

ID # ____ - ____ - _____

**MARYLAND LUNG AND PROSTATE
CANCER STUDY AND
MULTI-ORGAN STUDIES**

QUESTIONNAIRE

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I.D. # ____ - ____ - _____

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- 1. Date: ____ / ____ / _____
- 2. Interviewer's name: _____ Interviewer's ID ____
- 3. Hospital: _____
- 4. Doctor's Name: _____
- 5. Patient's Medical Record # _____
- 6. Race ()₁ African American
()₂ Caucasian American
- 7. Gender ()₁ Male
()₂ Female
- 8. Time started: ____ : ____ ()₁ AM
()₂ PM

OFFICE USE ONLY

Review

Reviewer's initials: _____ Date reviewed: ____ / ____ / _____

Coding and Editing

Coder's Initials: _____ Date coded: ____ / ____ / _____

Data Entry

First Entry → Initials: _____ Date Entered: ____ / ____ / _____

Second Entry → Initials: _____ Date Entered: ____ / ____ / _____

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8. What is the name, address and telephone number of a person who can help us contact you in the future, or your next-of-kin (or person who was interviewed if other than patient)?

Name Relationship to patient

Street Apt. No.

City State Zip Code

Home telephone number # (____) _____ - _____

TYPE OF STUDY PARTICIPANT () ₁ Lung Cancer Case () ₂ Prostate Cancer Case () ₃ Hospital Control () ₄ Population Control () ₅ Multi-organ patient

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c. NUTRITIONAL SUPPLEMENTS

Now I would like to learn more about your typical eating and drinking habits.

1. During the last 7 days, have you taken any vitamins or calcium?
 ()₀ No **(Skip to C. 3)** ()₁ Yes

2.	Did you take:	How many tablets in the past 7 days?
a.	Multivitamins, one-a-day type, such as Centrum () ₀ No (Skip to 2b) () ₁ Yes	_____
b.	Multivitamins, stress tabs () ₀ No (Skip to 2c) () ₁ Yes	_____
c.	Multivitamins, therapeutic type such as Theragram () ₀ No (Skip to 2d) () ₁ Yes	_____
d.	Multivitamins, other () ₀ No (Skip to 2e) () ₁ Yes If yes, (specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, (specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____ _____
e.	Vitamin A () ₀ No (Skip to 2f) () ₁ Yes	_____
f.	Vitamin E () ₀ No (Skip to 2g) () ₁ Yes	_____
g.	Vitamin C () ₀ No (Skip to 2h) () ₁ Yes	_____
h.	Beta Carotene () ₀ No (Skip to 2i) () ₁ Yes	_____
i.	Calcium () ₀ No (Skip to 2j) () ₁ Yes	_____

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j.	Other vitamins () ₀ No (Skip to 3) () ₁ Yes If yes, (specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, (specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____ _____
k.	Other vitamins () ₀ No (Skip to 3) () ₁ Yes If yes, (specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, (specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____ _____
l.	Other vitamins () ₀ No (Skip to 3) () ₁ Yes If yes, (specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> If yes, (specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____ _____

3. During the **past seven days**, have you eaten any special foods, food supplements such as those purchased through a natural food store or health food store?
 ()₀ No (**Skip to C.5**) ()₁ Yes

4. Please tell me what those foods, food supplements or vitamins were:

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5. Please answer the following questions about supplements that you may have taken regularly during the past 5 years, at least 1 pill/week for 2 months.

Have you taken the following regularly - at least 1/week for 2 months during the past 5 years?	How many pills per day or week did you take regularly, during the past 5 years?	How long did you take regularly, during the past 5 years?	Did you take regularly one year prior to interview?
a. Aspirin or aspirin containing compounds (such as Bufferin, Anacin, Ascriptin, Excedrin) <input type="checkbox"/> ₀ no <input type="checkbox"/> ₁ yes <input type="checkbox"/> ₈ Don't know	___ # pills per: <input type="checkbox"/> ₁ day <input type="checkbox"/> ₂ week <input type="checkbox"/> ₈ Don't know	___ ___ <input type="checkbox"/> ₁ weeks <input type="checkbox"/> ₂ months <input type="checkbox"/> ₃ years <input type="checkbox"/> ₈ Don't know	<input type="checkbox"/> ₀ no <input type="checkbox"/> ₁ yes <input type="checkbox"/> ₈ Don't know
b. Tylenol and acetaminophen compounds (such as Tylenol or Aspirin-free Anacin, or Excedrin-PM) <input type="checkbox"/> ₀ no <input type="checkbox"/> ₁ yes <input type="checkbox"/> ₈ Don't know	___ # pills per: <input type="checkbox"/> ₁ day <input type="checkbox"/> ₂ week <input type="checkbox"/> ₈ Don't know	___ ___ <input type="checkbox"/> ₁ weeks <input type="checkbox"/> ₂ months <input type="checkbox"/> ₃ years <input type="checkbox"/> ₈ Don't know	<input type="checkbox"/> ₀ no <input type="checkbox"/> ₁ yes <input type="checkbox"/> ₈ Don't know
c. Pain relievers not containing aspirin or Tylenol (such as Aleve, Ibuprofen, Motrin, Advil, Nuprin, Naprosyn, Feldene, Indocin, Clinoril) <input type="checkbox"/> ₀ no <input type="checkbox"/> ₁ yes <input type="checkbox"/> ₈ Don't know	___ # pills per: <input type="checkbox"/> ₁ day <input type="checkbox"/> ₂ week <input type="checkbox"/> ₈ Don't know	___ ___ <input type="checkbox"/> ₁ weeks <input type="checkbox"/> ₂ months <input type="checkbox"/> ₃ years <input type="checkbox"/> ₈ Don't know	<input type="checkbox"/> ₀ no <input type="checkbox"/> ₁ yes <input type="checkbox"/> ₈ Don't know

SUPPLEMENT INFO. ₁ Very good ₂ Good ₃ Fair ₄ Poor

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D. TOBACCO HISTORY

Next, I would like to ask you some questions about any smoking history you may have.

