNOW

Has a <u>doctor</u> ever told you that you had any of the following conditions. . .	If YES, when did your <u>doctor</u> FIRST tell you that you had. . .
<p>B5. Familial adenomatous polyposis or FAP?</p> <p><i>[PROBE: This is a condition, sometimes occurring in families, in which numerous polyps line the inside of the large bowel or colon.]</i></p> <p><input type="checkbox"/> YES _____ →</p> <p><input type="checkbox"/> NO (GO TO NEXT MEDICAL CONDITION)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MEDICAL CONDITION)</p>	<p>B5a. Familial adenomatous polyposis or FAP?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B6. Crohn's disease?</p> <p><i>[PROBE: This is an inflammation that extends into the deeper layers of the intestinal wall. It may also affect other parts of the digestive tract, including the mouth, esophagus, stomach and small intestine.]</i></p> <p><input type="checkbox"/> YES _____ →</p> <p><input type="checkbox"/> NO (GO TO NEXT MEDICAL CONDITION)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MEDICAL CONDITION)</p>	<p>B6a. Crohn's disease?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B7. Ulcerative colitis?</p> <p><i>[PROBE: This is an inflammation and ulceration of the lining of the bowel (colon and rectum). It is <u>not</u> a stomach ulcer.]</i></p> <p><input type="checkbox"/> YES _____ →</p> <p><input type="checkbox"/> NO (GO TO NEXT MEDICAL CONDITION)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MEDICAL CONDITION)</p>	<p>B7a. Ulcerative colitis?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B8. Irritable bowel syndrome or IBS?</p> <p><i>[PROBE: This is a disorder of the bowels leading to cramping, gassiness, bloating and alternating diarrhea and constipation.]</i></p> <p><input type="checkbox"/> YES _____ →</p> <p><input type="checkbox"/> NO (GO TO NEXT MEDICAL CONDITION)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MEDICAL CONDITION)</p>	<p>B8a. Irritable bowel syndrome or IBS?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B9. Diverticular disease?</p> <p><i>[PROBE: This may also be called diverticulosis or diverticulitis. It is a condition in which the bowel may become infected, and can lead to pain and chronic problems with bowel habits.]</i></p> <p><input type="checkbox"/> YES _____ →</p> <p><input type="checkbox"/> NO (GO TO B10)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO B10)</p>	<p>B9a. Diverticular disease?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>

B10. Have you ever had any of your large bowel or colon removed?

- YES 
- NO (GO TO B11)
- DON'T KNOW (GO TO B11)


B10a. Was it completely removed, or was only part of it removed?

- COMPLETELY REMOVED
- PARTLY REMOVED
- DON'T KNOW

B10b. When did you FIRST have any of your bowel or colon removed?

- AGE: |_|_| OR
- YEAR: |_|_|_|_| OR
- YEARS AGO |_|_|
- DON'T KNOW


B10c. Have you had more than one surgery to remove your bowel or colon?

- YES 
- NO (GO TO B11)
- DON'T KNOW (GO TO B11)

B10c(1). When did you LAST have this operation to remove all or part of your bowel or colon?

- AGE: |_|_| OR
- YEAR: |_|_|_|_| OR
- YEARS AGO |_|_|
- DON'T KNOW

B11. Have you had your gallbladder removed?

- YES 
- NO (GO TO B12)
- DON'T KNOW (GO TO B12)

B11a. When did you have your gallbladder removed?

- AGE: |_|_| OR
- YEAR: |_|_|_|_| OR
- YEARS AGO |_|_|
- DON'T KNOW

B12. Has a doctor ever told you that you had diabetes?

[PROBE: Do not include diabetes which you had only during pregnancy - gestational diabetes.]

- YES →
- NO (GO TO B13)
- DON'T KNOW (GO TO B13)

B12a. When did your doctor FIRST tell you that you had diabetes?

- AGE: **OR**
 YEAR: **OR**
 YEARS AGO
- DON'T KNOW

B12b. Did you ever take medication to control your diabetes?

- YES
- NO (GO TO B13 on NEXT PAGE)
- DON'T KNOW (GO TO B13 on NEXT PAGE)

What type of medication did you use . . . [medication]?	When you were taking this medication, how often did you take it?	[SKIP IF DX IS UNDER 2 YEARS] About TWO years ago [or ARY* _____] were you taking it?	How long, in total, have you taken this medication?
B12c(1) Pills? <input type="checkbox"/> YES → <input type="checkbox"/> NO (GO TO NEXT MED) <input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)	B12c(2) Pills? _____ TIMES <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	B12c(3) Pills? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	B12c(4) Pills? _____ NUMBER <input type="checkbox"/> MONTHS <input type="checkbox"/> YEARS <input type="checkbox"/> DON'T KNOW
B12d(1) Insulin injections? <input type="checkbox"/> YES → <input type="checkbox"/> NO (GO TO NEXT MED) <input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)	B12d(2) Insulin injections? _____ TIMES <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	B12d(3) Insulin injections? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	B12d(4) Insulin injections? _____ NUMBER <input type="checkbox"/> MONTHS <input type="checkbox"/> YEARS <input type="checkbox"/> DON'T KNOW
B12e(1) Insulin pump? <input type="checkbox"/> YES → <input type="checkbox"/> NO (GO TO B13) <input type="checkbox"/> DON'T KNOW (GO TO B13)	B12e(2) Insulin pump? _____ TIMES <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	B12e(3) Insulin pump? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	B12e(4) Insulin pump? _____ NUMBER <input type="checkbox"/> MONTHS <input type="checkbox"/> YEARS <input type="checkbox"/> DON'T KNOW

*ARY = Appropriate Reference Year

B13. Has a doctor ever told you that you had high cholesterol?

- YES →
- NO (GO TO B14)
- DON'T KNOW (GO TO B14)

B13a. When did your doctor FIRST tell you that you had high cholesterol?

- AGE: **OR**
 YEAR: **OR**
 YEARS AGO
 DON'T KNOW

B13b. Did you ever take medication to control your high cholesterol?

- YES
- NO (GO TO B14)
- DON'T KNOW (GO TO B14)

INCLUDE ALL MEDICATION FOR HIGH CHOLESTEROL	B13b(1) When you were taking medication for your high cholesterol, how often did you take it?	[SKIP IF DX IS UNDER 2 YEARS] B13b(2) About TWO years ago [or ARY _____] were you taking it?	B13b(3) How long, in total, have you taken this medication? [IF NECESSARY, CALCULATE TOTAL USE BY PROBING FOR START/STOP TIMES.]
	<p><u> </u> <input type="checkbox"/> PER DAY</p> <p><u> </u> <input type="checkbox"/> PER WEEK</p> <p><u> </u> <input type="checkbox"/> PER MONTH</p> <p><u> </u> <input type="checkbox"/> PER YEAR</p> <p><u> </u> <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><i>[PROBE: When did you first take medication? When did you stop? When did you resume taking medication...?]</i></p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p><u> </u> <input type="checkbox"/> MONTHS</p> <p><u> </u> <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>

B14. Has a doctor ever told you that you had high levels of triglycerides in your blood? These are other types of fats.

- YES →
- NO (GO TO B15)
- DON'T KNOW (GO TO B15)

B14a. When did your doctor FIRST tell you that you had high triglycerides?

AGE: **OR**

YEAR: **OR**

YEARS AGO

DON'T KNOW

B14b. Did you ever take medication to control your high triglycerides?

- YES
- NO (GO TO B15)
- DON'T KNOW (GO TO B15)

INCLUDE ALL MEDICATION FOR HIGH TRIGLYCERIDES	B14b(1) When you were taking medication for your high triglycerides, how often did you take it?	[SKIP IF DX IS UNDER 2 YEARS] B14b(2) About TWO years ago [or ARY_____] were you taking it?	B14b(3) How long, in total, have you taken this medication? [IF NECESSARY, CALCULATE TOTAL USE BY PROBING FOR START/STOP TIMES.]
	<p>_____ <input type="checkbox"/> PER DAY</p> <p><i>TIMES</i> <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="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p><i>[PROBE: When did you first take medication? When did you stop? When did you resume taking medication...?]</i></p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p><i>TOTAL NUMBER</i> <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>

B15. Has a doctor ever told you that you had any type of cancer? [PROBE (FOR PROBAND AND OTHER AFFECTED MEMBERS): This may seem obvious, but I have to ask this question of everyone.]

- YES
- NO (GO TO B15e)
- DON'T KNOW (GO TO B15e)

What type of cancer was it? (IF SKIN CANCER, PROBE FOR TYPE OF SKIN CANCER - MELANOMA v. NON-MELANOMA. EXCLUDE METASASES.)	When did your doctor FIRST tell you that you had this type of cancer?	Were you treated with chemotherapy?	Were you treated with radiation therapy or radiotherapy? [PROBE: This radiation may have been called cobalt therapy, radium therapy, radioisotope therapy or x-ray therapy. It could have been delivered in the form of implants, shots or irradiation by machine.]
B15a: 1st Cancer CANCER: _____ _____ 	B15a(1): 1st Cancer AGE OR YEAR: OR YEARS AGO <input type="checkbox"/> DON'T KNOW	BB15a(2): 1st Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	B15a(2): 1st Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
B15b: 2nd Cancer CANCER: _____ _____ 	B15b(1): 2nd Cancer AGE OR YEAR: OR YEARS AGO <input type="checkbox"/> DON'T KNOW	BB15b(2): 2st Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	B15b(2): 2nd Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
B15c: 3rd Cancer CANCER: _____ _____ 	B15c(1): 3rd Cancer AGE OR YEAR: OR YEARS AGO <input type="checkbox"/> DON'T KNOW	BB15c(2): 3rd Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	B15c(2): 3rd Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
B15d: 4th Cancer CANCER: _____ _____ 	B15d(1): 4th Cancer AGE OR YEAR: OR YEARS AGO <input type="checkbox"/> DON'T KNOW	BB15d(2): 4th Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	B15d(2): 4th Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW

[Prompt: Have you had any other type of cancer?]
[IF YES, GO TO NEXT CANCER. IF NO, GO TO B15e]

[Prompt: Have you had any other type of cancer?]
[IF YES, GO TO NEXT CANCER. IF NO, GO TO B15e]

[Prompt: Have you had any other type of cancer?]
[IF YES, GO TO NEXT CANCER. IF NO, GO TO B15e]

B15e. Have you ever had a bone marrow transplant?

