METROPOLITAN NEW YORK REGISTRY

PERSONAL HISTORY QUESTIONNAIRE FOR FEMALE PARTICIPANTS

This questionnaire is about factors that may relate to your risk of developing cancer.

Please complete your own questionnaire

Please be sure to complete all questions in this questionnaire before returning it to your Registry Coordinator. Thank you.

If you have any questions, please call your

Registry Coordinator,____

At **1-855-34-FAMILY**

FOR OFFICE USE ONLY-PLEASE DO NOT WRITE BELOW THIS LINE

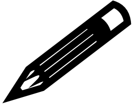
Site ID: |____|____|____| Date Received: ____/___/___

Family ID: |____|____|____|____|____|____|

Subject ID: |____|____|___|____|____|- |____|____|____|

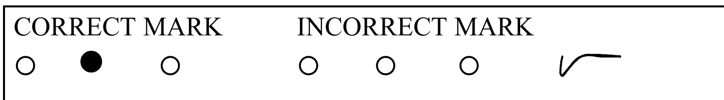
MARKING INSTRUCTIONS

This questionnaire was administered by: o Self
o Interviewer, Initials: |____|



Please use only No. 2 lead pencil to complete this form.

- Do **NOT** use ink or ballpoint pens.
- Fill in the circle completely, staying with in the circle.



- Erase cleanly any answer you wish to change.
- Do not make any stray marks in this booklet.

MARKING EXAMPLES

Example 1: If your age is 46, you would answer the following question like this:

A-1. How old are you?

● ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ● ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ● ⑦ ⑧ ⑨

↑ Then fill in the matching ovals for each box

Write numbers in the boxes

0 4 6

Age

Example 2: Sometimes you may be asked to write in numbers in boxes and/or within a space provided. **It is important to keep handwriting within the space provided.**

G-2Have you ever had any of the following diagnostic exams that include multiple x-rays of the chest area?

● No
○ Yes →
○ Don't know

What type of exam(s) did you Number of exams Age of first exam have

G-2.1 X-rays for heart catheterization ☐ ☐ ☐ Number ☐ ☐ ☐ Age

G-2.2 X-rays for scoliosis ☐ ☐ ☐ Number ☐ ☐ ☐ Age

G-2.3 Other intensive X-rays of the chest area ☐ ☐ ☐ Number ☐ ☐ ☐ Age

Please specify________________

_Female Template

A. General Information

A-1. How old are you?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Write the numbers in the boxes. → ☐☐☐ → *Then fill in the matching ovals for each box.*

Age

A-2. What is your date of birth?

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Month →	○	○	○	○	○	○	○	○	○	○	○	○

⓪ ① ② ③ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐

Day

⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

1☐☐☐

Year

A-3. How tall are you?

④ ⑤ ⑥ ⑦

☐

Feet

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐

Inches

A-4. What is your *current* weight?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐

Pounds

A-5. **Are you a twin?**

No ○ Yes ○

If yes, please read the following statement and answer the question

Non-identical or fraternal twins are no more alike than ordinary brothers and sisters. Genetically identical twins are always the same sex and strongly resemble each other in height, coloring, features of the face, etc. It is not uncommon for other people to mistake one twin for the other, especially during their childhood.

A-5.1 **Do you think you and your twin are genetically identical?**

No ○ Yes ○ Don't Know ○

A-6. **What Is the highest level of education you completed?**

- ○ Less than 8 years
- ○ 8 to 11 years (without graduation)
- ○ High school graduation
- ○ Vocational or technical school
- ○ Some college or university
- ○ Bachelor's degree
- ○ Graduate degree

A-7. **Are you currently:**

- ○ Married or living as married (with partner)
- ○ Widowed
- ○ Divorced
- ○ Separated
- ○ Never married

B. Menstrual and Contraceptive History

B-1. **Have you ever had a menstrual period?**

No ○ Yes ○

B-1.1 **At what age did you have your *first* menstrual period?**

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

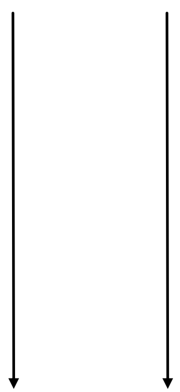
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Age

Go to next page.

B-2. **Has a doctor ever told you that you had *primary* amenorrhea (failure of menstrual periods to start naturally)?**

No ○ **Don't Know** ○ **Yes** ○



B-2.1 **How old were you when this was *first* diagnosed?**

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐

Age

Go to next page.

B-3. Have you ever used hormonal contraceptives, in the form of birth control pills, implants or injections?

No ○ **Don't Know** ○ **Yes** ○

B-3.1 How old were you when you *first* started taking hormonal contraceptives?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Age

B-3.2 Are you currently taking hormonal contraceptives?

Yes ○ **No** ○

B-3.3 How old were you when you *last* took hormonal contraceptives?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Age

B-3.4 In total, for about how many years and/or months have you taken hormonal contraceptives? ***Please do not include those times when you temporarily stopped taking them.***

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Years

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

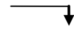
Months

Go to next page.