1. Have you ever smoked more than 100 cigarettes, which is equivalent to five packs, in your life?
 ₀ No (**Skip to D. 18**)
 ₁ Yes

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2. Please tell me about your smoking history. I will be asking you questions about any times you may have stopped or changed your patterns.

Period	1	2	3	4	5	6
a. In what year did you start smoking cigarettes or change your patterns?	_____	_____	_____	_____	_____	_____
b. What was the average number of cigarettes or packs per day you smoked during this time?	_____ () ₁ cigarettes () ₂ packs					
c. After starting, did you change your patterns or stop smoking for more than 6 months?	() ₀ No (D3) () ₁ Stopped smoking () ₂ changed pattern	() ₀ No (D3) () ₁ Stopped smoking () ₂ changed pattern	() ₀ No (D3) () ₁ Stopped smoking () ₂ changed pattern	() ₀ No (D3) () ₁ Stopped smoking () ₂ changed pattern	() ₀ No (D3) () ₁ Stopped smoking () ₂ changed pattern	() ₀ No (D3) () ₁ Stopped smoking () ₂ changed pattern
d. In what year did you stop smoking or change your patterns for more than six months?	_____ If this is a change of pattern, skip to D2a	_____ If this is a change of pattern, skip to D2a	_____ If this is a change of pattern, skip to D2a	_____ If this is a change of pattern, skip to D2a	_____ If this is a change of pattern, skip to D2a	_____
e. Did you start smoking again?	() ₀ No (D3) () ₁ Yes (D2a)	() ₀ No (D3) () ₁ Yes (D2a)	() ₀ No (D3) () ₁ Yes (D2a)	() ₀ No (D3) () ₁ Yes (D2a)	() ₀ No (D3) () ₁ Yes (D2a)	() ₀ No (D3) () ₁ Yes (D2a)

If R stopped smoking more than 6 months ago, Skip to D. 6

11. Which cigarette would you (hate/have hated) most to give up?
 ₀ None/can't decide
 ₁ The first one in the morning
 ₂ All others
 ₃ After Meals
12. (Do /Did) you smoke more frequently during the first hours after waking than during the rest of the day?
 ₀ No
 ₁ Yes
13. (Do\did) you smoke if you (are/were) so ill that you (are/were) in bed most of the day?
 ₀ No
 ₁ Yes
14. During periods when you smoke(d), (do/did) you usually smoke filter or non-filter cigarettes?
 ₁ Filter
 ₂ Non-Filter
 ₃ Both
15. During periods when you smoke(d), (do/did) you usually smoke menthol or non-menthol cigarettes?
 ₁ Menthol
 ₂ Non-Menthol
 ₃ Both
16. When smoking cigarettes, do/did you usually inhale?
 ₀ No **(Skip to D. 18)**
 ₁ Yes
17. Did you inhale slightly, moderately, or deeply?
 ₁ Slightly
 ₂ Moderately
 ₃ Deeply
18. Have you ever smoked at least one cigar a month for more than 6 months?
 ₀ No
 ₁ Yes
19. Have you ever smoked a pipe on a daily basis for more than 6 months?
 ₀ No
 ₁ Yes

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20. During your childhood, until you moved out of your childhood home, did anyone in your home smoke cigarettes?

()₀ No (**Skip to D. 23**)

()₁ Yes

21. How many people smoked in your home?

— —

22. Who smoked in your home during childhood? **(For Case-Control Participants Only. Multi-organ patients skip to question 23)**

		1	2	3	4
<i>Please tell me their first names.</i>					
a.	What is their relationship to you?	<input type="text"/> <input type="text"/> <input type="text"/>			
b.	Would you say they smoked lightly, moderately, heavy or you do not know?	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK
c.	On the average, how many cigars, pipes, cigarettes or packs per day (does/did) (he/she) smoke at home?	<input type="text"/> <input type="text"/> <input type="text"/> () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	<input type="text"/> <input type="text"/> <input type="text"/> () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	<input type="text"/> <input type="text"/> <input type="text"/> () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	<input type="text"/> <input type="text"/> <input type="text"/> () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes
d.	For how many years did (he/she) smoke while you were in the home?	<input type="text"/> <input type="text"/> < 1 year = 1 year	<input type="text"/> <input type="text"/> < 1 year = 1 yr	<input type="text"/> <input type="text"/> < 1 year = 1 yr	<input type="text"/> <input type="text"/> < 1 year = 1 yr

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		5	6	7	8
22. Con't: Please tell me their first names.					
e.	What is their relationship to you?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
f.	Would you say they smoked lightly, moderately, heavy or you do not know?	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK
g.	On the average, how many cigars, pipes, cigarettes or packs per day (does/did) (he/she) smoke at home?	<u> </u> <u> </u> <u> </u> () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	<u> </u> <u> </u> <u> </u> () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	<u> </u> <u> </u> <u> </u> () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	<u> </u> <u> </u> <u> </u> () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes
h.	For how many years did (he/she) smoke while you were in the home?	<u> </u> <u> </u> < 1 year = 1 yr	<u> </u> <u> </u> < 1 year = 1 yr	<u> </u> <u> </u> < 1 year = 1 yr	<u> </u> <u> </u> < 1 year = 1 yr

23. As an adult, does or did your (wife/husband/partner) or anyone else smoke or smoked cigarettes in your home? **(If smoking is done only outside the home then do not include.)**

- ()₀ No **(Skip to D.26)**
()₁ Yes

24. How many people smoke or smoked in your home?

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25. Who smoked in your home as an adult? **(For Case-Control Participants Only. Multi-organ patients skip to question 26)**