- YES
- NO
- DON'T KNOW

B16. Now I'd like to ask you some questions about medications you may have taken. We are only interested in medications you took as an adult, not as a child.

(IF RESPONDENT GIVES NAME OF UNFAMILIAR MEDICATION, RECORD THE INFORMATION.)

Have you ever taken the following medication at least TWICE A WEEK FOR MORE THAN A MONTH?	When you were taking [medication] regularly, how often did you take it?	About TWO years ago [or ARY _____] were you taking it regularly?	How long, in total, have you taken [medication] regularly? [IF NECESSARY, CALCULATE TOTAL USE BY PROBING FOR START/STOP TIMES.]
<p>B16a(1) Aspirin, for example, Anacin, baby aspirin, Bufferin, Bayer, Excedrin, Ecotrin?</p> <p><input type="checkbox"/> YES _____ →</p> <p><input type="checkbox"/> NO (GO TO NEXT MED)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)</p> <p>RECORD OTHER MEDICATION(S):</p> <p>_____</p> <p>_____</p>	<p>B16a(2) Aspirin?</p> <p>_____ <input type="checkbox"/> PER DAY</p> <p>TIMES _____ <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>B16a(3) Aspirin?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16a(4) Aspirin?</p> <p><i>[PROBE: When did you first take medication? When did you stop? When did you resume taking medication...?]</i></p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>TOTAL NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B16b(1) Acetaminophen, for example, Tylenol, Anacin-3, Panadol?</p> <p><input type="checkbox"/> YES _____ →</p> <p><input type="checkbox"/> NO (GO TO NEXT MED)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)</p> <p>RECORD OTHER MEDICATION(S):</p> <p>_____</p>	<p>B16b(2) Acetaminophen?</p> <p>_____ <input type="checkbox"/> PER DAY</p> <p>TIMES _____ <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>B16b(3) Acetaminophen?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16b(4) Acetaminophen?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>TOTAL NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B16c(1) Ibuprofen based medication, for example, Advil, Motrin, Nuprin, Medipren or other NSAIDS? [PROBE: NSAIDS are non-steroidal anti-inflammatory drugs]</p> <p><input type="checkbox"/> YES _____ →</p> <p><input type="checkbox"/> NO (GO TO NEXT MED)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)</p> <p>RECORD OTHER MEDICATION(S):</p> <p>_____</p>	<p>B16c(2) Ibuprofen based medication?</p> <p>_____ <input type="checkbox"/> PER DAY</p> <p>TIMES _____ <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>B16c(3) Ibuprofen based medication?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16c(4) Ibuprofen based medication?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>TOTAL NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>

Have you ever taken the following medication at least TWICE A WEEK FOR MORE THAN A MONTH?	When you were taking [medication] regularly, how often did you take it?	About TWO years ago [or ARY _____] were you taking it regularly?	How long, in total, have you taken [medication] regularly? [IF NECESSARY, CALCULATE TOTAL USE BY PROBING FOR START/STOP TIMES.]
<p>B16d(1) Bulk-forming laxatives, for example, Metamucil, Citrucel, FiberCon, Serutan, psyllium?</p> <p><input type="checkbox"/> YES \longrightarrow</p> <p><input type="checkbox"/> NO (GO TO NEXT MED)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)</p> <p>RECORD OTHER MEDICATION(S): _____</p>	<p>B16d(2) Bulk-forming laxatives?</p> <p>_____ TIMES</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>B16d(3) Bulk-forming laxatives?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16d(4) Bulk-forming laxatives?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ MONTHS</p> <p>TOTAL NUMBER _____ YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B16e(1) Other laxatives, for example, Ex-Lax, Correctol, Dulcolax, Senokot, Colace, castor oil, cod liver oil, mineral oil, milk of magnesia, lactulose, Epsom salts?</p> <p><input type="checkbox"/> YES \longrightarrow</p> <p><input type="checkbox"/> NO (GO TO NEXT MED)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)</p> <p>RECORD OTHER MEDICATION(S): _____</p>	<p>B16e(2) Other laxatives?</p> <p>_____ TIMES</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>B16e(3) Other laxatives?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16e(4) Other laxatives?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ MONTHS</p> <p>TOTAL NUMBER _____ YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B16f(1) Multi-vitamin pills or tablets, not individual vitamins?</p> <p><input type="checkbox"/> YES \longrightarrow</p> <p><input type="checkbox"/> NO (GO TO NEXT MED)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)</p> <p>RECORD OTHER MEDICATION(S): _____</p>	<p>B16f(2) Multi-vitamin pills or tablets?</p> <p>_____ TIMES</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>B16f(3) Multi-vitamin pills or tablets?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16f(4) Multi-vitamin pills or tablets?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ MONTHS</p> <p>TOTAL NUMBER _____ YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B16g(1) Separate folic acid or folate pills?</p> <p><input type="checkbox"/> YES \longrightarrow</p> <p><input type="checkbox"/> NO (GO TO NEXT MED)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)</p> <p>RECORD OTHER MEDICATION(S): _____</p>	<p>B16g(2) Separate folic acid or folate pills?</p> <p>_____ TIMES</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>B16g(3) Separate folic acid or folate pills?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16g(4) Separate folic acid or folate pills?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ MONTHS</p> <p>TOTAL NUMBER _____ YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>

Have you ever taken the following medication at least TWICE A WEEK FOR MORE THAN A MONTH?	When you were taking [medication] regularly, how often did you take it?	About TWO years ago [or ARY _____] were you taking it regularly?	How long, in total, have you taken [medication] regularly? [IF NECESSARY, CALCULATE TOTAL USE BY PROBING FOR START/STOP TIMES.]
<p>B16h(1) Separate calcium pills or tablets, not including antacids?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO NEXT MED)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT MED)</p> <p>RECORD OTHER MEDICATION(S):</p> <p>_____</p>	<p>B16h(2) Calcium pills or tablets?</p> <p>_____ TIMES</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>B16h(3) Calcium pills or tablets?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16h(4) Calcium pills or tablets?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>TOTAL NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B16i(1) Calcium-based antacids, for example: Tums, Rolaids, Alka-Mints, Chooz Antacid gum?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p> <p>RECORD OTHER MEDICATION(S):</p> <p>_____</p>	<p>B16i(2) Calcium-based antacids?</p> <p>_____ TIMES</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>B16i(3) Calcium-based antacids?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16i(4) Calcium-based antacids?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>TOTAL NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>B16j(1) Celebrex, Celecoxib, Vioxx, Rofecoxib, Bextra, Valdecobix, also known as COX-2 Inhibitors?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p> <p>RECORD OTHER MEDICATION(S):</p> <p>_____</p>	<p>B16j(2) COX-2 Inhibitors?</p> <p>_____ TIMES</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>B16j(3) COX-2 Inhibitors?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>B16j(4) COX-2 Inhibitors?</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>START _____</p> <p>STOP _____</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>TOTAL NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>

FOR FEMALE RESPONDENTS:

Go to next section, SECTION C

FOR MALE RESPONDENTS:

Go to SECTION E

C. MENSTRUATION, REPRODUCTIVE HISTORY, MENOPAUSE

This next series of questions are about menstruation and pregnancy.

C1. How old were you when you had your FIRST menstrual period?

|_|_| YEARS OF AGE

DON'T KNOW

NEVER HAD A MENSTRUAL PERIOD

C2. Have you ever been pregnant?

YES

NO (GO TO C3)

DON'T KNOW (GO TO C3)

C2a. How many times have you been pregnant, including miscarriages, stillbirths, tubal pregnancies and abortions. If you are pregnant now, please exclude your current pregnancy.

|_|_| NUMBER OF PREGNANCIES

DON'T KNOW

CURRENTLY PREGNANT FOR THE FIRST TIME (GO TO C3)

C2b. How many times were you pregnant with more than one baby?
[PROBE: TWINS, TRIPLETS OR MORE.]

NEVER

|_|_| NUMBER OF PREGNANCIES WITH MULTIPLES

DON'T KNOW

C2c. How many of your pregnancies lasted 6 months or longer?

ALL OF THEM

|_|_| NUMBER OF PREGNANCIES

DON'T KNOW

C2d. How many of your pregnancies resulted in live births?

ALL OF THEM

|_|_| NUMBER OF PREGNANCIES

NONE (GO TO C3)

DON'T KNOW (GO TO C3)

C2d(1). How old were you at the FIRST live birth?

AGE: |_|_| OR

YEAR: |_|_|_|_| OR

YEARS AGO |_|_|

DON'T KNOW

[IF ONLY ONE PREGNANCY,
GO TO C3]

(IF MORE THAN ONE LIVE BIRTH)

C2d(2). How old were you at the LAST live birth?

AGE: |__| |__| OR

YEAR: |__| |__| |__| |__| OR

YEARS AGO |__| |__|

DON'T KNOW

C3. Have you ever used birth control pills or other hormonal contraceptives (implants, injections or Progestasert IUD) for at least one year?