C. Pregnancy History

C-1. **Have you ever been pregnant?** ***Please include live births, stillbirths, miscarriages, ectopic/tubal pregnancies, and induced abortions.***

No ○ **Yes** ○



C-1.1 How many pregnancies have you had?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐ Number

C-1.2 How many live births have you had?

○ None

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐ Number

C-1.3 How old were you when you had your *first* live birth?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

C-1.4 How old were you when you had your *last* live birth?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

Please complete questions C-2 to C-7 for each pregnancy.

If you have never been pregnant go to question C-8.

For each pregnancy please answer questions C-2 through C-7. Please include information about all live births, stillbirths, miscarriages, ectopic/tubal pregnancies and induced abortions.

	1st Pregnancy	2nd Pregnancy	3rd Pregnancy
C-2. On what date did your pregnancy end? ***If you are currently pregnant please indicate estimated due date.***	|__|__| Month → ⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |__|__| Year → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	|__|__| Month → ⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |__|__| Year → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	|__|__| Month → ⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |__|__| Year → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
C-3. What was the outcome of this pregnancy?	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion
C-4. Did you take DES during this pregnancy?	No ○ Yes ○	No ○ Yes ○	No ○ Yes ○
C-5. How long was this pregnancy?	○ 3 months or under ○ 4 to 6 months ○ 7 or more months	○ 3 months or under ○ 4 to 6 months ○ 7 or more months	○ 3 months or under ○ 4 to 6 months ○ 7 or more months
For live births or stillbirths: **C-6. What was the sex of *each* child delivered from this pregnancy?**	Number of boys |__| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |__| → ⓪ ① ② ③ ④ ⑤ ⑥	Number of boys |__| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |__| → ⓪ ① ② ③ ④ ⑤ ⑥	Number of boys |__| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |__| → ⓪ ① ② ③ ④ ⑤ ⑥
For live births only: **C-7. Did you breast feed this child?**	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months

Continue on next page.

	4th Pregnancy	5th Pregnancy	6th Pregnancy
C-2. On what date did your pregnancy end? ***If you are currently pregnant please indicate estimated due date.***	|___|___| Month ⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |___|___| Year ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	|___|___| Month ⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |___|___| Year ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨	|___|___| Month ⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |___|___| Year ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ / ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
C-3. What was the outcome of this pregnancy?	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion
C-4. Did you take DES during this pregnancy?	No ○ Yes ○	No ○ Yes ○	No ○ Yes ○
C-5. How long was this pregnancy?	○ 3 months or under ○ 4 to 6 months ○ 7 or more months	○ 3 months or under ○ 4 to 6 months ○ 7 or more months	○ 3 months or under ○ 4 to 6 months ○ 7 or more months
For live births or stillbirths: **C-6. What was the sex of *each* child delivered from this pregnancy?**	Number of boys |___| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |___| → ⓪ ① ② ③ ④ ⑤ ⑥	Number of boys |___| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |___| → ⓪ ① ② ③ ④ ⑤ ⑥	Number of boys |___| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |___| → ⓪ ① ② ③ ④ ⑤ ⑥
For live births only: **C-7. Did you breast feed this child?**	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months

Go to next page.

	7th Pregnancy	8th Pregnancy	9th Pregnancy
C-2. On what date did your pregnancy end? ***If you are currently pregnant please indicate estimated due date.***	⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ |___|___| → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Month ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |___|___| → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Year	⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ |___|___| → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Month ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |___|___| → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Year	⓪ ① ○ ○ ○ ○ ○ ○ ○ ○ |___|___| → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Month ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ 19 |___|___| → ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ Year
C-3. What was the outcome of this pregnancy?	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion	○ Currently pregnant ○ Single live birth ○ Multiple birth ○ Still birth ○ Miscarriage ○ Ectopic/Tubal pregnancy ○ Induced abortion
C-4. Did you take DES during this pregnancy?	No ○ Yes ○	No ○ Yes ○	No ○ Yes ○
C-5. How long was this pregnancy?	○ 3 months or under ○ 4 to 6 months ○ 7 or more months	○ 3 months or under ○ 4 to 6 months ○ 7 or more months	○ 3 months or under ○ 4 to 6 months ○ 7 or more months
For live births or stillbirths: **C-6. What was the sex of *each* child delivered from this pregnancy?**	Number of boys |___| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |___| → ⓪ ① ② ③ ④ ⑤ ⑥	Number of boys |___| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |___| → ⓪ ① ② ③ ④ ⑤ ⑥	Number of boys |___| → ⓪ ① ② ③ ④ ⑤ ⑥ Number of girls |___| → ⓪ ① ② ③ ④ ⑤ ⑥
For live births only: **C-7. Did you breast feed this child?**	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months	No ○ Yes ○ → ○ Under 1 month ○ 1 to 5 months ○ 6 to 11 months ○ 12 to 24 months ○ Over 24 months

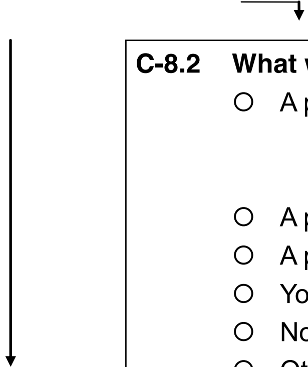
Continue on next page.