		1	2	3	4
<i>Please tell me their first names.</i>					
a.	What is their relationship to you?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
b.	Would you say they smoked lightly, moderately, heavy or you do not know?	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK
c.	On the average, how many cigars, pipes, cigarettes or packs per day (does/did) (he/she) smoke at home?	() ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	() ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	() ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	() ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes
d.	For how many years did (he/she) smoke while you were in the home?	___ ___ < 1 year = 1 yr			
e.	Did (he/she) stop smoking while you were in the house?	() ₀ No (25g) () ₁ Yes	() ₀ No (25g) () ₁ Yes	() ₀ No (25g) () ₁ Yes	() ₀ No (25g) () ₁ Yes
f.	How long ago did (he/she) stop smoking?	() ₁ months () ₂ years () ₃ weeks	() ₁ months () ₂ years () ₃ weeks	() ₁ months () ₂ years () ₃ weeks	() ₁ months () ₂ years () ₃ weeks
g.	During the last thirty days, how many cigars, pipes, or cigarettes per day did (he/she) smoke at home?	___ ___ 66= Deceased 77=Not living in the house			

I.D. # _ - _ - _ _ _ _ _ _

25. Smoked in your home as an adult (continued)

		5	6	7	8
<i>Please tell me their first names.</i>					
h.	What is their relationship to you?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
i.	Would you say they smoked lightly, moderately, heavy or you do not know?	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK	() ₁ light () ₂ moderate () ₃ heavy () ₈ DK
j.	On the average, how many cigars, pipes, cigarettes or packs per day (does/did) (he/she) smoke at home?	___ ___ ___ () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	___ ___ ___ () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	___ ___ ___ () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes	___ ___ ___ () ₁ cigarettes () ₂ packs () ₃ cigars () ₄ pipes
k.	For how many years did (he/she) smoke while you were in the home?	___ ___ < 1 year = 1 yr			
l.	Did (he/she) stop smoking while you were in the house?	() ₀ No (25n) () ₁ Yes	() ₀ No (25n) () ₁ Yes	() ₀ No (25n) () ₁ Yes	() ₀ No (25n) () ₁ Yes
m.	How long ago did (he/she) stop smoking?	___ ___ () ₁ months () ₂ years () ₃ weeks	___ ___ () ₁ months () ₂ years () ₃ weeks	___ ___ () ₁ months () ₂ years () ₃ weeks	___ ___ () ₁ months () ₂ years () ₃ weeks
n.	During the last thirty days, how many cigars, pipes, or cigarettes per day did (he/she) smoke at home?	___ ___ 66= Deceased 77=Not living in the house			

26. Were you exposed to cigarette smoke in your work place during the last 48 hours?

- ()₀ No
- ()₁ Yes
- ()₂ Not at work in the last 48 hours
- ()₃ Not currently working (or retired)

27. In your workplace, were you employed at a job or jobs for more than five years where co-workers smoked cigarettes in your immediate area?

- ()₀ No
- ()₁ Yes

28. For how many years were you working a job where people smoked regularly in your immediate work area?

___ ___ (If 00, skip to Section E)

29. How long ago has it been since you were working at a job where people smoked regularly in your immediate work area?

- ()₁ Today
- ()₂ ___ Day(s)
- ()₃ ___ Month(s)
- ()₄ ___ Year(s)

30. Would you say you were exposed at work to cigarette smoke lightly, moderately, heavy or you do not know?

- ()₁ Lightly
- ()₂ Moderately
- ()₃ Heavy
- ()₄ Do not know

TOBACCO HISTORY ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

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2. Tell me about the types of alcohol and when you were drinking them.

Period	1	2	3	4	5	6	7
a. At what age did you first start to drink/when you next began to drink?	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___
b. How many cans, bottles or 12 oz of beer did/do you drink?	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.
c. How many 4 oz glasses of wine did/do you drink?	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.
d. How many 1 ½ oz. shots of liquor, by itself or in a drink did/do you drink?	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.	___ ___ <input type="checkbox"/> ₁ Per day <input type="checkbox"/> ₂ Per wk. <input type="checkbox"/> ₃ Per mo. <input type="checkbox"/> ₄ Per yr.
e. Have you ever stopped drinking or changed your patterns for more than 12 months?	<input type="checkbox"/> ₀ No (E3) <input type="checkbox"/> ₁ Stopped <input type="checkbox"/> ₂ Changed pattern	<input type="checkbox"/> ₀ No (E3) <input type="checkbox"/> ₁ Stopped <input type="checkbox"/> ₂ Changed pattern	<input type="checkbox"/> ₀ No (E3) <input type="checkbox"/> ₁ Stopped <input type="checkbox"/> ₂ Changed pattern	<input type="checkbox"/> ₀ No (E3) <input type="checkbox"/> ₁ Stopped <input type="checkbox"/> ₂ Changed pattern	<input type="checkbox"/> ₀ No (E3) <input type="checkbox"/> ₁ Stopped <input type="checkbox"/> ₂ Changed pattern	<input type="checkbox"/> ₀ No (E3) <input type="checkbox"/> ₁ Stopped <input type="checkbox"/> ₂ Changed pattern	<input type="checkbox"/> ₀ No (E3) <input type="checkbox"/> ₁ Stopped <input type="checkbox"/> ₂ Changed pattern
f. What age did you stop drinking or change your patterns for more than 12 months?	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___	___ ___

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3. Have you had any alcoholic beverages such as beer, wine or liquor in the last 7 days?
 ()₀ No **(Skip to Section F)**
 ()₁ Yes

4. In the last seven days, how much did you drink of the following?:	Number:
a. Cans, bottles or 12 oz. glass of beer	___ ___ ___
b. 4 oz. glasses of wine	___ ___ ___
c. 1 ½ oz. shots of hard liquor or drinks containing a shot of hard liquor	___ ___ ___

ALCOHOL HISTORY ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

F. MEDICAL HISTORY

Now I would like to ask you some questions about your medical history and your health.