- YES →
- NO (GO TO C4)
- DON'T KNOW (GO TO C4)

C3a. How old were you when you FIRST used any of these hormonal contraceptives?

AGE: |__| |__| OR

YEAR: |__| |__| |__| |__| OR

YEARS AGO |__| |__|

DON'T KNOW

→ [IF FIRST USE IS WITHIN THE LAST TWO YEARS, GO TO C3c.]

C3b. Were you using hormonal contraceptives about TWO years ago [or ANY _____]?

- YES
- NO
- DON'T KNOW

C3c. In total, how long did you take these hormonal contraceptives?

|__| |__| NUMBER OF YEARS

DON'T KNOW

C4. Have you had a menstrual period in the last 12 months? That is, a natural menstrual period, one that occurred when you were not taking hormonal contraceptives or hormone replacement therapy.

- YES
- NO →
- DON'T KNOW (GO TO C5)

C4a. Have your natural periods stopped permanently, or only temporarily due to pregnancy, breast-feeding or other conditions?

- PERMANENTLY →
- TEMPORARILY (GO TO C5)
- DON'T KNOW (GO TO C5)

C4a(1). How old were you when your periods stopped permanently?

AGE: |__| |__| OR

YEAR: |__| |__| |__| |__| OR

YEARS AGO |__| |__|

DON'T KNOW

C4a(2). Why did your menstrual periods stop permanently?

- NATURAL MENOPAUSE (GO TO C5)
- GYNECOLOGIC SURGERY (GO TO C5)
- RADIATION OR CHEMOTHERAPY
- OTHER _____ (SPECIFY)
- DON'T KNOW (GO TO C5)

C4a(2)a. When did you first have [RADIATION/CHEMOTHERAPY] that caused your periods to stop permanently?

AGE: |_|_| OR
 YEAR: |_|_|_|_| OR
 YEARS AGO |_|_|
 DON'T KNOW

C4a(2)b. When did you first have [OTHER] that caused your periods to stop permanently?

AGE: |_|_| OR
 YEAR: |_|_|_|_| OR
 YEARS AGO |_|_|
 DON'T KNOW

C5. Have you had any gynecologic surgery? [PROBE: Surgery on your uterus or ovaries]

- YES
- NO (GO TO C6)
- DON'T KNOW

Have you had. . . ? [READ ALL RESPONSES, MARKING ALL THAT APPLY]																										
<p>C5a. . . a hysterectomy. . .</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO C5b)</p>	<p>C5a(2) How old were you when you had [appropriate surgery]?</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%; text-align: left;">AGE</th> <th style="width: 10%; text-align: center;">OR</th> <th style="width: 25%; text-align: left;">YEAR</th> <th style="width: 10%; text-align: center;">OR</th> <th style="width: 30%; text-align: left;">YEARS AGO</th> </tr> </thead> <tbody> <tr> <td style="border: 1px solid black;"> _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ </td> </tr> <tr> <td style="border: 1px solid black;"> _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ </td> </tr> <tr> <td style="border: 1px solid black;"> _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ </td> </tr> <tr> <td style="border: 1px solid black;"> _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ </td> </tr> </tbody> </table> <p style="text-align: right; font-size: small;">(GO TO C5c)</p> <p style="text-align: right; font-size: small;">(GO TO C5c)</p>	AGE	OR	YEAR	OR	YEARS AGO	_ _		_ _ _ _		_ _	_ _		_ _ _ _		_ _	_ _		_ _ _ _		_ _	_ _		_ _ _ _		_ _
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_ _		_ _ _ _		_ _																						
<p>C5b. . . a partial or complete removal of one or both ovaries? [OTHER THAN ABOVE]</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO C5c)</p>	<p>C5b(2) How old were you when you had [appropriate surgery]?</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%; text-align: left;">AGE</th> <th style="width: 10%; text-align: center;">OR</th> <th style="width: 25%; text-align: left;">YEAR</th> <th style="width: 10%; text-align: center;">OR</th> <th style="width: 30%; text-align: left;">YEARS AGO</th> </tr> </thead> <tbody> <tr> <td style="border: 1px solid black;"> _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ </td> </tr> <tr> <td style="border: 1px solid black;"> _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ </td> </tr> </tbody> </table>	AGE	OR	YEAR	OR	YEARS AGO	_ _		_ _ _ _		_ _	_ _		_ _ _ _		_ _										
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_ _		_ _ _ _		_ _																						
_ _		_ _ _ _		_ _																						
<p>C5c. . . other gynecologic surgery?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO C6)</p>	<p>C5c(2) How old were you when you had [appropriate surgery]?</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%; text-align: left;">AGE</th> <th style="width: 10%; text-align: center;">OR</th> <th style="width: 25%; text-align: left;">YEAR</th> <th style="width: 10%; text-align: center;">OR</th> <th style="width: 30%; text-align: left;">YEARS AGO</th> </tr> </thead> <tbody> <tr> <td style="border: 1px solid black;"> _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ </td> </tr> <tr> <td style="border: 1px solid black;"> _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ _ _ </td> <td></td> <td style="border: 1px solid black;"> _ _ </td> </tr> </tbody> </table>	AGE	OR	YEAR	OR	YEARS AGO	_ _		_ _ _ _		_ _	_ _		_ _ _ _		_ _										
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_ _		_ _ _ _		_ _																						

Now I will be asking you about different kinds of hormone replacement and hormone-related therapies. We are not asking about hormones in vaginal suppositories, vaginal creams or injections.

C6. Have you ever used a pill or patch form of hormone replacement therapy, such as Prempro, Provera, Evista, Raloxifene or Tamoxifen? Doctors prescribe hormone replacement treatment for many reasons including menopausal symptoms, surgical removal of the ovaries, osteoporosis, heart disease prevention and cancer therapy.
 [PROBE: Menopausal symptoms include hot flashes, sweating and depression.]

[DO NOT INCLUDE: BIRTH CONTROL HORMONES OR HORMONE THERAPY DELIVERED BY INJECTIONS, VAGINAL CREAMS OR VAGINAL SUPPOSITORIES.]

- YES →
- NO (GO TO SECTION E)
- DON'T KNOW (GO TO C6b)

C6a. Were you still having menstrual periods when you FIRST took these hormones?

- YES
- NO
- DON'T KNOW

Were you ever prescribed . . .	How old were you when you first took . . .	[SKIP IF UNDER 2 YEARS] About TWO years ago [or ARY _____] were you taking . . .	In total, how long did you take . . .
<p>C6b . . . an <u>estrogen-only</u> pill or patch (such as Premarin) for 6 months or longer? This does not include combination pills such as Prempro.</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES → <input type="checkbox"/> NO (GO TO NEXT HORMONE) <input type="checkbox"/> DON'T KNOW (GO TO NEXT HORMONE) 	<p>C6b(1) . . . estrogen-only medication?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6b(2) . . . estrogen-only medication?</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW 	<p>C6b(3) . . . estrogen-only medication?</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>C6c . . . <u>progesterone</u> or <u>progestin along with estrogens</u> for 6 months or longer? Progesterone or progestin is frequently prescribed by doctors along with estrogen. Some common brands are Provera and Prempro.</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES → <input type="checkbox"/> NO (GO TO NEXT HORMONE) <input type="checkbox"/> DON'T KNOW (GO TO NEXT HORMONE) 	<p>C6c(1) . . . progesterone or progestin along with estrogens?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6c(2) . . . progesterone or progestin along with estrogens?</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW 	<p>C6c(3) . . . progesterone or progestin along with estrogens?</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>C6d . . . any fertility drugs in the form of shots or pills for 6 months or longer?</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES → <input type="checkbox"/> NO (GO TO NEXT HORMONE) <input type="checkbox"/> DON'T KNOW (GO TO NEXT HORMONE) 	<p>C6d(1) . . . any fertility drugs?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6d(2) . . . any fertility drugs</p> <ul style="list-style-type: none"> <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW 	<p>C6d(3) . . . any fertility drugs?</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>

Were you ever prescribed . . .	How old were you when you first took . . .	[SKIP IF UNDER 2 YEARS] About TWO years ago [or ARY _____] were you taking . . .	In total, how long did you take . . .
<p>C6e . . . Raloxifene, also called Evista, for 6 months or longer?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO NEXT HORMONE)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT HORMONE)</p>	<p>C6e(1) . . . Raloxifene?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6e(2) . . . Raloxifene?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6e(3) . . . Raloxifene?</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>C6f . . . Tamoxifen for 6 months or longer?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO NEXT HORMONE)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT HORMONE)</p>	<p>C6f(1) . . . Tamoxifen?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6f(2) . . . Tamoxifen?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6f(3) . . . Tamoxifen?</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>C6g . . . Lupron (leuprolide acetate) or Danacrine (Danazol) or any other “anti-estrogen” medication for 6 months or longer?</p> <p><i>[PROBE: These are drugs commonly used to treat endometriosis.]</i></p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO NEXT HORMONE)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT HORMONE)</p>	<p>C6g(1) . . . Lupron, Danazol or any other “anti-estrogen” medication?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6g(2) . . . Lupron, Danazol or any other “anti-estrogen” medication?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6g(3) . . . Lupron, Danazol or other “anti-estrogen” medication?</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>C6h . . . testosterone for 6 months or longer?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO NEXT HORMONE)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO NEXT HORMONE)</p>	<p>C6h(1) . . . testosterone?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6h(2) . . .testosterone?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6h(3) . . .testosterone?</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>C6i . . . any other hormone pills or patches for 6 months or longer? <i>[PROBE: Reasons for taking hormones include treating acne, ovarian cysts, various menstrual problems (excessive bleeding or painful periods) or pelvic pain.]</i></p> <p><i>[A HORMONE PILL OR PATCH USED ONCE A MONTH WILL BE COUNTED IF THE DURATION WAS AT LEAST 6 MONTHS. READ “OTHER REASONS” ONLY IF NECESSARY.]</i></p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6i(1) . . . any other hormone pills or patches?</p> <p>AGE: _ _ OR</p> <p>YEAR: _ _ _ _ OR</p> <p>YEARS AGO _ _ </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6i(2) . . . any other hormone pills or patches?</p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>C6i(3) . . . any other hormone pills or patches?</p> <p>_____ <input type="checkbox"/> MONTHS</p> <p>NUMBER <input type="checkbox"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p>

E. DIET

Next I am going to ask you some questions about your diet. About two years ago [or ARY _____], on average how often did you eat a serving or portion of . . .

