Risk Factor Questionnaire v11
February 22, 2017

Canadian Partnership for Tomorrow Project

Projet de partenariat canadien Espoir pour demain

Participating Cohorts

Atlantic PATH
PARTNERSHIP FOR TOMORROW'S HEALTH
For the Benefit of Future Generations

BC GENERATIONS PROJECT
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The Tomorrow Project
Albertans for a Healthier Future

Follow-Up Questionnaire

Office use only

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L	C	V	QA

Directions For Completing This Questionnaire

This questionnaire may take about 35 to 60 minutes to answer.
Please follow the directions carefully. You will be asked to skip certain questions that do not apply to you.

- We appreciate you completing the whole questionnaire. However, if you prefer not to answer a question write '**Decline**' beside it.
- Use a ballpoint pen, not a felt pen.
- Shade in the bubbles completely, like this: ●
- Write numbers in boxes like this | 2 | 1 |

  If you are writing a single digit where there is more than one box, it does not matter which box you write the number in.
- If you make an error, put an X through the incorrect bubble like this:

Before starting the questionnaire please make sure to gather your prescription medications and a tape measure so these items are handy.

Please leave the booklet stapled together. The pages will be separated at the study centre.

If you are not sure how to answer a question, please feel free to contact us:

Atlantic Path:
Study: Halifax Area 494-7284
Toll Free 1-877-285-7284
info@atlanticpath.ca

Ontario Health
1-866-606-0686
info@ontariohealthstudy.ca

BC Generations Project:
Lower Mainland 604-675-8221
Toll Free 1-877-675-8221
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The Tomorrow Project:
Toll Free 1-877-919-9292
tomorrow@albertahealthservices.ca

CARTaGENE:
1-866-366-4249
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DEMOGRAPHIC INFORMATION

DE01 What is your date of birth? DD ☐☐ MM ☐☐ YYYY ☐☐☐☐

DE02 What was your sex at birth? ○ Male ○ Female

DE03 Postal code :
Your postal code will not be shared with researchers but may be used to define the characteristics of the environment where you currently live. If you do not wish to provide a 6-digit postal code, you may provide the first 3 digits or leave this blank.

☐ X0X0X0

DE04 How old were you when you started living in your current residence?

☐ Years

○ Prefer not to answer
○ Don't know

FAMILY CHARACTERISTICS

FA01 What is your current marital status? Please choose the **ONE** that best describes your current situation.

- o Married and/or living with a partner
- o Divorced
- o Widowed
- o Separated
- o Single, never married

HEALTH STATUS

HS01 How would you rate your general health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

HS02 When was the last time you had a routine medical check-up, undertaken by a doctor or a nurse? A medical check-up is a physical exam that usually includes at least a blood pressure measurement and height and weight measurement.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS03 When was the last time you saw a dental professional, including a dentist or a hygienist?

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS04 When was the last time you had a fecal occult blood test (FOBT) or a fecal immunochemical test (FIT)? Both are screening tests for colon cancer that check for blood in your stool, and are usually collected at home where you have a bowel movement. The FOBT uses a stick or a small brush to smear a small sample on a special card and is usually collected for two or three days in a row. The FIT uses a stick attached to the cap of a storage bottle to collect one small sample and place it in the bottle.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS06 When was the last time you had a colonoscopy?
A colonoscopy is an exam where a long tube is used to examine the entire colon for signs of cancer or other health problems. Before the procedure is done, you are usually given a sedative.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS07 When was the last time you had a sigmoidoscopy?
A sigmoidoscopy is an exam where a flexible tube is inserted into the rectum and lower part of the large bowel to look for signs of cancer or other problems. The procedure does **not** usually require sedation.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

HS08 Have you ever had a polyp removed from your colon?
A polyp is an abnormal growth of tissue.

- ○ Yes
- ○ No
- ○ Don't know

HS08 Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	○	○	○	○
2. Not being able to stop or control worrying	○	○	○	○
3. Worrying too much about different things	○	○	○	○
4. Trouble relaxing	○	○	○	○
5. Being so restless that it's hard to sit still	○	○	○	○
6. Becoming easily annoyed or irritable	○	○	○	○
7. Feeling afraid as if something awful might happen	○	○	○	○

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

HS09 Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

WOMEN SKIP TO WOMEN'S HEALTH - WH01 (NEXT PAGE)

MEN'S HEALTH

MH01 When was the last time you had a PSA blood test?
A PSA test is a specific blood test ordered by a doctor to test men for prostate cancer.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

MH02 How many children have you fathered, including live births only?

☐☐ Children

- ○ Don't know

MEN SKIP TO PERSONNAL MEDICAL HISTORY - PM01 (PAGE 13)

WOMEN'S HEALTH

WH01 Have you ever used any hormonal contraceptives for any reason? Hormonal contraceptives include birth control pills, implants, patches, injections, and rings or intra-uterine devices that release female hormones.

- ○ Yes
- ○ No → SKIP TO WH04 (THIS PAGE)
- ○ Don't know → SKIP TO WH04 (THIS PAGE)

WH02 How old were you when you started using hormonal contraceptives?

☐☐ Age when started using hormonal contraceptives

- ○ Don't know

WH03 In total, how many years or months did you use or have you been using hormonal contraceptives? Add up all the time that you used contraceptives even if you started and stopped several times.

☐☐ Years **OR** ☐☐ Months

- ○ Don't know

WH04 How many times have you been pregnant, including live births, stillbirths, spontaneous miscarriage or therapeutic abortions?

☐☐ Number of pregnancies

- ○ Never been pregnant → SKIP TO WH08 (NEXT PAGE)
- ○ Don't know → SKIP TO WH08 (NEXT PAGE)

WH05 Are you currently pregnant?

○ Yes → In what week are you? ☐☐ Weeks

If YES and it's your first pregnancy, SKIP TO WH08 (THIS PAGE)

○ No

○ Don't know

WH06 How many children have you given birth to, considering live births only?

☐☐ Live births

○ Don't know

WH07 How old were you when you last became pregnant?

☐☐ Age at last pregnancy

○ Don't know

WH08 Have you gone through menopause, meaning that your menstrual periods stopped for at least one year and did **not** restart?

○ Yes, natural menopause

○ Yes, other reasons (hysterectomy, surgery, chemotherapy, medication)

○ No → SKIP TO WH10 (NEXT PAGE)

○ Don't know →

WH09 How old were you when your menstrual periods stopped for at least one year and did not restart?

☐☐ Age when menstrual periods stopped

○ Don't know

WH10 Have you ever used hormone replacement therapy (HRT) prescribed by a doctor for any reason?
Hormone replacement therapy includes progesterone and/or estrogen. It includes all forms such as patches, rings, creams and other topical forms prescribed by a doctor. It does not include thyroid hormone treatment or hormonal contraceptives and it does not include other 'natural' treatments that can be bought over the counter. Do not include hormonal fertility treatment.

○ Yes
○ No → SKIP TO WH14 (NEXT PAGE)
○ Don't know →

WH11 Which type of hormone replacement therapy have you used the most?