1.	Did a doctor ever tell you that you had?:	Yes/No	How old were you when you were first diagnosed? DK = 888, condition at birth =000
a.	Chronic bronchitis	() ₀ No (Skip to 1b) () ₁ Yes	___ ___ ___
b.	Emphysema	() ₀ No (Skip to 1c) () ₁ Yes	___ ___ ___
c.	Asthma during adult years	() ₀ No (Skip to 1d) () ₁ Yes	___ ___ ___
d.	Tuberculosis	() ₀ No (Skip to 1e) () ₁ Yes	___ ___ ___
e.	Asbestosis	() ₀ No (Skip to 1f) () ₁ Yes	___ ___ ___

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1.	(Cont.) Did a doctor ever tell you that you had:	Yes/No	How old were you when you were first diagnosed? DK = 888, condition at birth =000
f.	Lung disease, other than cancer (specify) *do not include current lung cancer _____ <input type="checkbox"/> <input type="checkbox"/>	() ₀ No (Skip to 1g) () ₁ Yes	___ ___ ___
g.	Liver disease, such as chronic hepatitis or cirrhosis	() ₀ No (Skip to 1h) () ₁ Yes	___ ___ ___
h.	Kidney disease	() ₀ No (Skip to 1i) () ₁ Yes	___ ___ ___
i.	Heart disease	() ₀ No (Skip to 1j) () ₁ Yes	___ ___ ___
j.	Diabetes	() ₀ No (Skip to 1k) () ₁ Yes	___ ___ ___
k.	Lupus	() ₀ No (Skip to 1l) () ₁ Yes	___ ___ ___
l.	Rheumatoid arthritis	() ₀ No (Skip to 1m) () ₁ Yes	___ ___ ___
m	Thyroid condition (specify) _____ <input type="checkbox"/>	() ₀ No (Skip to 1n) () ₁ Yes	___ ___ ___
n.	Anemia (chronic anemia, not one episode)	() ₀ No (Skip to 1o) () ₁ Yes	___ ___ ___
o.	Stroke	() ₀ No (Skip to 2) () ₁ Yes	___ ___ ___

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2. Have you taken any prescription or non prescription medicines in the last 3 months?

()₀ No **(Skip to F.3)**

()₁ Yes

What is the name of the medicine?	Medication code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (office use)	When was the last time you took it?	What is it for?	Indication code <input type="checkbox"/> <input type="checkbox"/> (office use)
a.		___ / ___ / _____		
b.		___ / ___ / _____		
c.		___ / ___ / _____		
d.		___ / ___ / _____		
e.		___ / ___ / _____		
f.		___ / ___ / _____		
g.		___ / ___ / _____		
h.		___ / ___ / _____		
i.		___ / ___ / _____		
j.		___ / ___ / _____		
k.		___ / ___ / _____		
l.		___ / ___ / _____		
m.		___ / ___ / _____		

I.D. # - -

3. What is your current weight?

 lbs

4. What was your weight 10 years ago?

 lbs

5. What was your weight 2 years ago?

 lbs

6. How tall are you?

 feet inches

MEDICAL HISTORY ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

G. FAMILY HISTORY

Now, I would like to learn more about the members of your family. First, I need to get some background about the structure of your family.

1. I would like to ask how many children you have had. Please include only those children related to you by blood.

Children

2. Were you adopted?

()₀ No
()₁ Yes

3. Counting only the brothers and sisters related to you by blood, how many brothers and sisters have you had? Please include half brothers and sisters.

Brothers # Sisters

I.D. # - -

4. Counting only the aunts and uncles related to you by blood, how many aunts and uncles have you had?

 # Uncles # Aunts

5. Has anyone in your family that is related to you by blood, ever been told they have cancer, include children, parents, grandparents, brothers, sisters, great grand parents, cousins or immediate aunts or uncles? **(Include description of maternal or paternal relative)** ()₀ No **(Skip to G.7)** ()₁ Yes

6. Which relative?	First name	Where did the cancer start? DK = 888	How old were they when they were diagnosed?
a. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
b. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
c. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
d. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
e. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
f. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know

I.D. # _ - _ - _ _ _ _ _

6. Which relative?	First name	Where did the cancer start? DK = 888	How old were they when they were diagnosed?
g. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
h. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
i. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
j. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know
k. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₅ 50-59 () ₂ 20-29 () ₆ 60-69 () ₃ 30-39 () ₇ > 70 () ₄ 40-49 () ₈ Don't know

I.D. # _ - _ - _ _ _ _ _ _

7. For the next questions, I'd like you to think about all those members of your family, who have medical problems other than cancer. **(Include spouse, children, siblings, or parents.)**

	Did a doctor ever tell any member of your family that he or she had . . .	Which relatives had the problem?	First name	How old were they when they were diagnosed? DK=888
a.	Chronic bronchitis? () ₀ No (Skip to 7b) () ₁ Yes	<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"/>		__ __ __
b.	Emphysema () ₀ No (Skip to 7c) () ₁ Yes	<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"/>		__ __ __
c.	Asthma during adult years () ₀ No (Skip to 7d) () ₁ Yes	<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"/>		__ __ __
d.	Tuberculosis () ₀ No (Skip to 7e) () ₁ Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		__ __ __
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		__ __ __

I.D. # _ - _ - _ _ _ _ _ _

	Did a doctor ever tell any member of your family that he or she had . . .	Which relatives had the problem?	First name	How old were they when they were diagnosed? DK=888
e.	Asbestosis () ₀ No (Skip to 7f) () ₁ Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		__ __ __
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		__ __ __
f.	Other lung disease specify: _____ <input type="checkbox"/> <input type="checkbox"/> () ₀ No (Skip to H) () ₁ Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		__ __ __
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		__ __ __
g.	Other lung disease specify: _____ <input type="checkbox"/> <input type="checkbox"/> () ₀ No (Skip to H) () ₁ Yes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		__ __ __
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		__ __ __

FAMILY HISTORY ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

I.D. # ___ - ___ - _____

H. REPRODUCTIVE HISTORY (IF MALE, SKIP TO SECTION I, P.35)

This next set of questions may seem personal, but remember that your answers are very important to us.

1. Have you ever been pregnant? ()₀ No **(Skip to H. 7)**
 ()₁ Yes

2. How many times have you been pregnant? ___ ___

	1	2	3	4	5	6	7	8	9	10	11	12
3. How old were when you became pregnant? (Should be chronological)												
4. What was the outcome of this pregnancy? (Check one for each pregnancy)												
01 Single live birth												
02 Multiple live birth, any living												
03 Multiple birth, none living												
04 Stillbirth												
05 Miscarriage												
06 Induced Abortion												
07 Ectopic or tubal												
08 Currently pregnant												
09 Other (specify) _____ <input type="checkbox"/>												
If R had no live births, Skip to H.7												
	1	2	3	4	5	6	7	8	9	10	11	12
5. Did you breast feed any of these babies for at least two weeks or longer? () ₀ No (Skip to H.7) () ₁ Yes												
6. For how many weeks did you breast feed these babies, until you stopped all together?												