[SERVING SIZES SHOULD BE READ IN EACH SECTION OF THE DIET.]

E1. . . fruit?

A serving of fruit is:

- 1 medium fresh fruit
- ½ cup chopped, cooked, canned fruit
- ¼ cup dried fruit
- 6 oz. fruit juice

[PROBE for type of juice:
Count juices only if they
are 50%-100% juice.]

PORTIONS OR SERVINGS	<input type="checkbox"/> PER DAY
	<input type="checkbox"/> PER WEEK
	<input type="checkbox"/> PER MONTH
<input type="checkbox"/> DON'T KNOW	
<input type="checkbox"/> DID NOT EAT FRUIT	

E2. . . vegetables?

A serving of vegetables is:

- 1 cup raw leafy vegetables
- ½ cup other vegetables cooked or
chopped raw
- 6 oz. vegetable juice (tomato juice, carrot juice)

[PROBE: Vegetables include
beans, legumes, potatoes
and green salad.]

PORTIONS OR SERVINGS	<input type="checkbox"/> PER DAY
	<input type="checkbox"/> PER WEEK
	<input type="checkbox"/> PER MONTH
<input type="checkbox"/> DON'T KNOW	
<input type="checkbox"/> DID NOT EAT VEGETABLES	

E3. . . red meat (not chicken or fish)?

A serving of red meat is: 2-3 oz.
red meat, a piece of meat about
the size of a deck of cards.

Red meats include beef, steak,
hamburger, prime rib, ribs, veal,
lamb, pork, bacon, pork
sausages or venison.

PORTIONS OR SERVINGS	<input type="checkbox"/> PER DAY
	<input type="checkbox"/> PER WEEK
	<input type="checkbox"/> PER MONTH

- DON'T KNOW
- DID NOT EAT RED MEAT
(GO TO E4)

E3a. About TWO years ago [ARY _____], on average, how many servings of red meat did you eat that were cooked by pan-frying, broiling, grilling or barbequing?

[PROBE: Do not include Southern barbequing which is baking
meat in a pit in the ground or in an oven.]

PORTIONS OR SERVINGS	<input type="checkbox"/> PER DAY
	<input type="checkbox"/> PER WEEK
	<input type="checkbox"/> PER MONTH

- DON'T KNOW
- DID NOT EAT RED MEAT THAT WAS COOKED BY THESE METHODS
(GO TO E4)

E3b. On average, when you ate red meat cooked by those methods, which of the following best describes its outside appearance? (READ ALL RESPONSES. MAY BE NECESSARY TO REPEAT METHODS OF COOKING.)

- Lightly Browned
- Medium Browned
- Heavily Browned / Blackened
- DON'T KNOW

E3c. On average, when you ate red meat cooked by pan-frying, broiling, grilling or barbequing, which of the following best describes its inside appearance or how well done it was? (READ ALL RESPONSES.)

- Red (rare)
- Pink (medium)
- Brown (well-done)
- DON'T KNOW

About two years ago [or ARY _____], on average how often did you eat a serving or portion of . . .

[SERVING SIZES SHOULD BE READ IN EACH SECTION OF THE DIET.]

E4. . . .chicken, turkey or other fowl?

A serving of chicken or other fowl is:

- 2-3 oz. meat
- 1 drumstick
- 1 thigh
- half a breast
- 2 wings
- 3 nuggets

Include fowl in mixed dishes, for example, casseroles.

_____ PER DAY
PORTIONS OR
SERVINGS PER WEEK
 PER MONTH

- DON'T KNOW
- DID NOT EAT CHICKEN OR OTHER FOWL (GO TO SECTION F)

E4a. About TWO years ago [ARY _____], on average, how many servings of chicken or other fowl did you eat that were cooked by pan-frying, broiling, grilling or barbequing?

_____ PER DAY
PORTIONS OR
SERVINGS PER WEEK
 PER MONTH

- DON'T KNOW
- DID NOT EAT CHICKEN OR OTHER FOWL THAT WAS COOKED BY THESE METHODS (GO TO SECTION F)

E4b. On average, when you ate chicken or other fowl cooked by those methods, which of the following best describes its outside appearance?

(READ ALL RESPONSES. MAY BE NECESSARY TO REPEAT METHODS OF COOKING.)

- Lightly Browned
- Medium Browned
- Heavily Browned / Blackened
- DON'T KNOW

F. PHYSICAL ACTIVITY

The next section contains questions about your participation in a variety of physical activities during three periods of your life. 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 at least 3 months in a row. I will be asking about your 20s, 30s and 40s, and since you turned 50. [REPEAT FOR 30s-40s AND 50+ FOR EACH ACTIVITY BEFORE GOING TO NEXT ACTIVITY. DO NOT INCLUDE JOB-RELATED PHYSICAL ACTIVITIES.]

	. . . when you were in your 20s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 30 . . . when you were in your 30s & 40s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 50 . . . since turning 50?
F1: Did you <u>walk</u> for at least 30 minutes a week for 3 months in a row . . .	F1a: walk <input type="checkbox"/> YES (IF YES, GO TO F1a(1)) <input type="checkbox"/> NO →	F1b: walk <input type="checkbox"/> YES (IF YES, GO TO F1b(1)) <input type="checkbox"/> NO →	F1c: walk <input type="checkbox"/> YES (IF YES, GO TO F1c(1)) <input type="checkbox"/> NO (GO TO F2)
	F1a(1). For how many years did you . . .[ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> YEARS <small>[MAXIMUM=10]</small> </div>	F1b(1). For how many years did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> YEARS <small>[MAXIMUM=20]</small> </div>	F1c(1). For how many years did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> YEARS </div>
	F1a(2). For how many months of the year? <div style="text-align: center;"> <input type="text"/> <input type="text"/> MONTHS PER YEAR </div>	F1b(2). For how many months of the year? <div style="text-align: center;"> <input type="text"/> <input type="text"/> MONTHS PER YEAR </div>	F1c(2). For how many months of the year? <div style="text-align: center;"> <input type="text"/> <input type="text"/> MONTHS PER YEAR </div>
	F1a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> HOURS PER WEEK </div>	F1b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> HOURS PER WEEK </div>	F1c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> HOURS PER WEEK </div>
F2: Did you <u>jog</u> for at least 30 minutes a week for 3 months in a row. . . Jogging is running slower than a mile in 10 minutes.	F2a: jog <input type="checkbox"/> YES (IF YES, GO TO F2a(1)) <input type="checkbox"/> NO →	F2b: jog <input type="checkbox"/> YES (IF YES, GO TO F2b(1)) <input type="checkbox"/> NO →	F2c: jog <input type="checkbox"/> YES (IF YES, GO TO F2c(1)) <input type="checkbox"/> NO (GO TO F3)
	F2a(1). For how many years did you . . .[ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> YEARS <small>[MAXIMUM=10]</small> </div>	F2b(1). For how many years did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> YEARS <small>[MAXIMUM=20]</small> </div>	F2c(1). For how many years did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> YEARS </div>
	F2a(2). For how many months of the year? <div style="text-align: center;"> <input type="text"/> <input type="text"/> MONTHS PER YEAR </div>	F2b(2). For how many months of the year? <div style="text-align: center;"> <input type="text"/> <input type="text"/> MONTHS PER YEAR </div>	F2c(2). For how many months of the year? <div style="text-align: center;"> <input type="text"/> <input type="text"/> MONTHS PER YEAR </div>
	F2a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> HOURS PER WEEK </div>	F2b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> HOURS PER WEEK </div>	F2c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? <div style="text-align: center;"> <input type="text"/> <input type="text"/> HOURS PER WEEK </div>

	... when you were in your 20s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 30 ... when you were in your 30s & 40s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 50 ... since turning 50?
<p>F3: Did you <u>run</u> for at least 30 minutes a week for 3 months in a row. . .</p> <p>By running we mean going faster than a mile in 10 minutes.</p>	<p>F3a: run</p> <p><input type="checkbox"/> YES (IF YES, GO TO F3a(1))</p> <p><input type="checkbox"/> NO →</p>	<p>F3b: run</p> <p><input type="checkbox"/> YES (IF YES, GO TO F3b(1))</p> <p><input type="checkbox"/> NO →</p>	<p>F3c: run</p> <p><input type="checkbox"/> YES (IF YES, GO TO F3c(1))</p> <p><input type="checkbox"/> NO (GO TO F4)</p>
	<p>F3a(1). For how many years did you . . .[ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=10</i>]</p> <p>F3a(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F3a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F3b(1). For how many years did you . . . [ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=20</i>]</p> <p>F3b(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F3b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F3c(1). For how many years did you . . . [ACTIVITY]?</p> <p> _ _ YEAHS</p> <p>F3c(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F3c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>
<p>F4: Did you <u>bicycle</u> for at least 30 minutes a week for 3 months in a row. . .</p> <p>This includes stationary bicycling.</p>	<p>F4a: bicycle</p> <p><input type="checkbox"/> YES (IF YES, GO TO F4a(1))</p> <p><input type="checkbox"/> NO →</p>	<p>F4b: bicycle</p> <p><input type="checkbox"/> YES (IF YES, GO TO F4b(1))</p> <p><input type="checkbox"/> NO →</p>	<p>F4c: bicycle</p> <p><input type="checkbox"/> YES (IF YES, GO TO F4c(1))</p> <p><input type="checkbox"/> NO (GO TO F5)</p>
	<p>F4a(1). For how many years did you . . .[ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=10</i>]</p> <p>F4a(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F4a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F4b(1). For how many years did you . . . [ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=20</i>]</p> <p>F4b(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F4b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F4c(1). For how many years did you . . . [ACTIVITY]?</p> <p> _ _ YEAHS</p> <p>F4c(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F4c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>