C-8. **Has there ever been a period of 12 months or longer when you tried to become pregnant but were not able to?**

No ○ Yes ○

C-8.1. **Have you or your partner ever sought medical help because you had trouble getting pregnant?**

No ○ Yes ○

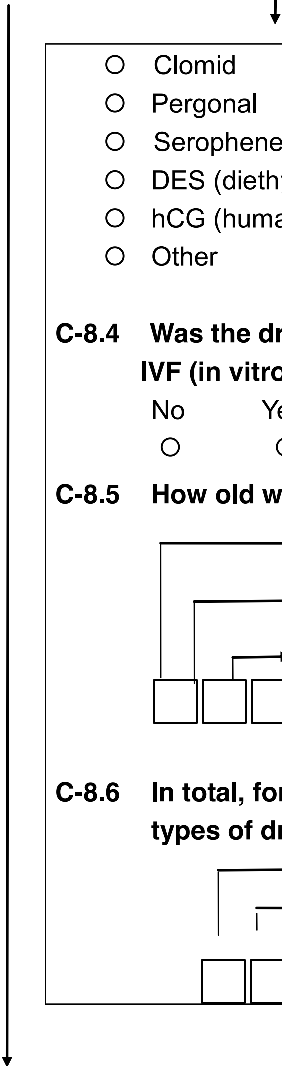


C-8.2 **What was the reason you had a problem getting pregnant?** *(Mark all that apply.)*

- ○ A problem with your ovaries or hormones,
  Due to chemotherapy or radiation?
  ○ Yes ○ No
- ○ A problem with your fallopian tubes,
- ○ A problem with your cervix or uterus, i.e. endometriosis,
- ○ Your partner had fertility problems,
- ○ No problem was found
- ○ Other (*Specify*): ______________________
- ○ Don't know

C-8.3 **Have you ever been prescribed any of the following medications for infertility or because your periods stopped?** ***Please mark all that apply.***

No ○ Yes ○



- ○ Clomid
- ○ Pergonal
- ○ Serophene
- ○ DES (diethylstilbestrol)
- ○ hCG (human chorionic gonadotropin)
- ○ Other *Please specify*______________________________

C-8.4 **Was the drug prescribed for infertility as part of GIFT (gamete inter-fallopian transfer) or IVF (in vitro fertilization)?**

No ○ Yes ○ Don't Know ○

C-8.5 **How old were you when you first used these drugs?**

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

C-8.6 **In total, for how many cycles did you take this/these types of drug(s)?**

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐ Cycles

D. Menopause and Hormone Replacement Therapy

D-1. Has there ever been a time that you did not menstruate for a period of 12 months or longer? ***Please do not include times when you were pregnant, breast feeding, during serious illness, or periods of strenuous exercise.***

No ○ Yes ○ →

FIRST TIME YOUR PERIODS STOPPED FOR A YEAR OR MORE

D-1.1 How old were you the first time you stopped having periods for one year or more?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

D-1.2 What was the reason your period stopped? ***Please mark all that apply.***

- ○ Natural menopause (periods stopped by themselves)
- ○ ***Hormone replacement therapy resulting in cessation of period***
- ○ Uterus was removed
- ○ Both ovaries removed
- ○ Radiation, chemotherapy or hormone therapy
- ○ Other *(Specify):* ______________________
- ○ Don't Know

D-1.3 For how long did your period stop?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

☐ ☐

Years Months ○ Never began again

SECOND TIME YOUR PERIODS STOPPED FOR A YEAR OR MORE

D-1.4 How old were you the second time you stopped having periods for one year or more?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

D-1.5 What was the reason your periods stopped? ***Please mark all that apply.***

- ○ Natural menopause (periods stopped by themselves)
- ○ ***Hormone replacement therapy resulting in cessation of period***
- ○ Uterus was removed
- ○ Both ovaries removed
- ○ Radiation, chemotherapy or hormone therapy
- ○ Other *(Specify):* ______________________
- ○ ***Don't Know***

D-1.6 For how long did your period stop?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ○

☐ ☐

Years Months ○ Never began again

D-2. Which statement best describes your menopausal status at the present time? (Please mark all that apply)

- ○ Have not begun menopause, am still having periods
- ○ I am using hormone replacement therapy, am still having periods
- ○ Have begun menopause
- ○ I am not sure if I have begun menopause
- ○ Have completed menopause

D-3. How long ago was your last period?