7. At what age did you have your first menstrual period? ___ ___

I.D. # - -

8. At what age did your menstrual periods become regular?
 (77 = period never became regular)

9. Have you used birth control, or family planning during your life?
 ()₀ No **(Skip to H.11)** ()₁ Yes

**For Case-Control Participants ONLY, MULTI-ORGAN patients
 answer only 10a and then skip to question #11**

10. What type of birth control or family planning, if any, have you used during your life?	At what age did you start?	At what age did you stop? 77= still using
a. Birth control pills () ₀ No (Skip to 11b) () ₁ Yes	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
b. Birth control shots or injections () ₀ No (Skip to 11c) () ₁ Yes	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
c. Implants, such as Norplant () ₀ No (Skip to 11d) () ₁ Yes	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
d. Condoms or rubbers () ₀ No (Skip to 11e) () ₁ Yes	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
e. Diaphragm, cap or sponge () ₀ No (Skip to 11f) () ₁ Yes	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
f. Foam, jelly, cream or suppositories () ₀ No (Skip to 11g) () ₁ Yes	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>
	<u> </u> <u> </u>	<u> </u> <u> </u>

I.D. # ___ - ___ - _____

10. What type of birth control or family planning, if any, have you used during your life?	At what age did you start?	At what age did you stop? 77= still using
g. Rhythm, calendar, ovulation or withdrawal () ₀ No (Skip to 11h) () ₁ Yes	___	___
	___	___
	___	___
h. IUD, intrauterine devise, such as a loop or coil () ₀ No (Skip to H.12) () ₁ Yes	___	___
	___	___

11. Did you ever have your tubes tied, sterilization?
 ()₀ No **(Skip to H.13)**
 ()₁ Yes

12. When did the surgery take place?
 ___ / ___ / _____

13. Did your partner ever have a vasectomy, male sterilization or surgery?
 ()₀ No **(Skip to H.15)**
 ()₁ Yes

14. When did the surgery take place?
 ___ / ___ / _____

15. Did you ever use birth control pills, shots or implants for any reason other than birth control?
 ()₀ No **(Skip to H.17)**
 ()₁ Yes

16. What was the reason? *Please answer yes or no to the following.*

- a. Regulate periods ()₀ No ()₁ Yes
- b. Acne ()₀ No ()₁ Yes
- c. Cramps or painful ovulation ()₀ No ()₁ Yes
- d. Menopausal symptoms ()₀ No ()₁ Yes
- e. Other ()₀ No ()₁ Yes

(specify) _____

17. Have you had a menstrual period in the last 6 weeks?

- ()₀ No
- ()₁ Yes

18. Are you still menstruating?

- ()₀ No
- ()₁ Yes **(Skip to H. 22)**

19. At what age was your last menstrual period?

20. What was the reason that your menstrual periods stopped?

- ()₁ Change of life or natural Menopause
- ()₂ Hysterectomy, still has ovaries
- ()₃ Hysterectomy, ovaries removed
- ()₄ Hysterectomy, don't know whether ovaries removed
- ()₅ Currently pregnant
- ()₆ Other reason (specify why):

21. Has a doctor or other health professional ever told you that you had completed menopause or the change in life?

- ()₀ No
- ()₁ Yes

I.D. # - -

22. Have you ever used hormonal medications just before, during or after menopause, such as pills, vaginal creams, shots, suppositories or skin patches?
 ()₀ No **(Skip to Section I)**
 ()₁ Yes

		At what age did you start to use them?	Total number of years used? 77= still using
a. Estrogen pills (Premarin, Estrace, Estratab, Ogen)	() ₀ No () ₁ Yes	___	___
b. Progesterone pills (Progestins, Provera, Megace)	() ₀ No () ₁ Yes	___	___
c. Estrogen and progesterone pills (Prempo)	() ₀ No () ₁ Yes	___	___
d. Estrogen and testosterone (Estratest)	() ₀ No () ₁ Yes	___	___
e. Estrogen vaginal cream	() ₀ No () ₁ Yes	___	___
f. Estrogen shots	() ₀ No () ₁ Yes	___	___
g. Estrogen skin patches (Estraderm)	() ₀ No () ₁ Yes	___	___
h. Estrogen patch and progesterone pills	() ₀ No () ₁ Yes	___	___
i. Suppository	() ₀ No () ₁ Yes	___	___
j. Other _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₀ No () ₁ Yes	___	___

REPRODUCTIVE HISTORY ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

I. OCCUPATIONAL HISTORY

Next, I would like to ask you some questions about your current and past jobs.

- 1. Are you currently employed?
()₀ No **(Skip to I. 3)**
()₁ Yes

- 2. What is your current job title?

- 3. What is or was your usual occupation for your adult life? That is, what occupation did you work at the longest during your adult life? **(If R never worked, Skip to J)**

Never worked

- 4. What is or was your usual activities in this job? **(Relates to Question 3)**

- 5. In what kind of business or industry did you work the longest in your life?