	... when you were in your 20s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 30 ... when you were in your 30s & 40s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 50 ... since turning 50?
F5: Did you <u>swim laps</u> for at least 30 minutes a week for 3 months in a row...	F5a: swim laps <input type="checkbox"/> YES (IF YES, GO TO F5a(1)) <input type="checkbox"/> NO →	F5b: swim laps <input type="checkbox"/> YES (IF YES, GO TO F5b(1)) <input type="checkbox"/> NO →	F5c: swim laps <input type="checkbox"/> YES (IF YES, GO TO F5c(1)) <input type="checkbox"/> NO (GO TO F6)
	F5a(1). For how many years did you ... [ACTIVITY]? _ _ YEARS <small>[MAXIMUM=10]</small>	F5b(1). For how many years did you ... [ACTIVITY]? _ _ YEARS <small>[MAXIMUM=20]</small>	F5c(1). For how many years did you ... [ACTIVITY]? _ _ YEARS
	F5a(2). For how many months of the year? _ _ MONTHS PER YEAR	F5b(2). For how many months of the year? _ _ MONTHS PER YEAR	F5c(2). For how many months of the year? _ _ MONTHS PER YEAR
F5a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]? _ _ HOURS PER WEEK	F5b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]? _ _ HOURS PER WEEK	F5c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]? _ _ HOURS PER WEEK	
F6: Did you play <u>tennis, racquetball or squash</u> for at least 30 minutes a week for 3 months in a row...	F6a: <input type="checkbox"/> YES (IF YES, GO TO F6a(1)) <input type="checkbox"/> NO →	F6b: <input type="checkbox"/> YES (IF YES, GO TO F6b(1)) <input type="checkbox"/> NO →	F6c: <input type="checkbox"/> YES (IF YES, GO TO F6c(1)) <input type="checkbox"/> NO (GO TO F7)
	F6a(1). For how many years did you ... [ACTIVITY]? _ _ YEARS <small>[MAXIMUM=10]</small>	F6b(1). For how many years did you ... [ACTIVITY]? _ _ YEARS <small>[MAXIMUM=20]</small>	F6c(1). For how many years did you ... [ACTIVITY]? _ _ YEARS
	F6a(2). For how many months of the year? _ _ MONTHS PER YEAR	F6b(2). For how many months of the year? _ _ MONTHS PER YEAR	F6c(2). For how many months of the year? _ _ MONTHS PER YEAR
F6a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]? _ _ HOURS PER WEEK	F6b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]? _ _ HOURS PER WEEK	F6c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]? _ _ HOURS PER WEEK	

	... when you were in your 20s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 30 ... when you were in your 30s & 40s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 50 ... since turning 50?
F7: Did you participate in <u>calisthenics, aerobics, vigorous dance, use a rowing machine or lift weights</u> for at least 30 minutes a week for 3 months in a row. . .	F7a: <input type="checkbox"/> YES (IF YES, GO TO F7a(1)) <input type="checkbox"/> NO →	F7b: <input type="checkbox"/> YES (IF YES, GO TO F7b(1)) <input type="checkbox"/> NO →	F7c: <input type="checkbox"/> YES (IF YES, GO TO F7c(1)) <input type="checkbox"/> NO (GO TO F8)
	F7a(1). For how many years did you . . .[ACTIVITY]? _ _ YEARS <small>[MAXIMUM=10]</small>	F7b(1). For how many years did you . . . [ACTIVITY]? _ _ YEARS <small>[MAXIMUM=20]</small>	F7c(1). For how many years did you . . . [ACTIVITY]? _ _ YEARS
	F7a(2). For how many months of the year? _ _ MONTHS PER YEAR	F7b(2). For how many months of the year? _ _ MONTHS PER YEAR	F7c(2). For how many months of the year? _ _ MONTHS PER YEAR
F7a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? _ _ HOURS PER WEEK	F7b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? _ _ HOURS PER WEEK	F7c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? _ _ HOURS PER WEEK	
F8: Did you play <u>football, soccer, rugby or basketball</u> for at least 30 minutes a week for 3 months in a row. . .	F8a: <input type="checkbox"/> YES (IF YES, GO TO F8a(1)) <input type="checkbox"/> NO →	F8b: <input type="checkbox"/> YES (IF YES, GO TO F8b(1)) <input type="checkbox"/> NO →	F8c: <input type="checkbox"/> YES (IF YES, GO TO F8c(1)) <input type="checkbox"/> NO (GO TO F9)
	F8a(1). For how many years did you . . .[ACTIVITY]? _ _ YEARS <small>[MAXIMUM=10]</small>	F8b(1). For how many years did you . . . [ACTIVITY]? _ _ YEARS <small>[MAXIMUM=20]</small>	F8c(1). For how many years did you . . . [ACTIVITY]? _ _ YEARS
	F8a(2). For how many months of the year? _ _ MONTHS PER YEAR	F8b(2). For how many months of the year? _ _ MONTHS PER YEAR	F8c(2). For how many months of the year? _ _ MONTHS PER YEAR
F8a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? _ _ HOURS PER WEEK	F8b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? _ _ HOURS PER WEEK	F8c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? _ _ HOURS PER WEEK	

	... when you were in your 20s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 30 ... when you were in your 30s & 40s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 50 ... since turning 50?
F9: Did you participate in any <u>other strenuous physical activities</u> for at least 30 minutes a week for 3 months in a row. . . Strenuous activity means something that increased your heart rate and caused you to sweat, such as skiing, skating, hockey, scuba diving, surfing and other activities. [RECORD EACH ACTIVITY SEPARATELY.] ACTIVITY 1: _____	F9a: <input type="checkbox"/> YES (IF YES, GO TO F9a(1)) <input type="checkbox"/> NO →	F9b: <input type="checkbox"/> YES (IF YES, GO TO F9b(1)) <input type="checkbox"/> NO →	F9c: <input type="checkbox"/> YES (IF YES, GO TO F9c(1)) <input type="checkbox"/> NO (GO TO F10)
	F9a(1). For how many years did you . . .[ACTIVITY]? __ __ YEARS <small>[MAXIMUM=10]</small>	F9b(1). For how many years did you . . . [ACTIVITY]? __ __ YEARS <small>[MAXIMUM=20]</small>	F9c(1). For how many years did you . . . [ACTIVITY]? __ __ YEARS
	F9a(2). For how many months of the year? __ __ MONTHS PER YEAR	F9b(2). For how many months of the year? __ __ MONTHS PER YEAR	F9c(2). For how many months of the year? __ __ MONTHS PER YEAR
	F9a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK	F9b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK	F9c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK
ACTIVITY 2: _____	F9a(1). For how many years did you . . .[ACTIVITY]? __ __ YEARS <small>[MAXIMUM=10]</small>	F9b(1). For how many years did you . . . [ACTIVITY]? __ __ YEARS <small>[MAXIMUM=20]</small>	F9c(1). For how many years did you . . . [ACTIVITY]? __ __ YEARS
	F9a(2). For how many months of the year? __ __ MONTHS PER YEAR	F9b(2). For how many months of the year? __ __ MONTHS PER YEAR	F9c(2). For how many months of the year? __ __ MONTHS PER YEAR
	F9a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK	F9b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK	F9c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK
ACTIVITY 3: _____	F9a(1). For how many years did you . . .[ACTIVITY]? __ __ YEARS <small>[MAXIMUM=10]</small>	F9b(1). For how many years did you . . . [ACTIVITY]? __ __ YEARS <small>[MAXIMUM=20]</small>	F9c(1). For how many years did you . . . [ACTIVITY]? __ __ YEARS
	F9a(2). For how many months of the year? __ __ MONTHS PER YEAR	F9b(2). For how many months of the year? __ __ MONTHS PER YEAR	F9c(2). For how many months of the year? __ __ MONTHS PER YEAR
	F9a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK	F9b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK	F9c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you . . . [ACTIVITY]? __ __ HOURS PER WEEK

	... when you were in your 20s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 30 ... when you were in your 30s & 40s?	<input type="checkbox"/> SKIP IF LESS THAN AGE 50 ... since turning 50?
ACTIVITY 4: _____	<p>F9a(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=10</i>]</p> <p>F9a(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F9a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F9b(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=20</i>]</p> <p>F9b(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F9b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F9c(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS</p> <p>F9c(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F9c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>
ACTIVITY 5: _____	<p>F9a(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=10</i>]</p> <p>F9a(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F9a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F9b(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=20</i>]</p> <p>F9b(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F9b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F9c(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS</p> <p>F9c(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F9c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>
<p>F10: Did you do any strenuous tasks in or around the house for at least 30 minutes a week for 3 months in a row. . .</p> <p>This would include activities such as mowing a lawn with a non-power mower, shoveling snow or dirt, or scrubbing floors vigorously.</p> <p>[RECORD ACTIVITIES COLLECTIVELY.]</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>F10a:</p> <p><input type="checkbox"/> YES (IF YES, GO TO F10a(1))</p> <p><input type="checkbox"/> NO →</p> <p>F10a(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=10</i>]</p> <p>F10a(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F10a(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F10b:</p> <p><input type="checkbox"/> YES (IF YES, GO TO F10b(1))</p> <p><input type="checkbox"/> NO →</p> <p>F10b(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS [<i>MAXIMUM=20</i>]</p> <p>F10b(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F10b(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>	<p>F10c:</p> <p><input type="checkbox"/> YES (IF YES, GO TO F10c(1))</p> <p><input type="checkbox"/> NO (GO TO F11)</p> <p>F10c(1). For how many years did you ... [ACTIVITY]?</p> <p> _ _ YEAHS</p> <p>F10c(2). For how many months of the year?</p> <p> _ _ MONTHS PER YEAR</p> <p>F10c(3). When you were participating in this exercise regularly, on average, how many <u>hours</u> per week did you ... [ACTIVITY]?</p> <p> _ _ HOURS PER WEEK</p>

What was your usual occupation. . .