- ○ Less than 1 month
- ○ 1 to 6 months
- ○ 7 months to less than 1 year
- ○ 1 year or more
- ○ Never had a period

Go to next page.

D-4. **Have you ever taken estrogen, progestin, or other female hormones for menopause? The preparation may be pills, injections/shots, skin patches, vaginal creams, or vaginal suppositories. Please do not include any hormones taken for birth control purposes, such as oral contraceptives**

No ○ Don't Know ○ Yes ○

D-4.1 **How old were you when you *first* took estrogen, progestin, or other female hormones?**

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Age

D-4.2 **Were you still having periods when you *first* took estrogen, progestin or other female hormones?**

No ○ Yes ○

D-4.3 **Are you currently taking estrogen, progestin, or other female hormones?**

Yes ○ No ○

D-4.4 **How old were you when you *last* took estrogen, progestin, or other female hormones?**

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Age

D-4.5 **In total, for about how many years have you taken estrogen, progestin, or other female hormones?**

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Years

Go to next page.

E. Medical History

E-1. Has a doctor ever told you that you had cancer, leukemia or a malignant tumor?

No ○ Don't Know ○ Yes ○

E-1.1 What was the *first* type of cancer?________________ Don't know ○

E-1.2 How old were you when this was *first* diagnosed?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

E-1.3 What was your weight at the time of your diagnosis, before you started any treatment?

⓪ ① ② ③ ④ ⑤ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Pounds

E-1.4 When and where were you treated?

Dr.(s) ________________________________month/yr. _____/______

Hosp: ____

Street Address: ________________________________

City: ____________________________State: __________

E-1.5 What was the *second* type of cancer? ________________ Don't know ○

E-1.6 How old were you when this was *first* diagnosed?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

E-1.7 What was your weight at the time of your diagnosis, before you started any treatment?

⓪ ① ② ③ ④ ⑤ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Pounds

E-1.8 When and where were you treated?

Dr.(s) ________________________________month/yr. ______/______

Hosp: ____

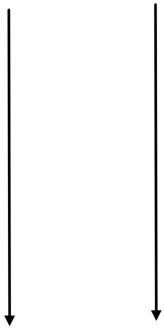
Address: ______________________________________

City: ____________________________State: __________

Go to next page.

E-2. **Has a doctor ever told you that you had *benign breast disease*, such as a non-cancerous cyst or breast lump?**

No ○ Don't Know ○ Yes ○



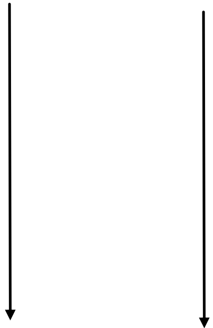
E-2.1 **How old were you when this was *first* diagnosed?**

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Age

E-3. **Has a doctor ever told you that you had cysts in one or both ovaries?**

No ○ Don't Know ○ Yes ○



E-3.1 **How old were you when this was *first* diagnosed?**

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Age

E-4. **When your mother was pregnant with you, did she take DES (diethylstilbestrol)? This drug was sometimes given to women to help prevent miscarriages.**

No ○ Don't Know ○ Yes ○

Go to next page.

F. Surgical History

F-1 Have you ever had surgery related to breast disease (Mastectomy, Lumpectomy or Biopsy)?

A mastectomy is the complete removal of a breast. A lumpectomy is the removal of a portion of the breast. A biopsy is the removal of tissue for the purpose of making a diagnosis. Please do not include fine needle aspiration biopsies.

No ○ Yes ○

F-1.1 The <u>first time</u> you had breast surgery, which breast was operated on?

Left breast ○ Right breast ○

F-1.2 Where and when was this surgery performed?

Dr.(s):_____________________ Month/Year? ____________

Hosp: ____

Addr: ____

City: __________________________State:______________

F-1.3 Was this surgery a biopsy?

Don't know ○ No ○ Yes ○

F-1.4 What was the outcome of this biopsy?

- ○ Benign (non-cancerous) lump, tumor or cyst
- ○ Malignant (cancerous) tumor
- ○ Don't know

F-1.5 Was this surgery a lumpectomy or mastectomy?

Don't know ○ No ○ Lumpectomy ○ Mastectomy ○

F-1.6 Why was this surgery performed?

- ○ To remove cancerous (malignant) breast tissue
- ○ To remove breast tissue to prevent possible future disease (prophylactic surgery)
- ○ Don't know

F-1.7 How old were you when you had this operation?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

Go to next page.

F-1.8 Have you had a second surgery on your breast?

No ○ Yes ○

F-1.9 The second time you had breast surgery, which breast was operated on?

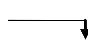
Left breast ○ Right breast ○

F-1.10 Where and when was this surgery performed?

Dr.(s):_____________________________ Month/Year? _________________
Hosp: ____
Addr: ____
City: ______________________________________State:__________________

F-1.11 Was this surgery a biopsy?

