
MARKING INSTRUCTIONS



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

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

CORRECT MARK	INCORRECT MARK
<input type="radio"/> ● <input type="radio"/>	<input type="radio"/> <input type="radio"/> 

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

MARKING EXAMPLE

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

A-1. How old are you?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" 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 checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

↑ Then fill in the matching ovals for each box

Write numbers in the boxes

Age

Please note: 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.**

PLEASE BEGIN QUESTIONNAIRE ON THE FOLLOWING PAGE
IF YOU HAVE QUESTIONS, PLEASE CALL YOUR REGISTRY COORDINATOR

A. General Information

A-1. How old are you?

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

→	①	②	③	○	○	○	○	○	○
→	①	②	③	④	⑤	⑥	⑦	⑧	⑨
<input type="text"/> <input type="text"/>									
Day									

→	⑧	⑨							
→	①	②	③	④	⑤	⑥	⑦	⑧	⑨
→	①	②	③	④	⑤	⑥	⑦	⑧	⑨
1 <input type="text"/> <input type="text"/> <input type="text"/>									
Year									

A-3. How tall are you?

→	④	⑤	⑥	⑦
<input type="text"/>				
Feet				

→	①	○	○	○	○	○	○	○	○
→	①	②	③	④	⑤	⑥	⑦	⑧	⑨
<input type="text"/> <input type="text"/>									
Inches									

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

→	①	②	③	④	⑤	⑥	⑦	⑧	⑨
→	①	②	③	④	⑤	⑥	⑦	⑧	⑨
→	①	②	③	④	⑤	⑥	⑦	⑧	⑨
<input type="text"/> <input type="text"/> <input type="text"/>									
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

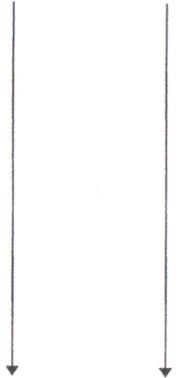
B-1.1 At what age did you have your first menstrual period?

→	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9
→	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9
→	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9
<input type="text"/> <input type="text"/> <input type="text"/>	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?

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

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 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

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 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

Months

Go to next page.

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 19 ____ ____ Year	_____ _____ Month 19 ____ ____ Year	_____ _____ Month 19 ____ ____ Year
C-3. What was the outcome of this pregnancy?	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion
C-4. Did you take DES during this pregnancy?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
C-5. How long was this pregnancy?	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months
For live births or stillbirths:	Number of boys _____ Number of girls _____	Number of boys _____ Number of girls _____	Number of boys _____ Number of girls _____
C-6. What was the sex of each child delivered from this pregnancy?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
C-7. Did you breast feed this child?	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> 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 19____ Year	_____ Month 19____ Year	_____ Month 19____ Year
C-3. What was the outcome of this pregnancy?	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion
C-4. Did you take DES during this pregnancy?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
C-5. How long was this pregnancy?	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months
For live births or stillbirths:	Number of boys _____ Number of girls _____	Number of boys _____ Number of girls _____	Number of boys _____ Number of girls _____
C-6. What was the sex of each child delivered from this pregnancy?	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months
For live births only:	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
C-7. Did you breast feed this child?	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> 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.	Month: <input type="text"/> <input type="text"/> Year: 19 <input type="text"/>	Month: <input type="text"/> <input type="text"/> Year: 19 <input type="text"/>	Month: <input type="text"/> <input type="text"/> Year: 19 <input type="text"/>
C-3. What was the outcome of this pregnancy?	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion	<input type="radio"/> Currently pregnant <input type="radio"/> Single live birth <input type="radio"/> Multiple birth <input type="radio"/> Still birth <input type="radio"/> Miscarriage <input type="radio"/> Ectopic/Tubal pregnancy <input type="radio"/> Induced abortion
C-4. Did you take DES during this pregnancy?	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>	No <input type="radio"/> Yes <input type="radio"/>
C-5. How long was this pregnancy?	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months	<input type="radio"/> 3 months or under <input type="radio"/> 4 to 6 months <input type="radio"/> 7 or more months
For live births or stillbirths:	Number of boys: <input type="text"/> <input type="text"/> Number of girls: <input type="text"/>	Number of boys: <input type="text"/> <input type="text"/> Number of girls: <input type="text"/>	Number of boys: <input type="text"/> <input type="text"/> Number of girls: <input type="text"/>
C-6. What was the sex of each child delivered from this pregnancy?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months
C-7. Did you breast feed this child?	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> Over 24 months	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Under 1 month <input type="radio"/> 1 to 5 months <input type="radio"/> 6 to 11 months <input type="radio"/> 12 to 24 months <input type="radio"/> 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,
- 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 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-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-.. 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 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