[IF NO OCCUPATION.]
 [PROBE: "Usual" is the longest-held activity including any paid or unpaid employment, such as being a student, homemaker or unemployed.]

What industry did you work in . . .

F11a. . . when you were in your 20s?	SKIP IF LESS THAN AGE 30 F11b. . . when you were in your 30s & 40s?	SKIP IF LESS THAN AGE 50 F11c. . . since turning 50?
<hr/> <hr/> [TO BE CODED] <input type="checkbox"/> DON'T KNOW	<hr/> <hr/> [TO BE CODED] <input type="checkbox"/> DON'T KNOW	<hr/> <hr/> [TO BE CODED] <input type="checkbox"/> DON'T KNOW
F12a. . . when you were in your 20s?	F12b. . . when you were in your 30s & 40s?	F12c. . . since turning 50?
<hr/> <hr/> [TO BE CODED] <input type="checkbox"/> DON'T KNOW	<hr/> <hr/> [TO BE CODED] <input type="checkbox"/> DON'T KNOW	<hr/> <hr/> [TO BE CODED] <input type="checkbox"/> DON'T KNOW

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G. ALCOHOL CONSUMPTION

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

<p>Think back to the period when you were in your 20s.</p> <p>G1. During that time, did you ever consume any alcoholic beverages at least once a week for 6 months or longer? <i>[PROBE: Alcoholic beverages include beer, hard cider, wine, sake, liquor, spirits, mixed drinks or cocktails.]</i></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"/> NEVER (GO TO SECTION H)</p>	<p style="text-align: center;">SKIP IF LESS THAN AGE 30</p> <p style="text-align: center;"><input type="checkbox"/> LESS THAN AGE 30 (GO TO G1a)</p>	<p style="text-align: center;">SKIP IF LESS THAN AGE 50</p> <p style="text-align: center;"><input type="checkbox"/> LESS THAN AGE 50 (GO TO G1a)</p>
<p>G2. In your 30s and 40s, did you ever consume any alcoholic beverages at least once a week for 6 months or longer? <i>[PROBE: Alcoholic beverages include beer, hard cider, wine, sake, liquor, spirits, mixed drinks or cocktails.]</i></p> <p><input type="checkbox"/> YES _____→</p> <p><input type="checkbox"/> NO _____→</p> <p><input type="checkbox"/> DON'T KNOW _____→</p>	<p>G3. Since turning 50, have you ever consumed any alcoholic beverages at least once a week for 6 months or longer? <i>[PROBE: Alcoholic beverages include beer, hard cider, wine, sake, liquor, spirits, mixed drinks or cocktails.]</i></p> <p><input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DON'T KNOW</p>	
<p>IF RESPONDENT NEVER CONSUMED ANY ALCOHOLIC BEVERAGES AT LEAST ONCE A WEEK FOR 6 MONTHS OR LONGER, FILL IN "NO" FOR G2 AND G3 AND GO TO SECTION H.</p>		

Now I will ask about specific beverages you may have consumed. First, I will ask you about beer and hard cider. Then, I will ask about wine and sake. Finally, I will ask about liquor [spirits], mixed drinks or cocktails.
 [CONFIRM SIZES (OUNCES) FOR SERVICES OF EACH BEVERAGE.]

In your 20s

NEVER CONSUMED ANY ALCOHOLIC BEVERAGES AT LEAST ONCE A WEEK FOR 6 MONTHS OR LONGER (SKIP TO G2a)

	For how many years did you consume [BEVERAGE]?	During the years when you consumed [BEVERAGE], how many[*] did you typically consume?
<p>G1a: Did you ever consume <u>beer</u> or <u>hard cider</u> at least once a week for 6 months or longer?</p> <p>beer hard cider</p> <p><input type="checkbox"/> <input type="checkbox"/> YES →</p> <p><input type="checkbox"/> <input type="checkbox"/> NO (GO TO G1b)</p> <p><input type="checkbox"/> <input type="checkbox"/> DON'T KNOW (GO TO G1b)</p>	<p>G1a(1).</p> <p>beer __ __ YEARS [MAXIMUM=10]</p> <p>hard cider __ __ YEARS [MAXIMUM=10]</p>	<p>G1a(2).</p> <p>beer _____ *12 OZ. CANS/ BOTTLES</p> <p>hard cider _____ *12 OZ. CANS/ BOTTLES</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p>
<p>G1b: Did you ever consume <u>wine</u> or <u>sake</u> at least once a week for 6 months or longer?</p> <p>wine sake</p> <p><input type="checkbox"/> <input type="checkbox"/> YES →</p> <p><input type="checkbox"/> <input type="checkbox"/> NO (GO TO G1c)</p> <p><input type="checkbox"/> <input type="checkbox"/> DON'T KNOW (GO TO G1c)</p>	<p>G1b(1).</p> <p>wine __ __ YEARS [MAXIMUM=10]</p> <p>sake __ __ YEARS [MAXIMUM=10]</p>	<p>G1b(2).</p> <p>wine _____ *4 OZ. GLASS</p> <p>sake _____ *1 OZ. SERVING</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p>
<p>G1c: Did you ever consume <u>liquor</u> [<u>spirits</u>], <u>mixed drinks</u> or <u>cocktails</u> at least once a week for 6 months or longer?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO G2a)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO G2a)</p>	<p>G1c(1).</p> <p>liquor/ spirits __ __ YEARS [MAXIMUM=10]</p> <p>SPECIFY: _____ [TYPE OF LIQUOR]</p>	<p>G1c(2).</p> <p>liquor/ spirits _____ 1 OZ. SHOT</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p>
<p>[ASK ONLY IF YES TO G1 BUT NO TO SPECIFIC BEVERAGES.]</p> <p>You said that you consumed alcoholic beverages at least once a week in your 20s, although your consumption of specific beverages was less than once a week. So, thinking about your <u>total</u> consumption of alcoholic beverages in your 20s . . .</p>	<p>G1d(1):</p> <p>. . . how many years in total did you consume at least one alcoholic beverage a week?</p> <p>_____ YEARS [MAXIMUM=10]</p>	<p>G1d(2):</p> <p>How many alcoholic beverages a week did you typically consume during those years?</p> <p>_____ PER WEEK</p> <p>[IF MORE THAN 2, GO BACK TO G1a - G1c AND PROBE FOR SPECIFIC BEVERAGE.]</p>

In your 30s and 40s

NEVER CONSUMED ANY ALCOHOLIC BEVERAGES AT LEAST ONCE A WEEK FOR 6 MONTHS OR LONGER **OR** LESS THAN AGE 30 (SKIP TO G3a)

	For how many years did you consume [BEVERAGE]?	During the years when you consumed [BEVERAGE], how many[*] did you typically consume?
<p>G2a: Did you ever consume <u>beer</u> or <u>hard cider</u> at least once a week for 6 months or longer?</p> <p>beer hard cider</p> <p><input type="checkbox"/> <input type="checkbox"/> YES →</p> <p><input type="checkbox"/> <input type="checkbox"/> NO (GO TO G2b)</p> <p><input type="checkbox"/> <input type="checkbox"/> DON'T KNOW (GO TO G2b)</p>	<p>G2a(1).</p> <p>beer _ _ YEARS [MAXIMUM=20]</p> <p>hard cider _ _ YEARS [MAXIMUM=20]</p>	<p>G2a(2).</p> <p>beer _____ *12 OZ. CANS/ BOTTLES</p> <p>hard cider _____ *12 OZ. CANS/ BOTTLES</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p>
<p>G2b: Did you ever consume <u>wine</u> or <u>sake</u> at least once a week for 6 months or longer?</p> <p>wine sake</p> <p><input type="checkbox"/> <input type="checkbox"/> YES →</p> <p><input type="checkbox"/> <input type="checkbox"/> NO (GO TO G2c)</p> <p><input type="checkbox"/> <input type="checkbox"/> DON'T KNOW (GO TO G2c)</p>	<p>G2b(1).</p> <p>wine _ _ YEARS [MAXIMUM=20]</p> <p>sake _ _ YEARS [MAXIMUM=20]</p>	<p>G2b(2).</p> <p>wine _____ *4 OZ. GLASS</p> <p>sake _____ *1 OZ. SERVING</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p>
<p>G2c: Did you ever consume <u>liquor</u> [<u>spirits</u>], <u>mixed drinks</u> or <u>cocktails</u> at least once a week for 6 months or longer?</p> <p><input type="checkbox"/> YES →</p> <p><input type="checkbox"/> NO (GO TO G3a)</p> <p><input type="checkbox"/> DON'T KNOW (GO TO G3a)</p>	<p>G2c(1).</p> <p>liquor/ _ _ YEARS spirits [MAXIMUM=20]</p> <p>SPECIFY: _____ [TYPE OF LIQUOR]</p>	<p>G2c(2).</p> <p>liquor/ _____ spirits 1 OZ. SHOT</p> <p><input type="checkbox"/> PER DAY <input type="checkbox"/> PER WEEK <input type="checkbox"/> DON'T KNOW</p>
<p>[ASK ONLY IF YES TO G2 BUT NO TO SPECIFIC BEVERAGES.]</p> <p>You said that you consumed alcoholic beverages at least once a week in your 30s and 40s, although your consumption of specific beverages was less than once a week. So, thinking about your <u>total</u> consumption of alcoholic beverages in your 30s and 40s . . .</p>	<p>G2d(1):</p> <p>. . . how many years in total did you consume at least one alcoholic beverage a week?</p> <p> _ _ YEARS [MAXIMUM=20]</p>	<p>G2d(2):</p> <p>How many alcoholic beverages a week did you typically consume during those years?</p> <p> _ _ PER WEEK</p> <p>[IF MORE THAN 2, GO BACK TO G2a - G2c AND PROBE FOR SPECIFIC BEVERAGE.]</p>