I.D. # ____ - ____ - _____

6. Have you ever had a job in the following industries?	Fill in Yes or No	What was your job title? (Code □□□)	In what year did you start working there?	What year were you last employed there? Still employed=7777
a. Shipbuilding	() ₀ No () ₁ Yes		_____	_____
b. Construction	() ₀ No () ₁ Yes		_____	_____
c. Fishing	() ₀ No () ₁ Yes		_____	_____
d. Lumber, wood, furniture, manufacturing or paper	() ₀ No () ₁ Yes		_____	_____
e. Petrochemical	() ₀ No () ₁ Yes		_____	_____
f. Metal refining, manufacturing, polishing or plating	() ₀ No () ₁ Yes		_____	_____
g. Chemical manufacturing	() ₀ No () ₁ Yes		_____	_____
h. Cement manufacture	() ₀ No () ₁ Yes		_____	_____
i. Demolition	() ₀ No () ₁ Yes		_____	_____
j. Steel mill or foundry	() ₀ No () ₁ Yes		_____	_____
k. Dye industry	() ₀ No () ₁ Yes		_____	_____
l. Hazardous waste removal	() ₀ No () ₁ Yes		_____	_____

OCCUPATIONAL HISTORY ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

I.D. # ____ - ____ - _____

J. RESIDENTIAL HISTORY

1. Where were you born? _____
City State

2. How many months or years did you live in the city or town where you were born?

_____ ()₁ months
 _____ ()₂ years

**If R lived here all his/her life, Skip to Section K
 (R needs to live in location 6 months to constitute residence.)**

3. Please tell me about each of the cities or town that you have lived in during your life.
() Military (check box)

Period		1.	2.	3.	4.
a. Where did you live next? Code country □□□	City/town				
	State	____	____	____	____
	Country				
b. Did you move from here?	Fill in Yes or No	() ₀ No (K) () ₁ Yes	() ₀ No (K) () ₁ Yes	() ₀ No (K) () ₁ Yes	() ₀ No (K) () ₁ Yes
c. At what age did you move from here?		____	____	____	____

Period		5.	6.	7.	8.
a. Where did you live next? Code country □□□	City/town				
	State	____	____	____	____
	Country				
b. Did you move from here?	Fill in Yes or No	() ₀ No (K) () ₁ Yes	() ₀ No (K) () ₁ Yes	() ₀ No (K) () ₁ Yes	() ₀ No (K) () ₁ Yes
c. At what age did you move from here?		____	____	____	____

I.D. # - -

Period		9.	10.	11.	12.
a. Where did you live next? Code country □□□	City/town				
	State	<u> </u> <u> </u>			
	Country				
b. Did you move from here?	Fill in Yes or No	(<input type="checkbox"/>) ₀ No (K) (<input type="checkbox"/>) ₁ Yes	(<input type="checkbox"/>) ₀ No (K) (<input type="checkbox"/>) ₁ Yes	(<input type="checkbox"/>) ₀ No (K) (<input type="checkbox"/>) ₁ Yes	(<input type="checkbox"/>) ₀ No (K) (<input type="checkbox"/>) ₁ Yes
c. At what age did you move from here?		<u> </u> <u> </u>			

RESIDENTIAL HISTORY ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

K. EXERCISE**For Case-Control Participants ONLY. Multi-organ patients skip to section L**

Please tell me about the kinds of activities you do during the week.

1. How would you describe your usual activity during your work in the past year?

- ()₀ Hard physical effort (ex. heavy lifting, digging).
Activities that make you breathe much harder than normal.
- ()₁ Moderate physical effort (ex. carrying light loads).
Activities that make you breathe somewhat harder than normal.
- ()₂ Less physical effort (ex. sitting at a desk, reading, working at a computer.)
- ()₃ Not working.
- ()₈ Don't Know

2. How would you describe your usual leisure time activity in the past year?

- ()₀ Hard physical effort (ex. heavy lifting, aerobics, or fast bicycling).
Activities that make you breathe much harder than normal.
- ()₁ Moderate physical effort (ex. carrying light loads, bicycling at a regular pace, gardening, or taking walks).
Activities that make you breathe somewhat harder than normal.
- ()₂ Less physical effort (ex. sitting at a desk, reading, visiting friends, or watching television.)
- ()₈ Don't Know

3. How would you describe your usual activity during your work 20 years ago?

- ()₀ Hard physical effort (ex. heavy lifting, digging).
Activities that make you breathe much harder than normal.
- ()₁ Moderate physical effort (ex. carrying light loads).
Activities that make you breathe somewhat harder than normal.
- ()₂ Less physical effort (ex. sitting at a desk, reading, working at a computer.)
- ()₃ Not working.
- ()₈ Don't Know

4. How would you describe your usual leisure time activity 20 years ago?

- ()₀ Hard physical effort (ex. heavy lifting, aerobics, or fast bicycling).
Activities that make you breathe much harder than normal.
- ()₁ Moderate physical effort (ex. carrying light loads, bicycling at a regular pace, gardening, or taking walks).
Activities that make you breathe somewhat harder than normal.
- ()₂ Less physical effort (ex. sitting at a desk, reading, visiting friends, or watching television.)
- ()₈ Don't Know

EXERCISE ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

I.D. # _ - _ - _ _ _ _ _ _

L. GENERAL INFORMATION:

- 1. What was the highest level of education that you completed:
 - ()₁ Elementary School (5th or 6th grade)
 - ()₂ Middle or Junior High School (7th, 8th or 9th grade)
 - ()₃ 10th or 11th grade
 - ()₄ High School or GED (12th grade)
 - ()₅ Some College (includes AA degree)
 - ()₆ Technical School
 - ()₇ College
 - ()₈ Professional School (includes MS, PhD, MD, etc)

- 2. *We need your social security number for the purposes of using it as a unique identifier. May I please have your social security number?*

_____ - _____ - _____

Fill in with 8s for Don't Know/Refused.

- 3. What is your current level of household income per year?
 - ()₁ Less than \$10,000
 - ()₂ \$10,000-29,999
 - ()₃ \$30,000-59,999
 - ()₄ \$60,000-90,000
 - ()₅ Greater than \$90,000
 - ()₈ Don't Know/Refused

- 4. How many people are currently supported in your household?

Fill in with 8s for Don't Know/Refused.