○ Both Estrogen and Progesterone
○ Estrogen (e.g. Premarin, Estrace)
○ Progesterone (e.g. Prometrium, Provera)
○ Estrogen gel or cream applied to the skin (e.g. Estraderm, Estrogel)
○ Intra-uterine device with progesterone
○ Don’t know

WH12 How old were you when you started using hormone replacement therapy?

☐☐ Age when started using hormone replacement therapy

○ Don't know

WH13 In **total**, for how many years or months did you use, or have you been using, hormone replacement therapy? Add up all the time that you used hormone replacement therapy even if you started and stopped several times.

☐☐ Years **OR** ☐☐ Months

○ Don't know

WH14 Have you ever had a hysterectomy (an operation to have your uterus or womb removed)?

- ○ Yes
- ○ No → SKIP TO WH16 (THIS PAGE)
- ○ Don't know → SKIP TO WH16 (THIS PAGE)

WH15 How old were you when you had your hysterectomy?

☐☐ Age at hysterectomy

WH16 Have you ever had an operation to have your ovaries removed?

- ○ Yes
- ○ No → SKIP TO WH20 (THIS PAGE)
- ○ Don't know → SKIP TO WH20 (THIS PAGE)

WH17 Did you have one or both ovaries removed?

- ○ One → SKIP TO WH19 (THIS PAGE)
- ○ Both
- ○ Don't know

WH18 Were both of your ovaries removed at the same time?

- ○ Yes
- ○ No
- ○ Don't know

WH19 How old were you when you had your ovary removal surgery? If you had two separate operations to remove your ovaries, please indicate the age of the **last** surgery.

☐☐ Age at last ovary removal surgery

- ○ Don't know

WH20 When was the last time you had a mammogram?
A mammogram is a low dose x-ray of the breast in a device that compresses and flattens the breast and is used as a screening test for breast cancer.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

WH21 When was the last time you had a Pap test or a smear test?
A Pap test (sometimes called a cervical smear) is a test performed by a doctor or a nurse where a sample of cells is taken from the cervix.

- ○ Less than 6 months ago
- ○ 6 months to less than 1 year ago
- ○ 1 year to less than 2 years ago
- ○ 2 years to less than 3 years ago
- ○ 3 or more years ago
- ○ Never
- ○ Don't know

PERSONAL MEDICAL HISTORY

PM01 Has a doctor ever told you that you had any of the following conditions? If yes, please provide your **age** when you were first diagnosed and whether you are currently being treated.

Condition	Diagnosed	Age at first Diagnosis	Are you currently being treated?
High blood pressure (hypertension, **not** including during pregnancy)	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
High cholesterol	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Heart attack (myocardial infarction)	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Stroke	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of stroke was it? |_| Thrombotic ---------->|_|_| |_|Don't know |_| Hemorrhagic ---------->|_|_| |_| Don't know |_|Don't know	|_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Heart and circulatory conditions	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of heart condition was it? |_| Atrial fibrillation ---------->|_|_| |_|Don't know |_| Angina ---------->|_|_| |_| Valvular heart disease (e.g. aortic stenosis, mitral valve prolapse) ---------->|_|_| |_|Don't know |_| Heart failure ---------->|_|_| |_| Atherosclerosis/ Coronary Heart Disease (including angioplasty or stents) --------->|_|_| |_|Don't know **|_|Other (please specify)** --->|_|_| |_|Don't know _____ |_| Don't know	|_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know

Multiple sclerosis	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Migraines	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Epilepsy or seizures	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Parkinson's Disease	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Alzheimer's disease	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Asthma	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Chronic obstructive pulmonary disease (COPD)	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of COPD was it? |_| Chronic bronchitis --------->|_|Don't know |_| Emphysema ----------> **|_|Other (please specify)** ---> _____ |_| Don't know	 |_|_| |_|_| |_|_|	 |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Sleep apnea	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Diabetes	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of diabetes was it? |_| Gestational diabetes **only**->|_|Don't know |_| Type 1 diabetes---------->|_|Don't know |_| Type 2 diabetes---------->|_|Don't know |_| Don't know	 |_|_| |_|_| |_|_|	 |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Thyroid disease	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of thyroid		

	disease was it? |_|Hypothyroid----------> |_|Hyperthyroid----------> |_|Other (please specify) ------> _____ |_| Don't know	|_|_| |_|Don't know |_|_| |_|Don't know |_|_| |_|Don't know	|_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Crohn's disease	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Ulcerative colitis	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Irritable bowel syndrome	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Stomach ulcers	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Persistent acid reflux (GERD)	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Liver cirrhosis	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Chronic hepatitis	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Fatty liver (NAFLD/ NASH)	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Pancreatitis	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Gall stones	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Cholecystitis	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Renal disease/kidney failure	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of renal disease was it? |_| Weak or failing kidney -----> |_| Acute renal failure --------->	|_|_| |_|Don't know |_|_| |_|Don't know	|_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know

	|_| Chronic renal failure -------> |_| Kidney stones ----------> |_| Pyelonephritis (kidney infection) ----------> **|_|Other (please specify)** --->_____ |_| Don't know	|_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know	|_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Mental health condition	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of mental health condition was is? |_| Major depression---------->|_| Bipolar disorder---------->|_| Minor depression---------->|_| Post-traumatic stress-------> disorder |_| Schizophrenia or ----------> schizoaffective disorder |_| Obsessive compulsive ----> disorder |_| Anxiety disorder---------->|_| Eating disorder---------->|_| Addiction disorder (e.g.,---> alcohol, drug or gambling dependence) |_| Other mental health -------> condition |_| Don't know	|_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know	|_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Osteoporosis	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Arthritis	|_|Yes ----------> |_|No |_|Don't know If yes, which **type(s)** of arthritis was it? |_|Rheumatoid arthritis--------->|_|Osteoarthritis----------	|_||_| |_|Don't know |_||_| |_|Don't know	|_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know

	|_|**Other (Please specify)**----> _____ |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Lupus	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Fibromyalgia	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Chronic fatigue syndrome	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Eczema	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Psoriasis	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Human Immunodeficiency virus (HIV)	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Genital warts (HPV infection)	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Genital herpes	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Eye vision conditions	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of eye vision condition was it? |_| Macular degeneration -----> |_| Glaucoma ----------> |_| Cataracts ----------> **|_|Other (please specify)** ----> _____ |_| Don't know	 |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know	 |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know