Since you turned 50

NEVER CONSUMED ANY ALCOHOLIC BEVERAGES AT LEAST ONCE A WEEK FOR 6 MONTHS OR LONGER **OR** LESS THAN AGE 50 (SKIP TO H1)

	For how many years did you consume [BEVERAGE]?	During the years when you consumed [BEVERAGE], how many[*] did you typically consume?
<p>G3a: Did you ever consume <u>beer</u> or <u>hard cider</u> at least once a week for 6 months or longer?</p> <p>beer hard cider</p> <p><input type="checkbox"/> <input type="checkbox"/> YES →</p> <p><input type="checkbox"/> <input type="checkbox"/> NO (GO TO G3b)</p> <p><input type="checkbox"/> <input type="checkbox"/> DON'T KNOW (GO TO G3b)</p>	<p>G3a(1).</p> <p>beer __ __ YEARS</p> <p>hard cider __ __ YEARS</p>	<p>G3a(2).</p> <p>beer _____</p> <p style="font-size: 0.8em;">*12 OZ. CANS/ BOTTLES</p> <p><input type="checkbox"/> PER DAY</p> <p><input type="checkbox"/> PER WEEK</p> <p><input type="checkbox"/> DON'T KNOW</p> <p>hard cider _____</p> <p style="font-size: 0.8em;">*12 OZ. CANS/ BOTTLES</p> <p><input type="checkbox"/> PER DAY</p> <p><input type="checkbox"/> PER WEEK</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>G3b: Did you ever consume <u>wine</u> or <u>sake</u> at least once a week for 6 months or longer?</p> <p>wine sake</p> <p><input type="checkbox"/> <input type="checkbox"/> YES →</p> <p><input type="checkbox"/> <input type="checkbox"/> NO (GO TO G3c)</p> <p><input type="checkbox"/> <input type="checkbox"/> DON'T KNOW (GO TO G3c)</p>	<p>G3b(1).</p> <p>wine __ __ YEARS</p> <p>sake __ __ YEARS</p>	<p>G3b(2).</p> <p>wine _____</p> <p style="font-size: 0.8em;">*4 OZ. GLASS</p> <p><input type="checkbox"/> PER DAY</p> <p><input type="checkbox"/> PER WEEK</p> <p><input type="checkbox"/> DON'T KNOW</p> <p>sake _____</p> <p style="font-size: 0.8em;">*1 OZ. SERVING</p> <p><input type="checkbox"/> PER DAY</p> <p><input type="checkbox"/> PER WEEK</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>G3c: Did you ever consume <u>liquor</u> [<u>spirits</u>], <u>mixed drinks</u> or <u>cocktails</u> at least once a week for 6 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>G3c(1).</p> <p>liquor/ __ __ YEARS</p> <p>spirits</p> <p>SPECIFY: _____</p> <p style="font-size: 0.8em;">[TYPE OF LIQUOR]</p>	<p>G3c(2).</p> <p>liquor/ _____</p> <p>spirits 1 OZ. SHOT</p> <p><input type="checkbox"/> PER DAY</p> <p><input type="checkbox"/> PER WEEK</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>[ASK ONLY IF YES TO G3 BUT NO TO SPECIFIC BEVERAGES.]</p> <p>You said that you consumed alcoholic beverages at least once a week since you turned 50, although your consumption of specific beverages was less than once a week. So, thinking about your <u>total</u> consumption of alcoholic beverages since you turned 50 . . .</p>	<p>G3d(1):</p> <p>. . . how many years in total did you consume at least one alcoholic beverage a week?</p> <p style="text-align: center;"> __ __ YEARS</p>	<p>G3d(2):</p> <p>How many alcoholic beverages a week did you typically consume during those years?</p> <p style="text-align: center;"> __ __ PER WEEK</p> <p>[IF MORE THAN 2, GO BACK TO G3a - G3c AND PROBE FOR SPECIFIC BEVERAGE.]</p>

H. SMOKING

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

H1. Have you ever smoked at least one cigarette a day for 3 months or longer?

- YES →
 NO (GO TO H2)
 DON'T KNOW (GO TO H2)

H1a. When did you FIRST start smoking at least one cigarette a day for three months or longer?

AGE: |_|_| OR
YEAR: |_|_|_|_| OR
YEARS AGO |_|_| DON'T KNOW

H1b. During periods when you smoked regularly, how many cigarettes did you typically smoke in a day?

[PROBE: "Regularly" means at least one cigarette a day.]
[20 cigarettes is the most common size of packs.]

|_|_|_| CIGARETTES PER DAY DON'T KNOW

H1c. Do you currently smoke at least one cigarette a day?

- YES (GO TO H1d)
 NO →
 DON'T KNOW →

H1c(1) When did you permanently stop smoking at least 1 cigarette a day?

AGE: |_|_| OR
YEAR: |_|_|_|_| OR
YEARS AGO |_|_|
 DON'T KNOW

IF MORE THAN 2 YEARS AGO,
[or ARY_____] SKIP TO H1e.

H1d. About TWO years ago [ARY____], were you smoking at least one cigarette a day?

- YES
 NO
 DON'T KNOW

H1e. Did you ever stop and restart smoking cigarettes for 3 months or longer during periods when you smoked regularly?

- YES →
 NO (GO TO H1f)
 DON'T KNOW
(GO TO H1f)


H1e(1): How long in total did you stop smoking?

TOTAL MONTHS
 YEARS

H1f. How many years in total did you smoke at least one cigarette per day for 3 months or longer?

|_|_| YEARS


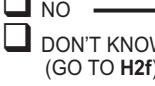
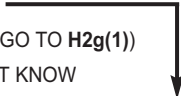
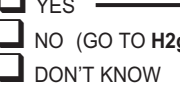
H2. Have you ever smoked at least one cigar or one pipe per month for at least 3 months?

- YES 
 NO (GO TO SECTION I)
 DON'T KNOW (GO TO SECTION I)

H2a. Did you smoke cigars or pipes or both?

- CIGARS
 PIPES
 BOTH

[IF BOTH, ITERATE QXS BELOW ONCE FOR CIGARS, ONCE FOR PIPES]

	CIGARS	PIPES
H2b. When did you first start smoking at least one [CIGAR OR PIPE] a month?	H2b(1): AGE: _ _ OR YEAR: _ _ _ OR YEARS AGO _ _ <input type="checkbox"/> DON'T KNOW	H2b(2): AGE: _ _ OR YEAR: _ _ _ OR YEARS AGO _ _ <input type="checkbox"/> DON'T KNOW
H2c. During periods when you smoked regularly, how many [CIGARS OR PIPES] did you typically smoke in a month? <i>[PROBE: "Regularly" means at least one cigar or pipe a month.]</i>	H2c(1): _ _ _ CIGARS/MONTH <input type="checkbox"/> DON'T KNOW	H2c(2): _ _ _ PIPES/MONTH <input type="checkbox"/> DON'T KNOW
H2d. About TWO years ago [ARY _____] were you smoking at least one [CIGAR OR PIPE] a month?	H2d(1): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW	H2d(2): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW
H2e. Do you still smoke at least one [CIGAR OR PIPE] a month?	H2e(1): <input type="checkbox"/> YES (GO TO H2f) <input type="checkbox"/> NO  <input type="checkbox"/> DON'T KNOW (GO TO H2f)	H2e(2): <input type="checkbox"/> YES (GO TO H2f) <input type="checkbox"/> NO  <input type="checkbox"/> DON'T KNOW (GO TO H2f)
	H2e(1)a. When did you permanently stop smoking at least one cigar a month? AGE: _ _ OR YEAR: _ _ _ OR YEARS AGO _ _ <input type="checkbox"/> DON'T KNOW	H2e(2)a. When did you permanently stop smoking at least one pipe a month? AGE: _ _ OR YEAR: _ _ _ OR YEARS AGO _ _ <input type="checkbox"/> DON'T KNOW
H2f. Did you ever stop and restart smoking [CIGARS OR PIPES] for 3 months or longer during periods you smoked regularly?	H2f(1): <input type="checkbox"/> YES  <input type="checkbox"/> NO (GO TO H2g(1)) <input type="checkbox"/> DON'T KNOW	H2f(2): <input type="checkbox"/> YES  <input type="checkbox"/> NO (GO TO H2g(2)) <input type="checkbox"/> DON'T KNOW
	H2f(1)a: How long in total did you stop smoking? _____ TOTAL <input type="checkbox"/> MONTHS <input type="checkbox"/> YEARS	H2f(2)a: How long in total did you stop smoking? _____ TOTAL <input type="checkbox"/> MONTHS <input type="checkbox"/> YEARS
H2g. How many years in total did you smoke at least one [CIGAR OR PIPE] a month for 3 months or longer?	H2g(1): _ _ YEARS	H2g(2): _ _ YEARS

I. HEIGHT AND WEIGHT

The last set of questions are to gather some background information about you.