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

Natural menopause (periods stopped by themselves)

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 11

0 1 2 3 4 5 6 7 8 9 10 11

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 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

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

Natural menopause (periods stopped by themselves)

Uterus was removed

Both ovaries removed

Radiation or chemotherapy

Other (*Specify*): _____

D-1.6 For how long did your period stop?

0 1 2 3 4 5 6 7 8 9 10 11

0 1 2 3 4 5 6 7 8 9 10 11

Years Months Never began again

D-2. Which statement best describes your menopausal status at the present time?

- Have not begun menopause, 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 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

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 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

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

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

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 →

Vertical lines for marking answers to E-1.1 and E-1.2.

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 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

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

→ 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

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 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

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

→ 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

E-1.8 When and where were you treated?

Dr.(s) _____ month/yr. ____ / ____

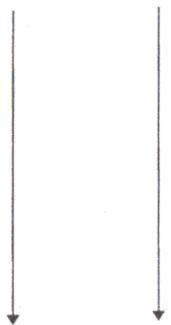
Hosp: _____

Address: _____

City: _____ State: _____

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



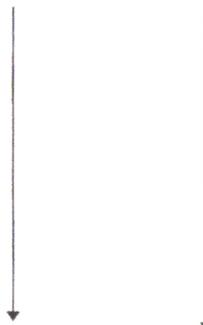
E-2.1 How old were you when this was *first* diagnosed?

<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										

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?

<input type="checkbox"/>										
<input type="checkbox"/>										
<input type="checkbox"/>										

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 first time 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 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

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?

Age

→	<input type="radio"/>									
→	<input type="radio"/>									
→	<input type="radio"/>									

Go to next page.

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?

<input type="radio"/>									
<input type="radio"/>									
<input type="radio"/>									

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	0	0	0	0	0	0	0
→	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?

Age

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

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?

→	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
→	①	②	③	④	⑤	⑥	⑦	⑧	⑨	
→	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?

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

Age removed

F-2.3 Why was this surgery performed?

- To remove benign tumor
- 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?

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

Age removed

F-2.7 Why was this surgery performed?

- To remove benign tumor
- To remove cancerous (malignant) tissue
- To remove tissue to prevent disease (prophylactic)

F-2.8 Where and when was this surgery performed?

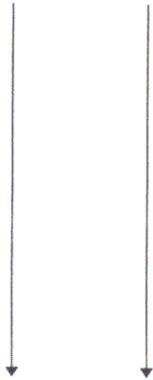
Dr.(s): _____ Month/Year? _____
Hosp. _____
Addr: _____
City: _____ State: _____

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?

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	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-2.2 X-rays for scoliosis	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-2.3 Other X-rays of the chest area Please specify _____	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> 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

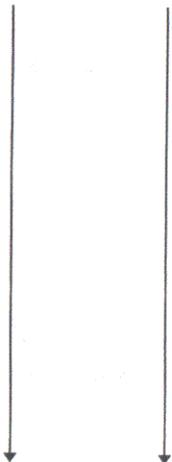


What condition were you treated for?	Number of treatments	Age at first treatment	Age at last treatment
G-3.1 Cancer	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-3.2 Enlarged thymus gland	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-3.3 Acne	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-3.4 Hemangioma	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-3.5 Tuberculosis	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-3.6 Mastitis	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-3.7 Other Please specify _____	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age

Go to next page.