Hearing conditions	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of hearing condition was it? |_| Tinnitus (sound in your ears or head) ----------> |_| Hearing loss ----------> **|_|Other (please specify)** ---> _____ |_| Don't know	 |_|_| |_|Don't know |_|_| |_|Don't know |_|_| |_|Don't know	 |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Condition	**Diagnosed**	**Age at first Diagnosis**	**Are you currently being treated?**
High blood pressure (hypertension, **not** including during pregnancy)	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
High cholesterol	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Heart attack (myocardial infarction)	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Stroke	|_|Yes ----------> |_|No |_|Don't know If yes, which **type** of stroke was it? |_| Thrombotic |_| Hemorrhagic |_| Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Heart and circulatory conditions	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of heart condition was it? |_| Atrial fibrillation ----------> |_| Angina ----------> |_| Valvular heart disease (e.g. aortic stenosis, mitral valve prolapse) ----------> |_| Heart failure ----------> |_| Atherosclerosis/ Coronary Heart Disease (including angioplasty or stents) --------->	 |_|_| |_|Don't know |_|_| |_|Don't know |_|_| |_|Don't know |_|_| |_|Don't know |_|_| |_|Don't know	 |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know

	|_|Other (please specify) ---> _____ |_| Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Multiple sclerosis	|_|Yes ---------->|_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Migraines	|_|Yes ---------->|_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Epilepsy or seizures	|_|Yes ---------->|_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Parkinson's Disease	|_|Yes ---------->|_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Alzheimer's disease	|_|Yes ---------->|_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Asthma	|_|Yes ---------->|_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Chronic obstructive pulmonary disease (COPD)	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of COPD was it? |_| Chronic bronchitis --------->|_|Don't know |_| Emphysema ---------->|_|Don't know **|_|Other (please specify)** ---> _____ |_| Don't know	 |_|_| |_|_| |_|_|	 |_|Yes |_|No |_|Yes |_|No |_|Yes |_|No |_|Don't know
Sleep apnea	|_|Yes ---------->|_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Diabetes	|_|Yes ---------->|_|No |_|Don't know If yes, which **type** of diabetes was it? |_| Gestational diabetes **only** |_| Type 1 diabetes |_| Type 2 diabetes |_| Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know

Thyroid disease	|_|Yes ----------> |_|No |_|Don't know If yes, which **type** of thyroid disease was it? |_|Hypothyroid |_|Hyperthyroid |_|Other (please specify) _____ |_| Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Crohn's disease	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Ulcerative colitis	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Irritable bowel syndrome	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Stomach ulcers	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Persistent acid reflux (GERD)	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Liver cirrhosis	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Chronic hepatitis	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Fatty liver (NAFLD/ NASH)	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Pancreatitis	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Gall stones	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Cholecystitis	|_|Yes ----------> |_|No |_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Renal disease/kidney failure	|_|Yes |_|No |_|Don't know If yes, which **type** of renal disease was it? |_| Weak or failing kidney ----->	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know

	|_| Acute renal failure ---------> |_| Chronic renal failure ------->|_| Kidney stones ---------->|_| Pyelonephritis (kidney infection) ---------->|_|**Other (please specify)** --->_____ |_| Don't know	|_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know |_||_| |_|Don't know	|_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Mental health condition	|_|Yes ---------->|_|No|_|Don't know If yes, which **type(s)** of mental health condition was is? Please select all that apply|_| Major depression|_| Bipolar disorder|_| Minor depression|_| Post-traumatic stress disorder|_| Schizophrenia or schizoaffective disorder|_| Obsessive compulsive disorder|_| Anxiety disorder|_| Eating disorder|_| Addiction disorder (e.g., alcohol, drug or gambling dependence)|_| Other mental health condition	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Osteoporosis	|_|Yes ---------->|_|No|_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Arthritis	|_|Yes ---------->|_|No|_|Don't know If yes, which **type** of arthritis was it?|_|Rheumatoid arthritis|_|Osteoarthritis|_|Other (Please specify):_____|_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Lupus	|_|Yes ---------->|_|No|_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know
Fibromyalgia	|_|Yes ---------->|_|No|_|Don't know	|_||_| |_|Don't know	|_|Yes |_|No |_|Don't know

Chronic fatigue syndrome	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Eczema	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Psoriasis	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Human Immunodeficiency virus (HIV)	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Genital warts (HPV infection)	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Genital herpes	|_|Yes ----------> |_|No |_|Don't know	|_|_| |_|Don't know	|_|Yes |_|No |_|Don't know
Eye vision conditions	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of eye vision condition was it? |_| Macular degeneration -----> |_| Glaucoma ----------> |_| Cataracts ----------> **|_|Other (please specify)** ----> _____ |_| Don't know	 |_|_| |_|Don't know |_|_| |_|Don't know |_|_| |_|Don't know |_|_| |_|Don't know	 |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know
Hearing conditions	|_|Yes |_|No |_|Don't know If yes, which **type(s)** of hearing condition was it? |_| Tinnitus (sound in your ears or head) ----------> |_| Hearing loss ----------> **|_|Other (please specify)** ---> _____ |_| Don't know	 |_|_| |_|Don't know |_|_| |_|Don't know |_|_| |_|Don't know	 |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know |_|Yes |_|No |_|Don't know

PM02 Has a doctor ever told you that you had cancer or a malignancy of any kind?

- ○ Yes
- ○ No → SKIP TO PM04 (PAGE 19)
- ○ Don't know →

PM03 What **type** of cancer was it and how **old** were you when the cancer was <u>first</u> diagnosed? Select only one cancer.

- First type of Cancer

Cancer type	Age at first Diagnosis	Treatment	Type of treatment
o Bladder o Brain o Breast o Cervix o Colon o Esophagus o Kidney o Larynx o Leukemia o Liver o Lung and bronchus o Lymphoma (Hodgkin Lymphoma) o Lymphoma (Non-Hodgkin Lymphoma, other) o Mouth, tongue and throat o Multiple myeloma o Ovary o Pancreas o Prostate o Rectum o Skin (Melanoma) o Skin (Non-Melanoma) o Small intestine o Stomach o Testicular o Thyroid o Uterus o Other Specify: [ ] o Don't know	[ ][ ] Age at first Diagnosis o Don't know	Did you receive treatment for this cancer? o Yes → o No o Don't know	What type of treatment was it? **(Choose ALL that apply)** o Chemotherapy o Radiation o Surgery o Laser therapy o Stem cell therapy o Other Specify: [ ] o Don't know

Second type of cancer

What type of cancer was it and how old were you when the cancer was first diagnosed?

Select only one cancer.

Cancer type	Age at first Diagnosis	Treatment	Type of treatment
o Bladder o Brain o Breast o Cervix o Colon o Esophagus o Kidney o Larynx o Leukemia o Liver o Lung and bronchus o Lymphoma (Hodgkin Lymphoma) o Lymphoma (Non-Hodgkin Lymphoma, other) o Mouth, tongue and throat o Multiple myeloma o Ovary o Pancreas o Prostate o Rectum o Skin (Melanoma) o Skin (Non-Melanoma) o Small intestine o Stomach o Testicular o Thyroid o Uterus o Other Specify: [ ] o Don't know	[ ][ ] Age at first Diagnosis o Don't know	Did you receive treatment for this cancer? o Yes → o No o Don't know	What type of treatment was it? **(Choose ALL that apply)** o Chemotherapy o Radiation o Surgery o Laser therapy o Stem cell therapy o Other Specify: [ ] o Don't know

Third type of cancer

What type of cancer was it and how old were you when the cancer was first diagnosed?

Select only one cancer.