- 5. What was the current level of household income in your home twenty years ago?
 - ()₁ Less than \$10,000
 - ()₂ \$10,000-29,999
 - ()₃ \$30,000-59,999
 - ()₄ \$60,000-90,000
 - ()₅ Greater than \$90,000
 - ()₈ Don't Know/Refused

I.D. # _ - _ - _ _ _ _ _ _

6. Twenty years ago, how many people were supported in your household?

ASK LUNG AND PROSTATE CANCER CASE PATIENTS ONLY (Questions 7-9)

7. Are you having any surgery in the near future?
()₀ No (**Skip to Ending**)
()₁ Yes

8. What kind of surgery are you having?
_____ .

9. When are you having this surgery?
_____ / _____ / _____

FOR ALL PARTICIPANTS

10. May we contact you again later if we need to clarify any of the information you have provided. ()₀ No
()₁ Yes

11. Time ended: ___ : ___ ()₁ AM
()₂ PM

For Case-Control Participants ONLY – First get specimen samples and then provide reimbursement of \$50.00.

Blood Specimen Collected

Urine Specimen Collected

I.D. # _ - _ - _ _ _ _ _ _

M. ADMINISTRATIVE INFORMATION

- 1. Date form completed: ___ / ___ / _____
- 2. Name of Interviewer _____ / _____ / _____
- 3. Interviewer ID number: _____
- 4. Interviewer's Signature: _____

N. INTERVIEWER REMARKS

- 1. Interview was conducted:
 - ()₁ Home
 - ()₂ Hospital - inpatient (specify) _____
 - ()₃ Hospital - outpatient (specify) _____
 - ()₄ Non-residential, non-hospital location
(specify) _____
 - ()₅ One of the Study Offices
 - ()₆ Other (specify) _____

- 2. Respondent's cooperation was:
 - ()₁ Very good
 - ()₂ Good
 - ()₃ Fair
 - ()₄ Poor

- 3. The overall quality of the interview was:
 - ()₁ Very good
 - ()₂ Good
 - ()₃ Fair
 - ()₄ Poor

I.D. # _ - _ - _ _ _ _ _

4. Did any of the following occur during the interview?
- a. R did not know enough information regarding the topics()₀ No ()₁ Yes
 - b. R did not want to be more specific ()₀ No ()₁ Yes
 - c. R did not understand or speak English well ()₀ No ()₁ Yes
 - d. R was upset or depressed ()₀ No ()₁ Yes
 - e. R had poor hearing or speech ()₀ No ()₁ Yes
 - f. R was confused by frequent interruptions ()₀ No ()₁ Yes
 - g. R was emotionally unstable ()₀ No ()₁ Yes
 - h. Others helped with the answers ()₀ No ()₁ Yes
 - i. R required a lot of probing ()₀ No ()₁ Yes
 - j. Patient was reserved ()₀ No ()₁ Yes
 - k. R was physically ill ()₀ No ()₁ Yes
 - l. Other, specify _____ ()₀ No ()₁ Yes

5. Comments/Remarks:

4. During the past 6 months, how often have you eaten beef or lamb (includes steaks, stew, hamburger, roast, or hotdog)?

()₀ daily
()₁ 4-6 per week
()₂ 2-3 per week
()₃ once per week
()₄ 1-3 per month
()₅ never or less than once a month

5. During the past 6 months, how often have you eaten pork (includes bacon, chops, roast, or sausage)?

()₀ daily
()₁ 4-6 per week
()₂ 2-3 per week
()₃ once per week
()₄ 1-3 per month
()₅ never or less than once a month

6. During the past 6 months, how often have you eaten poultry (includes chicken, turkey, or duck)?

()₀ daily
()₁ 4-6 per week
()₂ 2-3 per week
()₃ once per week
()₄ 1-3 per month
()₅ never or less than once a month

7. How is your meat usually cooked? (*Includes chicken, beef, pork and lamb but not fish*) (**Code all that apply**)

- ()₀ never eats meat (**skip to question 8**)
- ()₁ eats meat (**skip to question 7a**)

	How is your meat usually cooked?	
a.	baked	() ₀ no () ₁ yes
b.	boiled	() ₀ no () ₁ yes
c.	fried	() ₀ no () ₁ yes
d.	grilled	() ₀ no () ₁ yes
e.	steamed	() ₀ no () ₁ yes
f.	microwaved	() ₀ no () ₁ yes
e.	broiled	() ₀ no () ₁ yes

8. Which method do you use most often? (*Includes chicken, beef, pork and lamb but not fish*)

- ()₀ baked
- ()₁ boiled
- ()₂ fried
- ()₃ grilled
- ()₄ steamed
- ()₅ microwaved
- ()₆ broiled
- ()₇ never eats meat

9. The red meat you eat is usually (*Includes beef and pork*)

- ()₀ well done
- ()₁ medium
- ()₂ rare
- ()₃ never eats meat

10. How often do you eat fish? (*Fresh fish, not canned fish*)

- ()₀ daily
- ()₁ 4-6 per week
- ()₂ 2-3 per week
- ()₃ once per week
- ()₄ 1-3 per month
- ()₅ never or less than once a month

11. How much fish do you usually eat per serving?

For help: three ounces of grilled fish is the size of a typical checkbook.

- ()₀ more than 12 ounces
- ()₁ 7-12 ounces
- ()₂ 3-6 ounces
- ()₃ less than 3 ounces

12. What kinds of fat is used in the foods you eat? (**Code all that apply**)

- ()₀ none (**skip to question 13**)
- ()₁ eats fat (**skip to question 12a**)

	What kinds of fat is used in the foods you eat?	
a.	butter	() ₀ no () ₁ yes
b.	bacon-fat	() ₀ no () ₁ yes
c.	margarine	() ₀ no () ₁ yes
d.	olive oil	() ₀ no () ₁ yes
e.	canola oil	() ₀ no () ₁ yes
f.	other oils	() ₀ no () ₁ yes

13. During the past 6 months, how often did you have bacon-fat or drippings in your meals (includes breakfast, lunch, dinner)?