I1. About how tall are you without your shoes on?

|_| FEET |_| INCHES OR |_|_| CENTIMETERS

DON'T KNOW

I2. How much did you weigh about TWO years ago [or ANY ___]?

|_|_| POUNDS OR |_|_| KILOS

DON'T KNOW

I3. How much did you weigh when you were about 20 years old?

|_|_| POUNDS OR |_|_| KILOS

DON'T KNOW

J. DEMOGRAPHICS AND BACKGROUND INFORMATION

J1. What is the highest level of education you completed? [USE LIST AS PROBES.]

- Less than 8 years
- 8 to 11 years
- High school graduate
- Vocational or technical school
- Some college or university
- Bachelor's degree
- Some graduate school
- Graduate Degree
- DON'T KNOW

J2. Now I'd like to ask some information about you, your parents and your grandparents. For each, I'll be asking about country of birth, race and ethnicity. Scientists have found that diseases often occur in different patterns for people of different backgrounds. We would like to know if this is true for colorectal cancer.

Family Member		Racial or Ethnic Background
<p>First I'd like to ask about <u>you</u>.</p> <p>J2a. In which country were you born?</p> <p>_____</p> <p><small>COUNTRY</small> <input style="width: 40px;" type="text"/></p>	<p>J2a(1). How many years have you lived in the U.S.?</p> <p><input type="checkbox"/> ALL MY LIFE</p> <p><input style="width: 40px;" type="text"/> YEARS</p> <p><input type="checkbox"/> DON'T KNOW</p> <p><input type="checkbox"/> NEVER</p>	<p>J2b-1. Do you consider yourself to be Hispanic or Latino?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DON'T KNOW / REFUSED</p> <p>J2b-2. Which of the following most closely describes your race or ethnicity? [READ ALL RESPONSES AND MARK ALL THAT APPLY.]</p> <p><input type="checkbox"/> African-American/Black <input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Asian (SPECIFY) _____ <input type="checkbox"/> DON'T KNOW</p> <p><input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> OTHER</p> <p><input type="checkbox"/> Native American <small>SPECIFY RACE OR ETHNICITY</small> <input style="width: 40px;" type="text"/></p>
<p>Next I'm going to ask about your <u>mother</u>.</p> <p>J3a. In which country was she born?</p> <p>_____</p> <p><small>COUNTRY</small> <input style="width: 40px;" type="text"/></p> <p><input type="checkbox"/> DON'T KNOW</p>		<p>J3b. Which of the following most closely describes her race or ethnicity? [READ ALL RESPONSES AND MARK ALL THAT APPLY.]</p> <p><input type="checkbox"/> African-American/Black <input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Asian (SPECIFY) _____ <input type="checkbox"/> DON'T KNOW</p> <p><input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> OTHER</p> <p><input type="checkbox"/> Native American <small>SPECIFY RACE OR ETHNICITY</small> <input style="width: 40px;" type="text"/></p>
<p>Next I'm going to ask about your <u>father</u>.</p> <p>J4a. In which country was he born?</p> <p>_____</p> <p><small>COUNTRY</small> <input style="width: 40px;" type="text"/></p> <p><input type="checkbox"/> DON'T KNOW</p>		<p>J4b. Which of the following most closely describes his race or ethnicity? [READ ALL RESPONSES AND MARK ALL THAT APPLY.]</p> <p><input type="checkbox"/> African-American/Black <input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Asian (SPECIFY) _____ <input type="checkbox"/> DON'T KNOW</p> <p><input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> OTHER</p> <p><input type="checkbox"/> Native American <small>SPECIFY RACE OR ETHNICITY</small> <input style="width: 40px;" type="text"/></p>

Family Member	Racial or Ethnic Background	Country of Ancestors
<p>Now, I'm going to ask you about your mother's mother, your maternal grandmother.</p> <p>J5a. In which country was she born?</p> <p>_____</p> <p>COUNTRY </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>J5b. Which of the following most closely describes her race or ethnicity? [READ ALL RESPONSES AND MARK ALL THAT APPLY.]</p> <p><input type="checkbox"/> African-American/Black <input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Asian (SPECIFY) <input type="checkbox"/> DON'T KNOW</p> <p>_____ <input type="checkbox"/> OTHER</p> <p><input type="checkbox"/> Hispanic/Latino _____</p> <p><input type="checkbox"/> Native American SPECIFY RACE OR ETHNICITY</p> <p>_____ </p>	<p>J5c. What countries were her ancestors from?</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>Now, I'm going to ask you about your mother's father, your maternal grandfather.</p> <p>J6a. In which country was he born?</p> <p>_____</p> <p>COUNTRY </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>J6b. Which of the following most closely describes his race or ethnicity? [READ ALL RESPONSES AND MARK ALL THAT APPLY.]</p> <p><input type="checkbox"/> African-American/Black <input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Asian (SPECIFY) <input type="checkbox"/> DON'T KNOW</p> <p>_____ <input type="checkbox"/> OTHER</p> <p><input type="checkbox"/> Hispanic/Latino _____</p> <p><input type="checkbox"/> Native American SPECIFY RACE OR ETHNICITY</p> <p>_____ </p>	<p>J6c. What countries were his ancestors from?</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>Now, I'm going to ask you about your father's mother, your paternal grandmother.</p> <p>J7a. In which country was she born?</p> <p>_____</p> <p>COUNTRY </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>J7b. Which of the following most closely describes her race or ethnicity? [READ ALL RESPONSES AND MARK ALL THAT APPLY.]</p> <p><input type="checkbox"/> African-American/Black <input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Asian (SPECIFY) <input type="checkbox"/> DON'T KNOW</p> <p>_____ <input type="checkbox"/> OTHER</p> <p><input type="checkbox"/> Hispanic/Latino _____</p> <p><input type="checkbox"/> Native American SPECIFY RACE OR ETHNICITY</p> <p>_____ </p>	<p>J7c. What countries were her ancestors from?</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> DON'T KNOW</p>
<p>Now, I'm going to ask you about your father's father, your paternal grandfather.</p> <p>J8a. In which country was he born?</p> <p>_____</p> <p>COUNTRY </p> <p><input type="checkbox"/> DON'T KNOW</p>	<p>J8b. Which of the following most closely describes his race or ethnicity? [READ ALL RESPONSES AND MARK ALL THAT APPLY.]</p> <p><input type="checkbox"/> African-American/Black <input type="checkbox"/> White or Caucasian</p> <p><input type="checkbox"/> Asian (SPECIFY) <input type="checkbox"/> DON'T KNOW</p> <p>_____ <input type="checkbox"/> OTHER</p> <p><input type="checkbox"/> Hispanic/Latino _____</p> <p><input type="checkbox"/> Native American SPECIFY RACE OR ETHNICITY</p> <p>_____ </p>	<p>J8c. What countries were his ancestors from?</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> DON'T KNOW</p>

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

J9. Are you, your parents or grandparents of Jewish descent?

- YES
- NO (GO TO J10)
- DON'T KNOW (GO TO J10)

<p>J9a. Which of these family members are of Jewish descent?</p> <p><input type="checkbox"/> ALL OF THEM OR</p> <p><input type="checkbox"/> SELF</p> <p><input type="checkbox"/> MOTHER</p> <p><input type="checkbox"/> FATHER</p> <p><input type="checkbox"/> MOTHER'S MOTHER</p> <p><input type="checkbox"/> MOTHER'S FATHER</p> <p><input type="checkbox"/> FATHER'S MOTHER</p> <p><input type="checkbox"/> FATHER'S FATHER</p>	<p>J9b. [IF JEWISH] . . . was he/she . . . ?</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Ashkenazi</th> <th style="text-align: left; border-bottom: 1px solid black;">Sephardic</th> <th style="text-align: left; border-bottom: 1px solid black;">Other (SPECIFY)</th> <th style="text-align: left; border-bottom: 1px solid black;">DON'T KNOW</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> ALL ASHKENAZI</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> ALL SEPHARDIC</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> _____</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> </tr> <tr> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> _____</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> </tr> <tr> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> _____</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> </tr> <tr> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> _____</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> </tr> <tr> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/> _____</td> <td style="border-bottom: 1px solid black;"><input type="checkbox"/></td> </tr> </tbody> </table>	Ashkenazi	Sephardic	Other (SPECIFY)	DON'T KNOW	<input type="checkbox"/> ALL ASHKENAZI	<input type="checkbox"/> ALL SEPHARDIC	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____	<input type="checkbox"/>																						

J10. Have you or your family participated in other research studies of familial cancer, or ever attended a genetic counseling session relating to cancer?

- YES
- NO (GO TO J11)
- DON'T KNOW (GO TO J11)

J10a. Please specify study or session:

_____ (SPECIFY)

Scientists have found that diseases are sometimes more or less prevalent for people of different income levels. We would like to know if this is true for colorectal cancer.

J11. As of about two years ago [or ARY _____], which of the following best describes your total annual household income from all sources before taxes. . .

- less than \$15,000
- between \$15,000-\$29,000
- between \$30,000-\$44,000
- between \$45,000-\$69,000
- \$70,000 or more
- REFUSED
- DON'T KNOW