Cancer type	Age at first Diagnosis	Treatment	Type of treatment
o Bladder o Brain o Breast o Cervix o Colon o Esophagus o Kidney o Larynx o Leukemia o Liver o Lung and bronchus o Lymphoma (Hodgkin Lymphoma) o Lymphoma (Non-Hodgkin Lymphoma, other) o Mouth, tongue and throat o Multiple myeloma o Ovary o Pancreas o Prostate o Rectum o Skin (Melanoma) o Skin (Non-Melanoma) o Small intestine o Stomach o Testicular o Thyroid o Uterus o Other Specify: [ ] o Don't know	[ ][ ] Age at first Diagnosis o Don't know	Did you receive treatment for this cancer? o Yes → o No o Don't know	What type of treatment was it? **(Choose ALL that apply)** o Chemotherapy o Radiation o Surgery o Laser therapy o Stem cell therapy o Other Specify: [ ] o Don't know

PM04 Do you have or have you had any other **long-term health conditions**?

- ○ Yes
- ○ No → SKIP TO PRESCRIPTION MEDICATION – ME01 (NEXT PAGE)
- ○ Don't know →

Please list these long-term conditions.

Long term condition 1: [ ]

Long term condition 2: [ ]

Long term condition 3: [ ]

PRESCRIBED MEDICATION

ME01 Are you currently taking any medications prescribed by a doctor and dispensed by a pharmacist? Prescription medication could include such things as insulin, nicotine patches, birth control (pills, patches or injections) and other hormonal therapies.

You can add up to 10 different prescriptions..

- ○ Yes
- ○ No → SKIP TO ME02 (NEXT PAGE)
- ○ Don't know → SKIP TO ME02 (NEXT PAGE)

For **each** prescribed medication that you are currently taking, please write down the name of the medication and the drug identification number (DIN).

If you have access to the bottles and containers, write down the name of each medication and DIN from the label. The DIN is an 8 digit number that should be printed on the label that is attached to the container by the pharmacist. It is NOT the prescription number.

Medication	Name of Medication	Drug Identification Number (DIN)
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

ME02 Do you **regularly** take **aspirin** or **pain relievers *4 times a month or more***? (Including aspirin for disease prevention)

- ○ Yes
- ○ No → SKIP TO FAMILY HEALTH HISTORY – FM01 (NEXT PAGE)
- ○ Don't know → SKIP TO FAMILY HEALTH HISTORY – FM01 (NEXT PAGE)

If Yes, mark all that apply below	Average number of	
	Days per Month	Pills per Day (on days used)
Low-dose or “baby” aspirin (81 mg tablet)	☐☐	☐☐
Regular or extra-strength aspirin (Include Excedrin and powders with aspirin)	☐☐	☐☐
Ibuprofen (such as Motrin, Advil, Nuprin)	☐☐	☐☐
Acetaminophen (such as Tylenol)	☐☐	☐☐
Naproxen (such as Naprosyn, Aleve)	☐☐	☐☐
Other NSAID pain relievers (Such as Celebrex, meloxicam, diclofenac, nabumetone, indomethacin, sundac or piroxicam. Do not include narcotics or Lyrica)	☐☐	☐☐

FAMILY HEALTH HISTORY

For your family health history, please **ONLY** include **immediate blood relatives**, including your mother, father, children, full and half brothers and sisters. Do not include relatives by marriage, stepbrothers and stepsisters, parents by adoption, stepchildren or adopted children.

FM01 Have any of your **immediate blood relatives** ever been diagnosed by a medical doctor with any of the following long-term health conditions?

	Health Condition			
Mother	Heart attack (myocardial infarction)	O Yes	O No	O Don't know
	Stroke	O Yes	O No	O Don't know
	Diabetes	O Yes	O No	O Don't know
	Chronic obstructive pulmonary disease	O Yes	O No	O Don't know
	High blood pressure	O Yes	O No	O Don't know
	Asthma	O Yes	O No	O Don't know
	Major Depression	O Yes	O No	O Don't know
	Liver cirrhosis	O Yes	O No	O Don't know
	Chronic hepatitis	O Yes	O No	O Don't know
	Crohn's disease	O Yes	O No	O Don't know
	Ulcerative colitis	O Yes	O No	O Don't know
	Irritable bowel syndrome	O Yes	O No	O Don't know
	Eczema	O Yes	O No	O Don't know
	Lupus	O Yes	O No	O Don't know
	Psoriasis	O Yes	O No	O Don't know
	Multiple sclerosis	O Yes	O No	O Don't know
	Osteoporosis	O Yes	O No	O Don't know
	Arthritis	O Yes	O No	O Don't know
	Other, please specify _____	O Yes	O No	O Don't know

	Health Condition			
Father	Heart attack (myocardial infarction)	O Yes	O No	O Don't know
	Stroke	O Yes	O No	O Don't know
	Diabetes	O Yes	O No	O Don't know
	Chronic obstructive pulmonary disease	O Yes	O No	O Don't know
	High blood pressure	O Yes	O No	O Don't know
	Asthma	O Yes	O No	O Don't know
	Major Depression	O Yes	O No	O Don't know
	Liver cirrhosis	O Yes	O No	O Don't know
	Chronic hepatitis	O Yes	O No	O Don't know
	Crohn's disease	O Yes	O No	O Don't know
	Ulcerative colitis	O Yes	O No	O Don't know
	Irritable bowel syndrome	O Yes	O No	O Don't know
	Eczema	O Yes	O No	O Don't know
	Lupus	O Yes	O No	O Don't know
	Psoriasis	O Yes	O No	O Don't know
	Multiple sclerosis	O Yes	O No	O Don't know
	Osteoporosis	O Yes	O No	O Don't know
	Arthritis	O Yes	O No	O Don't know
	Other, please specify _____	O Yes	O No	O Don't know

Siblings ○ I do not have any siblings	Heart attack (myocardial infarction) O Yes O No O Don't know	If yes, # of siblings ☐☐
	Stroke O Yes O No O Don't know	If yes, # of siblings ☐☐
	Diabetes O Yes O No O Don't know	If yes, # of siblings ☐☐
	Chronic obstructive pulmonary disease O Yes O No O Don't know	If yes, # of siblings ☐☐
	High blood pressure O Yes O No O Don't know	If yes, # of siblings ☐☐
	Asthma O Yes O No O Don't know	If yes, # of siblings ☐☐
	Major Depression O Yes O No O Don't know	If yes, # of siblings ☐☐
	Liver cirrhosis O Yes O No O Don't know	If yes, # of siblings ☐☐
	Chronic hepatitis O Yes O No O Don't know	If yes, # of siblings ☐☐
	Crohn's disease O Yes O No O Don't know	If yes, # of siblings ☐☐
	Ulcerative colitis O Yes O No O Don't know	If yes, # of siblings ☐☐
	Irritable bowel syndrome O Yes O No O Don't know	If yes, # of siblings ☐☐
	Eczema O Yes O No O Don't know	If yes, # of siblings ☐☐
	Lupus O Yes O No O Don't know	If yes, # of siblings ☐☐
	Psoriasis O Yes O No O Don't know	If yes, # of siblings ☐☐
	Multiple sclerosis O Yes O No O Don't know	If yes, # of siblings ☐☐
	Osteoporosis O Yes O No O Don't know	If yes, # of siblings ☐☐
	Arthritis O Yes O No O Don't know	If yes, # of siblings ☐☐
	Other, please specify _____ ○Yes ○ No ○Don't Know	If yes, # of siblings ☐☐