Don't know ○ No ○ Yes ○



F-1.12 What was the outcome of this biopsy?

○ Benign (non-cancerous) lump, tumor or cyst
○ Malignant (cancerous) tumor
○ Don't know

F-1.13 Was this surgery a lumpectomy or mastectomy?

Don't know ○ No ○ Lumpectomy ○ Mastectomy ○

F-1.14 Why was this surgery performed?

○ To remove cancerous (malignant) breast tissue
○ To remove breast tissue to prevent possible future disease (prophylactic surgery)
○ Don't know

F-1.15 How old were you when you had this operation?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

F-1.16 Have you had a third surgery on your breast?

No ○ Yes ○

F-1.17 The third time you had breast surgery, which breast was operated on?

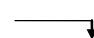
Left breast ○ Right breast ○

F-1.18 Where and when was this surgery performed?

Dr.(s):______________________________ Month/Year? __________________
Hosp: ____
Addr: ____
City: _______________________________________State:__________________

F-1.19 Was this surgery a biopsy?

Don't know ○ No ○ Yes ○



F-1.20 What was the outcome of this biopsy?

- ○ Benign (non-cancerous) lump, tumor or cyst
- ○ Malignant (cancerous) tumor
- ○ Don't know

F-1.21 Was this surgery a lumpectomy or mastectomy?

Don't know ○ No ○ Lumpectomy ○ Mastectomy ○

F-1.22 Why was this surgery performed?

- ○ To remove cancerous (malignant) breast tissue
- ○ To remove breast tissue to prevent possible future disease (prophylactic surgery)
- ○ Don't know

F-1.23 How old were you when you had this operation?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

Go to next page.

F-1.24 Have you had a fourth surgery on your breast?

No ○ Yes ○

F-1.25 The fourth time you had breast surgery, which breast was operated on?

Left breast ○ Right breast ○

F-1.26 Where and when was this surgery performed?

Dr.(s):______________________________ Month/Year? __________________
Hosp: ____
Addr: ____
City: ____State:_________________

F-1.27 Was this surgery a biopsy?

Don't know ○ No ○ Yes ○

F-1.28 What was the outcome of this biopsy?

- ○ Benign (non-cancerous) lump, tumor or cyst
- ○ Malignant (cancerous) tumor
- ○ Don't know

F-1.29 Was this surgery a lumpectomy or mastectomy?

Don't know ○ No ○ Lumpectomy ○ Mastectomy ○

F-1.30 Why was this surgery performed?

- ○ To remove cancerous (malignant) breast tissue
- ○ To remove breast tissue to prevent possible future disease (prophylactic surgery)
- ○ Don't know

F-1.31 How old were you when you had this operation?

⓪	①	○	○	○	○	○	○	○	○
⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨
⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨

☐☐☐ Age

Go to next page.

F-1.32 Have you had a fifth surgery on your breast?

No ○ Yes ○

F-1.33 The fifth time you had breast surgery, which breast was operated on?

Left breast ○ Right breast ○

F-1.34 Where and when was this surgery performed?

Dr.(s):______________________________ Month/Year? __________________
Hosp: ____
Addr: ____
City: _______________________________________State:___________________

F-1.35 Was this surgery a biopsy?

Don't know ○ No ○ Yes ○

F-1.36 What was the outcome of this biopsy?

- ○ Benign (non-cancerous) lump, tumor or cyst
- ○ Malignant (cancerous) tumor
- ○ Don't know

F-1.37 Was this surgery a lumpectomy or mastectomy?

Don't know ○ No ○ Lumpectomy ○ Mastectomy ○

F-1.38 Why was this surgery performed?

- ○ To remove cancerous (malignant) breast tissue
- ○ To remove breast tissue to prevent possible future disease (prophylactic surgery)
- ○ Don't know

F-1.39 How old were you when you had this operation?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

Go to next page.

F-1.40 Have you had a sixth surgery on your breast?

No ○ Yes ○

F-1.41 The sixth time you had breast surgery, which breast was operated on?

Left breast ○ Right breast ○

F-1.42 Where and when was this surgery performed?

Dr.(s):______________________________ Month/Year: __________________

Hosp: ____

Addr: ____

City: ____State:__________________

F-1.43 Was this surgery a biopsy?

Don't know ○ No ○ Yes ○

F-1.44 What was the outcome of this biopsy?

- ○ Benign (non-cancerous) lump, tumor or cyst
- ○ Malignant (cancerous) tumor
- ○ Don't know

F-1.45 Was this surgery a lumpectomy or mastectomy?

Don't know ○ No ○ Lumpectomy ○ Mastectomy ○

F-1.46 Why was this surgery performed?

- ○ To remove cancerous (malignant) breast tissue
- ○ To remove breast tissue to prevent possible future disease (prophylactic surgery)
- ○ Don't know

F-1.47 How old were you when you had this operation?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

Go to next page.

F-2. Have you ever had an ovary completely removed?