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

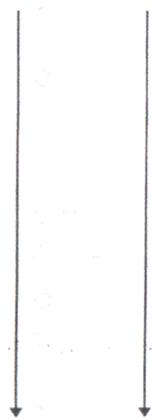
No Don't Know Yes



What type of exams did you have?	Number of exams	Age first exam	Age last exam
G-4.1 Fluoroscopic x-rays	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-4.2 Barium examination of the lower bowel	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-4.3 CT scan or x-rays of the lower spine or pelvis	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-4.4 Other <i>Please specify</i> _____	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age

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

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	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-5.2 Bleeding from the uterus or womb	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-5.3 Growth on the uterus or womb	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age
G-5.4 Other <i>Please specify</i> _____	<input type="text"/> <input type="text"/> <input type="text"/> Number	<input type="text"/> <input type="text"/> <input type="text"/> Age	<input type="text"/> <input type="text"/> <input type="text"/> Age

Go to next page.

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*?

Age

<input type="radio"/>									
<input type="radio"/>									
<input type="radio"/>									

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

Years

<input type="radio"/>									
<input type="radio"/>									
<input type="radio"/>									

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 12 to 17	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 18 to 24	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 25 to 34	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 35 to 44	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 45 to 54	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
55 or more years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 12 to 17	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 18 to 24	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 25 to 34	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 35 to 44	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ages 45 to 54	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
55 or more years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

K. Ethnic and Religious Background

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

	<i>You</i>	<i>Your mother</i>	<i>Your mother's mother</i>	<i>Your mother's father</i>	<i>Your father</i>	<i>Your father's mother</i>	<i>Your father's father</i>
Buddhist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Catholic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eastern Orthodox	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hindu	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jewish, Ashkenazi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jewish, Sephardic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jewish, other/uncertain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LDS or Mormon	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muslim	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Protestant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seventh Day Adventist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Don't know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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		<input type="radio"/>
b. Your mother		<input type="radio"/>
c. Your father		<input type="radio"/>
d. Your mother's mother		<input type="radio"/>
e. Your mother's father		<input type="radio"/>
f. Your father's mother		<input type="radio"/>
g. Your father's father		<input type="radio"/>

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. Tamoxifen for Treatment of Breast Cancer

L-1. Are you, or have you ever participated in a tamoxifen trial?

- Yes No

L-2. Have you ever taken tamoxifen?

- No Don't know Yes

L-2.1 How old were you when you *first* took tamoxifen?

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

L-2.2 Are you currently taking tamoxifen?

Yes No

L-2.3 How old were you when you *last* took tamoxifen?

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

L-2.4 In total, for how many years have you taken tamoxifen?

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.

Other Studies

L-3. Are you currently, or have you ever, been a participant in a cancer prevention study?

No Yes



L-3.1 What type of study was this? *Please check all that apply.*

- A dietary study
- Tamoxifen trial
- Other - *please specify* _____

L-4. Have you or your family participated in other research studies of familial cancer?

No Yes, *please specify* _____

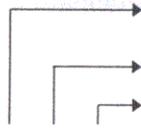
PLEASE FIND TWO BRIEF FORMS TO BE FILLED OUT ON THE FOLLOWING PAGES;
ONE ON MAMMOGRAPHY AND THE OTHER ON DIET.

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

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

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 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

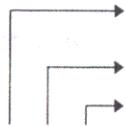
Write the numbers in the boxes.

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 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

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?.....
mammogram

- I've never had a
- within the past 12 months
- 1-2 years ago
- 3-4 years ago
- more than 4 years ago
- Don't know

When was your most recent breast exam by a health care provider?.....

- I have never had one
- within the past year
- 1-2 years ago
- 3-4 years ago
- more than 4 years ago
- Don't know

Do you currently do breast self-exams?.....

- Yes
- No
- Don't know

How frequently do you do breast self exams?.....

- more than once a month
- about once a month
- every 2-4 months
- less than every 4 months
- never
- Don't know

Thank you for your participation.

The following questions ask about your diet.

Have you ever made any MAJOR AND LASTING changes to your eating habits?

No Yes

How old were you when you made these changes in your diet?

	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9
	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9
	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9

Write the numbers in the boxes.

Then fill in the matching ovals for each box.

Age

How did the changes in your diet affect your intake of the following foods?

I began to consume....	More	Less	Same
Red Meat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chicken	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fried Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fruit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vegetables	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soy Products, Tofu	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low fat foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low fat dairy products	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High fiber foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pasta	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eggs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank you for your participation.