Children ○ I do not have any children	Heart attack (myocardial infarction) O Yes O No O Don't know	If yes, # of children ☐☐
	Stroke O Yes O No O Don't know	If yes, # of children ☐☐
	Diabetes O Yes O No O Don't know	If yes, # of children ☐☐
	Chronic obstructive pulmonary disease O Yes O No O Don't know	If yes, # of children ☐☐
	High blood pressure O Yes O No O Don't know	If yes, # of children ☐☐
	Asthma O Yes O No O Don't know	If yes, # of children ☐☐
	Major Depression O Yes O No O Don't know	If yes, # of children ☐☐
	Liver cirrhosis O Yes O No O Don't know	If yes, # of children ☐☐
	Chronic hepatitis O Yes O No O Don't know	If yes, # of children ☐☐
	Crohn's disease O Yes O No O Don't know	If yes, # of children ☐☐
	Ulcerative colitis O Yes O No O Don't know	If yes, # of children ☐☐
	Irritable bowel syndrome O Yes O No O Don't know	If yes, # of children ☐☐
	Eczema O Yes O No O Don't know	If yes, # of children ☐☐
	Lupus O Yes O No O Don't know	If yes, # of children ☐☐
	Psoriasis O Yes O No O Don't know	If yes, # of children ☐☐
	Multiple sclerosis O Yes O No O Don't know	If yes, # of children ☐☐
	Osteoporosis O Yes O No O Don't know	If yes, # of children ☐☐
	Arthritis O Yes O No O Don't know	If yes, # of children ☐☐
	Other, please specify _____ ○Yes ○ No ○Don't Know	If yes, # of children ☐☐

FM02 Have any of your **immediate blood relatives**, including your mother, father, children, full and half brothers and sisters ever been diagnosed with cancer?

- ○ Yes
- ○ No → SKIP TO SLEEP PATTERN – SP01 (PAGE 30)
- ○ Don't know →

FM03 Has your **biological** mother ever been diagnosed with cancer?

- ○ Yes
- ○ No → SKIP TO FM05 (THIS PAGE)
- ○ Don't know →

FM04 Which of the following **types** of cancer was your mother diagnosed with? Choose **ALL** that apply.

- ○ Bladder
- ○ Brain
- ○ Breast
- ○ Cervix
- ○ Colon
- ○ Esophagus
- ○ Kidney
- ○ Larynx
- ○ Leukemia
- ○ Liver
- ○ Lung and Bronchus
- ○ Lymphoma (Hodgkin Lymphoma)
- ○ Lymphoma (Non-Hodgkin Lymphoma, other)
- ○ Mouth, tongue and throat
- ○ Multiple Myeloma
- ○ Ovary
- ○ Pancreas
- ○ Rectum
- ○ Skin (Melanoma)
- ○ Skin (Non-Melanoma)
- ○ Small Intestine
- ○ Stomach
- ○ Thyroid
- ○ Uterus
- ○ Other, Specify: _____
- ○ Don't Know

FM05 Has your **biological** father ever been diagnosed with cancer?

- ○ Yes
- ○ No → SKIP TO FM07 (PAGE 28)
- ○ Don't know →

FM06 Which of the following **types** of cancer was your father diagnosed with? Choose **ALL** that apply.

- ○ Bladder
- ○ Brain
- ○ Breast
- ○ Colon
- ○ Esophagus
- ○ Kidney
- ○ Larynx
- ○ Leukemia
- ○ Liver
- ○ Lung
- ○ Lymphoma and Bronchus (Hodgkin Lymphoma)
- ○ Lymphoma (Non-Hodgkin Lymphoma, other)
- ○ Mouth, tongue and throat
- ○ Multiple Myeloma
- ○ Prostate
- ○ Pancreas
- ○ Rectum
- ○ Skin (Melanoma)
- ○ Skin (Non-Melanoma)
- ○ Small Intestine
- ○ Stomach
- ○ Testicle
- ○ Thyroid
- ○ Other, Specify: [ ]
- ○ Don't Know

FM07 Have any of your **biological** siblings ever been diagnosed with cancer?

- ○ Yes → If yes, how many siblings ☐☐
  - ○ Don't know
- ○ No
- ○ I do not have any siblings
- ○ Don't know

FM08 Have any of your **biological** children ever been diagnosed with cancer?

- ○ Yes → If yes, how many children ☐☐
  - ○ Don't know
- ○ No
- ○ I do not have any children
- ○ Don't know

IF "NO" FOR FM07 AND FM08 **OR**
IF "DON'T HAVE SIBLINGS AND CHILDREN" **OR**
IF, "DON'T KNOW" FOR FM07 AND FM08

SKIP TO SLEEP PATTERN - SP01 (PAGE 30)

FM09 For your biological siblings and children, please indicate how many siblings and children have been diagnosed with the cancer types listed below. Leave blank if none of your siblings or children have been diagnosed with a particular type of cancer.

Cancer type	Number siblings diagnosed	Number children diagnosed
Bladder	|_||_| Number of siblings	|_||_| Number of children
Brain	|_||_| Number of siblings	|_||_| Number of children
Breast	|_||_| Number of siblings	|_||_| Number of children
Cervix	|_||_| Number of siblings	|_||_| Number of children
Colon	|_||_| Number of siblings	|_||_| Number of children
Esophagus	|_||_| Number of siblings	|_||_| Number of children
Kidney	|_||_| Number of siblings	|_||_| Number of children
Larynx	|_||_| Number of siblings	|_||_| Number of children
Leukemia	|_||_| Number of siblings	|_||_| Number of children
Liver	|_||_| Number of siblings	|_||_| Number of children
Lung and Bronchus	|_||_| Number of siblings	|_||_| Number of children
Lymphoma (Hodgkin Lymphoma)	|_||_| Number of siblings	|_||_| Number of children
Lymphoma (Non-Hodgkin Lymphoma, other)	|_||_| Number of siblings	|_||_| Number of children
Mouth, tongue and throat	|_||_| Number of siblings	|_||_| Number of children
Multiple Myeloma	|_||_| Number of siblings	|_||_| Number of children
Ovary	|_||_| Number of siblings	|_||_| Number of children
Pancreas	|_||_| Number of siblings	|_||_| Number of children
Prostate	|_||_| Number of siblings	|_||_| Number of children
Rectum	|_||_| Number of siblings	|_||_| Number of children
Skin (Melanoma)	|_||_| Number of siblings	|_||_| Number of children
Skin (Non-Melanoma)	|_||_| Number of siblings	|_||_| Number of children
Small Intestine	|_||_| Number of siblings	|_||_| Number of children
Stomach	|_||_| Number of siblings	|_||_| Number of children
Testicle	|_||_| Number of siblings	|_||_| Number of children
Thyroid	|_||_| Number of siblings	|_||_| Number of children
Uterus	|_||_| Number of siblings	|_||_| Number of children
Other	|_||_| Number of siblings Specify the cancer type _____ _____	|_||_| Number of children Specify the cancer type: _____ _____
Don't Know	|_||_| Number of siblings	|_||_| Number of children

FM10 Indicate which, if any of your **second degree relatives** including your uncles, aunts, and your grandparents have ever been diagnosed with cancer?