No ○ Don't Know ○ Yes ○

Please tell us about each surgery you had to remove an ovary.

FIRST SURGERY:

F-2.1 Which ovary was removed?

Left ovary ○ Right ovary ○ Both ovaries ○

F-2.2 What was your age when this surgery was done?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age removed

F-2.3 Why was this surgery performed?

○ To remove benign tumor or cysts
○ To remove cancerous (malignant) tissue
○ To remove tissue to prevent disease (prophylactic)

F-2.4 Where and when was this surgery performed?

Dr.(s):____________________________ Month/Year?________________
Hosp.____
Addr: ____
City: _________________________________State: ___________________

SECOND SURGERY:

F-2.5 Which ovary was removed?

Right ovary ○ Left ovary ○

F-2.6 What was your age when this surgery was done?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age removed

F-2.7 Why was this surgery performed?

○ To remove benign tumor or cysts
○ To remove cancerous (malignant) tissue
○ To remove tissue to prevent disease (prophylactic)

F-2.8 Where and when was this surgery performed?

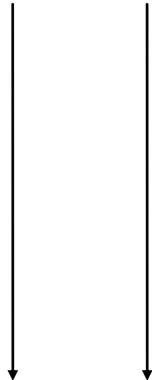
Dr.(s):____________________________ Month/Year? ________________
Hosp.____
Addr: ____
City: _________________________________State: ___________________

Go to next page.

G. Radiation Exposure

G-1. Have you ever had a mammogram (x-ray examination of the breast)?

No ○ Don't Know ○ Yes ○



G-1.1 When and where did you have your *last* mammogram?

Hospital/Clinic:________________________________

City: __________________________State:_________ Date: ____/____
Month - Year

G-1.2 In total, how many mammograms have you had?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

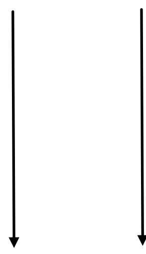
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Number

G-2. Have you ever had any of the following diagnostic exams that include multiple x-rays of the chest area (excluding Mammograms)?

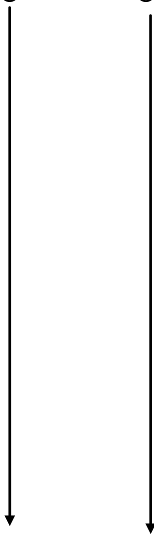
No ○ Don't Know ○ Yes ○



What type of exam did you have?	Number of exams	Age first exam	Age last exam
G-2.1 X-rays for heart catheterization	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-2.2 X-rays for scoliosis	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-2.3 Other X-rays of the chest area Please specify_______________	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age

G-3. Have you ever had a condition that was treated with radiation (x-rays, cobalt treatments, radium treatments, etc.) that included the chest area?

No ○ Don't Know ○ Yes ○

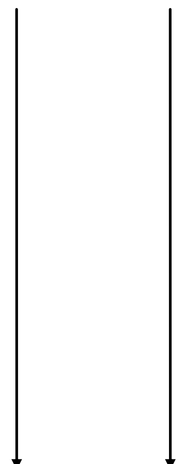


What condition were you treated for?	Number of treatments	Age at first treatment	Age at last treatment
G-3.1 Cancer	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-3.2 Enlarged thymus gland	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-3.3 Acne	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-3.4 Hemangioma	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-3.5 Tuberculosis	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-3.6 Mastitis	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-3.7 Other Please specify_______________	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age

Go to next page.

G-4. **Have you ever had any of the following diagnostic exams that include multiple x-rays of the <u>lower abdomen or pelvis</u>?**

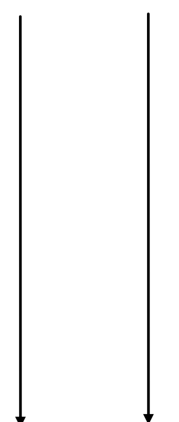
No ○ Don't Know ○ Yes ○



What type of exams did you have?	Number of exams	Age first exam	Age last exam
G-4.1 Fluoroscopic x-rays	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-4.2 Barium examination of the lower bowel	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-4.3 CT scan or x-rays of the lower spine or pelvis	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-4.4 Other *Please specify*_______________	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age

G-5. **Have you ever been treated for a condition with radiation that included the <u>lower abdomen or pelvis?</u>**

No ○ Don't Know ○ Yes ○



What condition were you treated for?	Number of treatments	Age at first treatment	Age at last treatment
G-5.1 Cancer	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-5.2 Bleeding from the uterus or womb	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-5.3 Growth on the uterus or womb	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age
G-5.4 Other *Please specify*_________________	☐☐☐ Number	☐☐☐ Age	☐☐☐ Age

Go to next page.

H. Alcohol Consumption

H-1. Have you ever consumed any alcoholic beverages, such as beer, wine, or liquor *regularly* (at least once per week for 6 months or longer)?