()₀ two-times or more per day
()₁ once per day
()₂ 4-6 per week
()₃ 2-3 per week
()₄ once per week
()₅ less than once per week
()₆ none or less than once per month

14. Two years ago, how often did you have bacon-fat or drippings in your meals?

()₀ as frequently as it has been in the past 6 months
()₁ twice per day
()₂ once per day
()₃ 4-6 per week
()₄ 2-3 per week
()₅ once per week
()₆ less than once per week
()₇ none or less than once per month

15. During the past 6 months, how much butter have you eaten per week?
For help: eight tablespoons of butter are equal to a stick of butter

()₀ more than 24 tablespoons (or more than 3 sticks)
()₁ 17-24 tablespoons (or 2-3 sticks)
()₂ 9-16 tablespoons (or 1-2 sticks)
()₃ 8 tablespoons or less (or less than a stick)
()₄ none

16. Two years ago, how much butter did you eat per week?

()₀ more than 24 tablespoons (or more than 3 sticks)
()₁ 17-24 tablespoons (or 2-3 sticks)
()₂ 9-16 tablespoons (or 1-2 sticks)
()₃ 8 tablespoons or less (or less than 1 stick)
()₄ none

17. During the past 6 months, how often have you eaten vegetables (includes garlic, onions)?

- ()₀ daily
- ()₁ 4-6 per week
- ()₂ 2-3 per week
- ()₃ once per week
- ()₄ 1-3 per month
- ()₅ never or less than once a month

18. Two years ago, how often did you eat vegetables (includes garlic, onions)?

- ()₀ as frequently as it has been in the past 6 months
- ()₁ daily
- ()₂ 4-6 per week
- ()₃ 2-3 per week
- ()₄ once per week
- ()₅ 1-3 per month
- ()₆ never or less than once a month

19. How many vegetables do you usually eat per serving?
For help: Your fist is approximately one cup.

- ()₀ 2 cups or more
- ()₁ between 1 and 2 cups
- ()₂ ½ cup to 1 cup
- ()₃ less than ½ a cup
- ()₄ none

20. How are your vegetables usually cooked?

- ()₀ steamed
- ()₁ sauteed
- ()₂ boiled
- ()₃ fried
- ()₄ microwaved
- ()₅ fresh/uncooked
- ()₆ never eats vegetables

21. Over the past 6 months, how often did you eat broccoli (fresh or frozen)?

- ()₀ never (**Skip to question O.23**)
- ()₁ less than once per month
- ()₂ 2-3 times per month
- ()₃ 1 time per week
- ()₄ 2 times per week
- ()₅ 3-4 times per week
- ()₆ 5-6 times per week
- ()₇ 1 time per day
- ()₈ 2 or more times per day

22. Each time you ate broccoli, how much did you usually eat?
For help: Your fist is approximately one cup.

- ()₀ Less than 1/4 cup
- ()₁ 1/4 to 1 cup
- ()₂ More than 1 cup

23. During the past 6 months, how often have you eaten garlic?

- ()₀ daily
- ()₁ 4-6 per week
- ()₂ 2-3 per week
- ()₃ once per week
- ()₄ 1-3 per month
- ()₅ never or less than once a month

24. Two years ago, how often did you eat garlic?

- ()₀ as frequently as it has been in the past 6 months
- ()₁ daily
- ()₂ 4-6 per week
- ()₃ 2-3 per week
- ()₄ once per week
- ()₅ 1-3 per month
- ()₆ never or less than once a month

25. How much fresh garlic do you have in your food per week?

- ()₀ more than 2 heads
- ()₁ 2 heads
- ()₂ 1 head
- ()₃ half a head
- ()₄ a clove
- ()₅ none

26. During the past 6 months, how often have you eaten onions?

- ()₀ daily
- ()₁ 4-6 per week
- ()₂ 2-3 per week
- ()₃ once per week
- ()₄ 1-3 per month
- ()₅ never or less than once a month

27. Two years ago, how often did you eat onions?

- ()₀ as frequently as it has been in the past 6 months
- ()₁ daily
- ()₂ 4-6 per week
- ()₃ 2-3 per week
- ()₄ once per week
- ()₅ 1-3 per month
- ()₆ never or less than once a month

28. How many onions do you eat with your food per week?

- ()₀ more than 4 onions
- ()₁ 3-4 onions
- ()₂ 2 onions
- ()₃ 1 onion
- ()₄ half an onion or less
- ()₅ none

29. How often do you eat other types of allium vegetables such as leek, chives or scallions?

- ()₀ daily
- ()₁ 4-6 per week
- ()₂ 2-3 per week
- ()₃ once per week
- ()₄ 1-3 per month
- ()₅ never or less than once a month

30. During the past 6 months, how often have you eaten fresh tomatoes?

- ()₀ daily
- ()₁ 4-6 per week
- ()₂ 2-3 per week
- ()₃ once per week
- ()₄ 1-3 per month
- ()₅ never or less than once a month

31. Two years ago, how often did you eat fresh tomatoes?

- ()₀ as frequently as it has been in the past 6 months
- ()₁ daily
- ()₂ 4-6 per week
- ()₃ 2-3 per week
- ()₄ once per week
- ()₅ 1-3 per month
- ()₆ never or less than once a month

32. How many fresh tomatoes do you eat per week?

- ()₀ more than 10
- ()₁ 6-10
- ()₂ 3-5
- ()₃ 1-2
- ()₄ less than one

I.D. # _ - _ - _ _ _ _ _ _

33. How often do you eat food with processed tomatoes (puree, sauce)?
Examples are: spaghetti or pizza with tomato sauce.

- ()₀ daily
- ()₁ 4-6 per week
- ()₂ 2-3 per week
- ()₃ once per week
- ()₄ 1-3 per month
- ()₅ never or less than once a month

34. How often do you have ketchup with your food?

- ()₀ daily
- ()₁ 4-6 per week
- ()₂ 2-3 per week
- ()₃ once per week
- ()₄ 1-3 per month
- ()₅ never or less than once a month **(Skip to end)**

35. How much ketchup do you usually eat per meal?

- ()₀ more than 6 tablespoons
- ()₁ 4-6 tablespoons
- ()₂ 1-3 tablespoons
- ()₃ less than 1 tablespoon

This completes this portion of the interview.

Time ended ___ : ___ ()₁ AM
()₂ PM

NUTRITION ()₁ Very good ()₂ Good ()₃ Fair ()₄ Poor

This completes our interview. I would like to now take the blood and urine sample. I want to thank you very much for the time you have spent in answering my questions today.