***Note**: Do NOT include relatives by marriage*

- ○ Maternal grand-father
- ○ Maternal grand-mother
- ○ Paternal grand-father
- ○ Paternal grand-mother
- ○ Maternal uncle
- ○ Maternal aunt
- ○ Paternal uncle
- ○ Paternal aunt
- ○ None → SKIP TO SLEEP PATTERN – SP01 (PAGE 30)
- ○ Don't know → Other choices, show only selected items from FM11 to FM18

FM11 Which of the following types of cancer was **your grand-father on your mother's side** (maternal grand-father) diagnosed with?

Note: *Choose ALL that apply*

Cancer type	maternal grand-father
Bladder	|_| yes |_| no |_| don't know
Brain	|_| yes |_| no |_| don't know
Breast	|_| yes |_| no |_| don't know
Colon	|_| yes |_| no |_| don't know
Esophagus	|_| yes |_| no |_| don't know
Kidney	|_| yes |_| no |_| don't know
Larynx	|_| yes |_| no |_| don't know
Leukemia	|_| yes |_| no |_| don't know
Liver	|_| yes |_| no |_| don't know
Lung and Bronchus	|_| yes |_| no |_| don't know
Lymphoma (Hodgkin Lymphoma)	|_| yes |_| no |_| don't know
Lymphoma (Non-Hodgkin Lymphoma, other)	|_| yes |_| no |_| don't know
Mouth, tongue and throat	|_| yes |_| no |_| don't know
Multiple Myeloma	|_| yes |_| no |_| don't know
Pancreas	|_| yes |_| no |_| don't know
Prostate	|_| yes |_| no |_| don't know
Rectum	|_| yes |_| no |_| don't know
Skin (Melanoma)	|_| yes |_| no |_| don't know
Skin (Non-Melanoma)	|_| yes |_| no |_| don't know
Small Intestine	|_| yes |_| no |_| don't know
Stomach	|_| yes |_| no |_| don't know
Testicle	|_| yes |_| no |_| don't know
Thyroid	|_| yes |_| no |_| don't know
Other _____	Specify the cancer type

FM12 Which of the following types of cancer was **your grand-mother on your mother's side** (maternal grand-mother) diagnosed with?

Note: *Choose ALL that apply*

Cancer type	maternal grand-mother
Bladder	|_| yes |_| no |_| don't know
Brain	|_| yes |_| no |_| don't know
Breast	|_| yes |_| no |_| don't know
Cervix	|_| yes |_| no |_| don't know
Colon	|_| yes |_| no |_| don't know
Esophagus	|_| yes |_| no |_| don't know
Kidney	|_| yes |_| no |_| don't know
Larynx	|_| yes |_| no |_| don't know
Leukemia	|_| yes |_| no |_| don't know
Liver	|_| yes |_| no |_| don't know
Lung and Bronchus	|_| yes |_| no |_| don't know
Lymphoma (Hodgkin Lymphoma)	|_| yes |_| no |_| don't know
Lymphoma (Non-Hodgkin Lymphoma, other)	|_| yes |_| no |_| don't know
Mouth, tongue and throat	|_| yes |_| no |_| don't know
Multiple Myeloma	|_| yes |_| no |_| don't know
Ovary	|_| yes |_| no |_| don't know
Pancreas	|_| yes |_| no |_| don't know
Rectum	|_| yes |_| no |_| don't know
Skin (Melanoma)	|_| yes |_| no |_| don't know
Skin (Non-Melanoma)	|_| yes |_| no |_| don't know
Small Intestine	|_| yes |_| no |_| don't know
Stomach	|_| yes |_| no |_| don't know
Thyroid	|_| yes |_| no |_| don't know
Uterus	|_| yes |_| no |_| don't know
Other _____	Specify the cancer type

FM13 Which of the following types of cancer was **your grand-father on your father's side** (paternal grand-father) diagnosed with?

Note: *Choose ALL that apply*

Cancer type	paternal grand-father
Bladder	|_| yes |_| no |_| don't know
Brain	|_| yes |_| no |_| don't know
Breast	|_| yes |_| no |_| don't know
Colon	|_| yes |_| no |_| don't know
Esophagus	|_| yes |_| no |_| don't know
Kidney	|_| yes |_| no |_| don't know
Larynx	|_| yes |_| no |_| don't know
Leukemia	|_| yes |_| no |_| don't know
Liver	|_| yes |_| no |_| don't know
Lung and Bronchus	|_| yes |_| no |_| don't know
Lymphoma (Hodgkin Lymphoma)	|_| yes |_| no |_| don't know

Lymphoma (Non-Hodgkin Lymphoma, other)	|_| yes |_| no |_| don't know
Mouth, tongue and throat	|_| yes |_| no |_| don't know
Multiple Myeloma	|_| yes |_| no |_| don't know
Pancreas	|_| yes |_| no |_| don't know
Prostate	|_| yes |_| no |_| don't know
Rectum	|_| yes |_| no |_| don't know
Skin (Melanoma)	|_| yes |_| no |_| don't know
Skin (Non-Melanoma)	|_| yes |_| no |_| don't know
Small Intestine	|_| yes |_| no |_| don't know
Stomach	|_| yes |_| no |_| don't know
Testicle	|_| yes |_| no |_| don't know
Thyroid	|_| yes |_| no |_| don't know
Other	Specify the cancer type

FM14 Which of the following types of cancer was **your grand-mother on your father's side** (paternal grand-mother) diagnosed with?

Note: *Choose ALL that apply*

Cancer type	paternal grand-mother
Bladder	|_| yes |_| no |_| don't know
Brain	|_| yes |_| no |_| don't know
Breast	|_| yes |_| no |_| don't know
Cervix	|_| yes |_| no |_| don't know
Colon	|_| yes |_| no |_| don't know
Esophagus	|_| yes |_| no |_| don't know
Kidney	|_| yes |_| no |_| don't know
Larynx	|_| yes |_| no |_| don't know
Leukemia	|_| yes |_| no |_| don't know
Liver	|_| yes |_| no |_| don't know
Lung and Bronchus	|_| yes |_| no |_| don't know
Lymphoma (Hodgkin Lymphoma)	|_| yes |_| no |_| don't know
Lymphoma (Non-Hodgkin Lymphoma, other)	|_| yes |_| no |_| don't know
Mouth, tongue and throat	|_| yes |_| no |_| don't know
Multiple Myeloma	|_| yes |_| no |_| don't know
Ovary	|_| yes |_| no |_| don't know
Pancreas	|_| yes |_| no |_| don't know
Rectum	|_| yes |_| no |_| don't know
Skin (Melanoma)	|_| yes |_| no |_| don't know
Skin (Non-Melanoma)	|_| yes |_| no |_| don't know
Small Intestine	|_| yes |_| no |_| don't know
Stomach	|_| yes |_| no |_| don't know
Thyroid	|_| yes |_| no |_| don't know
Uterus	|_| yes |_| no |_| don't know
Other _____	Specify the cancer type

FM15 Please indicate how many **uncles on your mother's side** (maternal uncles) have been diagnosed with the cancer types listed below. Leave blank if none of your maternal uncles have been diagnosed with a particular type of cancer.