No ○ Yes ○

H-1.1 At what age did you *first* start consuming alcohol *at least once per week for 6 months or longer*?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

H-1.2 For each of the age groups below that apply to you, please ESTIMATE how many drinks of beer, wine or wine coolers, and hard liquor you <u>usually</u> had in one week when you consume(d) alcohol on a regular basis.

Beer

Average number of 12 oz. bottles or cans of **beer** you drank in a week							
Age ranges	None	1-2	3-4	5-6	7-8	9-10	10+
Last 3 years	○	○	○	○	○	○	○
Age 12 to 17 years	○	○	○	○	○	○	○
Age 18 to 24 years	○	○	○	○	○	○	○
Age 25 to 34 years	○	○	○	○	○	○	○
Age 35 to 44 years	○	○	○	○	○	○	○
Age 45 to 54 years	○	○	○	○	○	○	○
Age 55 or more years	○	○	○	○	○	○	○

Wine or wine coolers

Average number of **wine** (1 medium glass) **or wine coolers** you drank in a week							
Age ranges	None	1-2	3-4	5-6	7-8	9-10	10+
Last 3 years	○	○	○	○	○	○	○
Age 12 to 17 years	○	○	○	○	○	○	○
Age 18 to 24 years	○	○	○	○	○	○	○
Age 25 to 34 years	○	○	○	○	○	○	○
Age 35 to 44 years	○	○	○	○	○	○	○
Age 45 to 54 years	○	○	○	○	○	○	○
Age 55 or more years	○	○	○	○	○	○	○

Hard Liquor

Average number of **hard liquor** drinks (1 shot) you drank in a week							
Age ranges	None	1-2	3-4	5-6	7-8	9-10	10+
Last 3 years	○	○	○	○	○	○	○
Age 12 to 17 years	○	○	○	○	○	○	○
Age 18 to 24 years	○	○	○	○	○	○	○
Age 25 to 34 years	○	○	○	○	○	○	○
Age 35 to 44 years	○	○	○	○	○	○	○
Age 45 to 54 years	○	○	○	○	○	○	○
Age 55 or more years	○	○	○	○	○	○	○

Go to H-1.3

H-1.3 Are you currently consuming alcohol *at least once per week*?

Yes ○ No ○

H-1.4 At what age did you *stop* consuming alcohol at least once per week?

⓪	①	○	○	○	○	○	○	○	○
⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨
⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨

☐☐☐

Age

H-1.5 In total, for how many years have you consumed alcohol *at least once per week*?

⓪	①	○	○	○	○	○	○	○	○
⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨
⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨

☐☐☐ Years

Go to next page.

I. Smoking

I-1. Over your lifetime, have you smoked more than 100 cigarettes?

No ○ Yes ○

I-2 Has there ever been a time when you smoked cigarettes regularly (at least one cigarette a day for 3 months or longer)?

No ○ Yes ○

I-2.1 At what age did you *first* start smoking cigarettes regularly (at least one cigarette per day for 3 months or longer)?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

I-2.2 When you smoke(d) *regularly*, how many cigarettes do (did) you usually smoke in a day?

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Number of cigarettes per day

I-2.3 Are you currently smoking *regularly*?

Yes ○ No ○

I-2.4 At what age did you *stop* smoking cigarettes regularly?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Age

I-2.5 For how many years in total have you smoked cigarettes *regularly*?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨
⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

☐☐☐ Years

Go to next page.

J. Physical Activity

The following are questions about your physical activity at various times in your life. For each of the ages below that apply, please estimate the average amount of time each week and the average number of months each year you spent in strenuous exercise and moderate exercise.

Moderate Exercise

J-1. How often did you participate in moderate exercise activities or sports (e.g., brisk walking, golf, volleyball, cycling on level streets recreation tennis, or softball)?

	Average hours per week									Average months per year			
	None	½	1	1-1½	2	3	4 - 6	7-10	11+	1-3	4-6	7-9	10-12
Past 3 years	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 12 to 17	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 18 to 24	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 25 to 34	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 35 to 44	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 45 to 54	O	O	O	O	O	O	O	O	O	O	O	O	O
55 or more years	O	O	O	O	O	O	O	O	O	O	O	O	O

Strenuous Exercise

J-2. How often did you participate in strenuous exercise activities or sports (e.g., swimming laps, aerobics, calisthenics, running, jogging, basketball, cycling on hills, racquetball)?