Cancer type	Number maternal uncles diagnosed
Bladder	|_||_| Number maternal uncles
Brain	|_||_| Number maternal uncles
Breast	|_||_| Number maternal uncles
Colon	|_||_| Number maternal uncles
Esophagus	|_||_| Number maternal uncles
Kidney	|_||_| Number maternal uncles
Larynx	|_||_| Number maternal uncles
Leukemia	|_||_| Number maternal uncles
Liver	|_||_| Number maternal uncles
Lung and Bronchus	|_||_| Number maternal uncles
Lymphoma (Hodgkin Lymphoma)	|_||_| Number maternal uncles
Lymphoma (Non-Hodgkin Lymphoma, other)	|_||_| Number maternal uncles
Mouth, tongue and throat	|_||_| Number maternal uncles
Multiple Myeloma	|_||_| Number maternal uncles
Pancreas	|_||_| Number maternal uncles
Prostate	|_||_| Number maternal uncles
Rectum	|_||_| Number maternal uncles
Skin (Melanoma)	|_||_| Number maternal uncles
Skin (Non-Melanoma)	|_||_| Number maternal uncles
Small Intestine	|_||_| Number maternal uncles
Stomach	|_||_| Number maternal uncles
Testicle	|_||_| Number maternal uncles
Thyroid	|_||_| Number maternal uncles
Other _____	|_||_| Number maternal uncles Specify the cancer type

FM16 Please indicate how many **aunts on your mother's side** (maternal aunts) have been diagnosed with the cancer types listed below. Leave blank if none of your maternal aunts have been diagnosed with a particular type of cancer.

Cancer type	Number maternal aunts diagnosed
Bladder	|_||_| Number maternal aunts
Brain	|_||_| Number maternal aunts
Breast	|_||_| Number maternal aunts
Cervix	|_||_| Number maternal aunts
Colon	|_||_| Number maternal aunts
Esophagus	|_||_| Number maternal aunts
Kidney	|_||_| Number maternal aunts
Larynx	|_||_| Number maternal aunts
Leukemia	|_||_| Number maternal aunts
Liver	|_||_| Number maternal aunts
Lung and Bronchus	|_||_| Number maternal aunts
Lymphoma (Hodgkin Lymphoma)	|_||_| Number maternal aunts
Lymphoma (Non-Hodgkin Lymphoma, other)	|_||_| Number maternal aunts
Mouth, tongue and throat	|_||_| Number maternal aunts
Multiple Myeloma	|_||_| Number maternal aunts
Ovary	|_||_| Number maternal aunts
Pancreas	|_||_| Number maternal aunts
Rectum	|_||_| Number maternal aunts
Skin (Melanoma)	|_||_| Number maternal aunts
Skin (Non-Melanoma)	|_||_| Number maternal aunts
Small Intestine	|_||_| Number maternal aunts
Stomach	|_||_| Number maternal aunts
Thyroid	|_||_| Number maternal aunts
Uterus	|_||_| Number maternal aunts
Other _____	|_||_| Number maternal aunts Specify the cancer type

FM17 Please indicate how many **uncles on your father's side** (paternal uncles) have been diagnosed with the cancer types listed below. Leave blank if none of your paternal uncles have been diagnosed with a particular type of cancer

Cancer type	Number paternal uncles diagnosed
Bladder	|_||_| Number paternal uncles
Brain	|_||_| Number paternal uncles
Breast	|_||_| Number paternal uncles
Colon	|_||_| Number paternal uncles
Esophagus	|_||_| Number paternal uncles
Kidney	|_||_| Number paternal uncles

Larynx	|_||_| Number paternal uncles
Leukemia	|_||_| Number paternal uncles
Liver	|_||_| Number paternal uncles
Lung and Bronchus	|_||_| Number paternal uncles
Lymphoma (Hodgkin Lymphoma)	|_||_| Number paternal uncles
Lymphoma (Non-Hodgkin Lymphoma, other)	|_||_| Number paternal uncles
Mouth, tongue and throat	|_||_| Number paternal uncles
Multiple Myeloma	|_||_| Number paternal uncles
Pancreas	|_||_| Number paternal uncles
Prostate	|_||_| Number paternal uncles
Rectum	|_||_| Number paternal uncles
Skin (Melanoma)	|_||_| Number paternal uncles
Skin (Non-Melanoma)	|_||_| Number paternal uncles
Small Intestine	|_||_| Number paternal uncles
Stomach	|_||_| Number paternal uncles
Testicle	|_||_| Number paternal uncles
Thyroid	|_||_| Number paternal uncles
Other _____	|_||_| Number paternal uncles Specify the cancer type

FM18 Please indicate how many **aunts on your father's side** (paternal aunts) have been diagnosed with the cancer types listed below. Leave blank if none of your paternal aunts have been diagnosed with a particular type of cancer.

Cancer type	Number paternal aunts diagnosed
Bladder	|_||_| Number paternal aunts
Brain	|_||_| Number paternal aunts
Breast	|_||_| Number paternal aunts
Cervix	|_||_| Number paternal aunts
Colon	|_||_| Number paternal aunts
Esophagus	|_||_| Number paternal aunts
Kidney	|_||_| Number paternal aunts
Larynx	|_||_| Number paternal aunts
Leukemia	|_||_| Number paternal aunts
Liver	|_||_| Number paternal aunts
Lung and Bronchus	|_||_| Number paternal aunts
Lymphoma (Hodgkin Lymphoma)	|_||_| Number paternal aunts
Lymphoma (Non-Hodgkin Lymphoma, other)	|_||_| Number paternal aunts
Mouth, tongue and throat	|_||_| Number paternal aunts
Multiple Myeloma	|_||_| Number paternal aunts
Ovary	|_||_| Number paternal aunts
Pancreas	|_||_| Number paternal aunts

Rectum	|_||_| Number paternal aunts
Skin (Melanoma)	|_||_| Number paternal aunts
Skin (Non-Melanoma)	|_||_| Number paternal aunts
Small Intestine	|_||_| Number paternal aunts
Stomach	|_||_| Number paternal aunts
Thyroid	|_||_| Number paternal aunts
Uterus	|_||_| Number paternal aunts
Other _____	|_||_| Number paternal aunts Specify the cancer type

SLEEP PATTERN

SP01 This section is about your sleeping pattern. On average, how many hours per day do you usually sleep, including naps? A day refers to a 24 hour period

☐☐ Hours **AND** ☐☐ Minutes

○ Don't know

SP02 How often do you have trouble going to sleep or staying asleep?

○ None of the time
○ A little of the time
○ Some of the time
○ Most of the time
○ All the time
○ Don’t know

Domain PHYSICAL ACTIVITY

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**.