	Average hours per week									Average months per year			
	None	½	1	1-1½	2	3	4 - 6	7-10	11+	1-3	4-6	7-9	10-12
Past 3 years	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 12 to17	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 18 to 24	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 25 to 34	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 35 to 44	O	O	O	O	O	O	O	O	O	O	O	O	O
ages 45 to 54	O	O	O	O	O	O	O	O	O	O	O	O	O
55 or more years	O	O	O	O	O	O	O	O	O	O	O	O	O

K. Ethnic and Religious Background

K-1. Please check the religion into which you, your parents and your grandparents were born:

	You	*Your mother*	*Your mother's mother*	*Your mother's father*	*Your father*	*Your father's mother*	*Your fathers father*
Buddhist	O	O	O	O	O	O	O
Catholic	O	O	O	O	O	O	O
Eastern Orthodox	O	O	O	O	O	O	O
Hindu	O	O	O	O	O	O	O
Jewish, Ashkenazi	O	O	O	O	O	O	O
Jewish, Sephardic	O	O	O	O	O	O	O
Jewish, other/uncertain	O	O	O	O	O	O	O
LDS or Mormon	O	O	O	O	O	O	O
Muslim	O	O	O	O	O	O	O
Protestant	O	O	O	O	O	O	O
Seventh Day Adventist	O	O	O	O	O	O	O
None	O	O	O	O	O	O	O
Other	O	O	O	O	O	O	O
Don't know	O	O	O	O	O	O	O

K-2. Please mark the religion you currently practice:

- ○ Buddhist
- ○ Catholic
- ○ Eastern Orthodox
- ○ Hindu
- ○ Jewish, Ashkenazi
- ○ Jewish, Sephardic
- ○ Jewish, other/uncertain
- ○ Latter Day Saint or Mormon
- ○ Muslim
- ○ Protestant
- ○ Seventh Day Adventist
- ○ None
- ○ Other *Please specify* _____________

K-3. In which country were you, your parents and your grandparents born?

	Country	Don't Know
a. You		○
b. Your mother		○
c. Your father		○
d. Your mother's mother		○
e. Your mother's father		○
f. Your father's mother		○
g. Your father's father		○

K-4. What is your ethnic or racial background? *(Mark all that apply.)*

- ○ Black/African American
- ○ Cambodian
- ○ Chinese
- ○ Hispanic/Latino
- ○ Japanese
- ○ Korean
- ○ Laotian
- ○ Native American (e.g. Indian, Inuit)
- ○ South Asian (e.g. East Indian, Pakistani, Bangladeshi)
- ○ Vietnamese
- ○ White/Caucasian
- ○ Other, please specify _____________________________
- ○ Don't know

Go to next page.

L. STAR Trial (***for women who have never had breast cancer***)

L-1. Are you currently, or have you ever been a participant in STAR? (Study ofTamoxifen and Raloxifene Trial)

No ○ Yes ○

L-1.1 Please list your beginning and ending dates of enrollment as well as the arm of the study in which you participated

Date I started trial ________________________(month/year)
Date I stopped trial ________________________(month/year)

L-1.2 I was in the ○ Raloxifene arm
○ Tamoxifen arm

L-1.3 Are you now (please fill in one of the following)
○ continuing to take Tamoxifen
○ continuing to take Raloxifene
○ switched to Tamoxifen
○ switched to Raloxifene

L- 2.0 Some physicians are prescribing tamoxifen for the prevention of breast cancer in women who have never had breast cancer. Are you currently taking tamoxifen for those reasons?

No ○ Yes ○

M. Other Trials

M-1. Are you currently, or have you ever, been a participant in any other type of cancer prevention study?

No ○ **Yes** ○

M-1.1 What type of study was this? *Please check all that apply.*

○ A dietary study ____
Please indicate time period of study (mo./yr. – mo./yr.) _________________
○ Other - *please specify*____
Please indicate time period of study (mo./yr. – mo./yr.) _________________

M-1.2. Have you or your family participated in other research studies of familial cancer?

No ○ Yes, *please specify*____ ○

Please indicate time period of study (mo./yr. – mo./yr.) _________________

Go to next page

The following questions ask about mammograms and breast exams that you have had.

How old were you when you had your first mammogram?

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Write the numbers in the boxes. ☐☐☐ *Then fill in the matching ovals for each box.*

Age at first mammogram

How many mammograms have you had in the last five years?………….

○ Don't know

⓪ ① ○ ○ ○ ○ ○ ○ ○ ○

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

Write the numbers in the boxes. ☐☐☐ *Then fill in the matching ovals for each box.*

# of mammograms in last five years

When was your most recent mammograms?……………………………..…
- O I've never had a mammogram
- O within the past 12 months
- O 1-2 years ago
- O 3-4 years ago
- O more than 4 years ago
- O Don't know

When was your most recent breast exam by a health care provider?……..
- O I have never had one
- O within the past year
- O 1-2 years ago
- O 3-4 years ago
- O more than 4 years ago
- O Don't know

Do you currently do breast self-exams?…………………………………..
- O Yes
- O No
- O Don't know

How frequently do you do breast self exams?………………………………
- O more than once a month
- O about once a month
- O every 2-4 months
- O less than every 4 months
- O never
- O Don't know

Thank you for taking the time to fill out this questionnaire.
Your participation is very much appreciated.

PLEASE CHECK THAT YOU HAVE COMPLETED ALL QUESTIONS IN THIS QUESTIONNAIRE BEFORE RETURNING TO YOUR REGISTRY COORDINATOR