Please answer each question even if you do not consider yourself to be an active person.

Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous activities** that you did in the last 7 days. Vigorous physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

PA1 During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?
1=_____Days per week
2=No vigorous physical activity
8888=Prefer not to answer
9999=Don't know

PA2 How much time did you usually spend doing vigorous physical activities on one of those days? Indicate hours AND minutes.
1=_____Hours per day
2=_____ Minutes per day
8888=Prefer not to answer
9999=Don't know

Think about all the **moderate activities** that you did in the last 7days. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

PA3 During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis?
Do not include walking.
1=____Days per week
2=No moderate physical activities
8888=Prefer not to answer
9999=Don't know

PA4 How much time did you usually spend doing moderate physical activities on one of those days? Indicate hours AND minutes.
1=____Hours per day
2=____Minutes per day
8888=Prefer not to answer
9999=Don't know

Think about the time you spent **walking** in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

PA5 During the last 7 days, on how many days did you **walk** for at least 10 minutes at a time?
1=____Days per week
2=No walking
8888=Prefer not to answer
9999=Don't know

PA6 How much time did you usually spend **walking** on one of those days?
Indicate hours AND minutes.
1= ____Hours per day
2=____Minutes per day
8888=Prefer not to answer
9999=Don't know

The last question is about the time you spent **sitting** on weekdays during the last 7 days. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

PA7 During the last 7 days, how much time did you usually spend **sitting** on a week day?
Indicate hours AND minutes.
1=____Hours per day
2= ____ Minutes per day
8888=Prefer not to answer
9999=Don' know

ALCOHOL USE

AU01 Have you ever consumed alcohol?

- ○ Yes
- ○ No → SKIP TO TOBACCO USE - TU01 (PAGE 33)
- ○ Don't know → SKIP TO TOBACCO USE - TU01 (PAGE 33)

AU02 On average, over the last year, how often did you drink alcohol?

- ○ 6 to 7 times a week
- ○ 4 to 5 times a week
- ○ 2 to 3 times a week
- ○ Once a week
- ○ 2 to 3 times a month → SKIP TO AU04 (NEXT PAGE)
- ○ About once a month → SKIP TO AU04 (NEXT PAGE)
- ○ Less than once a month → SKIP TO AU04 (NEXT PAGE)
- ○ Never → SKIP TO TOBACCO USE - TU01 (PAGE 33)
- ○ Don't know → SKIP TO TOBACCO USE - TU01 (PAGE 33)

AU03 On average, how many drinks do you have during a typical week?

A standard drink means one glass of wine or a wine cooler (142 ml, 1/5 of a bottle, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43mL) of liquor.

	Drink(s) per week		
Red Wine	☐☐	○ None	○ Don't know
White Wine	☐☐	○ None	○ Don't know
Beer	☐☐	○ None	○ Don't know
Liquor/Spirits	☐☐	○ None	○ Don't know
Other Alcohol	☐☐	○ None	○ Don't know

MEN ONLY, WOMEN SKIP TO AU05

AU04 During the past 12 months, how often did you have five or more drinks at the same sitting or occasion?

A standard drink means one glass of wine or a wine cooler (142 ml, 1/5 of a bottle, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43mL) of liquor.

- ○ 6 to 7 times a week
- ○ 4 to 5 times a week
- ○ 2 to 3 times a week
- ○ Once a week
- ○ 2 to 3 times a month
- ○ About once a month
- ○ 6 to 11 times a year
- ○ 1 to 5 times a year
- ○ Never
- ○ Don't know

WOMEN ONLY, MEN SKIP TO TOBACCO USE - TU01 (NEXT PAGE)

AU05 During the past 12 months, how often did you have four or more drinks at the same sitting or occasion?

A standard drink means one glass of wine or a wine cooler (142 ml, 1/5 of a bottle, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43mL) of liquor.

- ○ 6 to 7 times a week
- ○ 4 to 5 times a week
- ○ 2 to 3 times a week
- ○ Once a week
- ○ 2 to 3 times a month
- ○ About once a month
- ○ 6 to 11 times a year
- ○ 1 to 5 times a year
- ○ Never
- ○ Don't know

TOBACCO USE

This section is about tobacco. The first questions are about **CIGARETTE SMOKING**. The term "cigarette" refers to cigarettes that are bought ready-made as well as those you roll yourself. Do not include cigars, cigarillos or pipes when you answer these questions about cigarettes.

In this section, **read the directions and follow the arrows carefully**. There are different "paths" for non-smokers, daily smokers, and occasional smokers.

TU01 Have you smoked at least 100 cigarettes in your life? (About 4 - 5 packs)

- ○ Yes
- ○ No
- ○ Don't know

TU02 At the present time, do you smoke cigarettes daily, occasionally, or not at all?

- ○ Daily (At least one cigarette every day for the past 30 days → GO TO TU03 (THIS PAGE)
- ○ Occasionally (At least one cigarette in the past 30 days, but not every day) → GO TO TU06 (NEXT PAGE)
- ○ Not at all (You did not smoke at all in the past 30 days) → GO TO MU01 (NEXT PAGE)

TU03 At what age did you begin smoking cigarettes daily?

☐☐ Age

TU04 How many cigarettes do you smoke each day now?

- ○ 1 – 5 cigarettes
- ○ 6 – 10 cigarettes
- ○ 11 – 15 cigarettes
- ○ 16 – 20 cigarettes
- ○ 21 – 25 cigarettes
- ○ 26+ cigarettes → If 26+, how many? ☐☐

TU05 How easy or difficult would you find it to go without smoking for a whole day?

- ○ Very easy
- ○ Fairly easy
- ○ Fairly difficult
- ○ Very difficult

→ If **you currently smoke <u>daily</u> SKIP** TO MU01

TU06 On how many of the last 30 days did you smoke at least one cigarette?

- ○ 1 – 5 days
- ○ 6 – 10 days
- ○ 11 – 20 days
- ○ 21 – 29 days

TU07 On the days that you smoked, how many cigarettes did you usually smoke?

- ○ 1 – 5 cigarettes
- ○ 6 – 10 cigarettes
- ○ 11 – 15 cigarettes
- ○ 16 – 20 cigarettes
- ○ 21 – 25 cigarettes
- ○ 26+ cigarettes

<u>MARIJUANA USE</u>

The following questions ask about use of marijuana and hashish. Marijuana is also called pot or grass. Marijuana is usually smoked, either in cigarettes, called joints, or in a pipe. It is sometimes cooked in food. Hashish is a form of marijuana that is also called 'hash'. It is usually smoked in a pipe. Another form of hashish is hash oil.

MU01 Do you currently have a prescription for medical marijuana?

- ○ Yes
- ○ No
- ○ Don’t know

MU02 Have you ever, even once, used marijuana or hashish?

- ○ Yes
- ○ No → SKIP TO ELC_01 (PAGE 37)
- ○ Prefer Not to Answer → SKIP TO ELC_01 (PAGE 37)
- ○ Don't know → SKIP TO ELC_01 (PAGE 37)

MU03 How old were you the first time you used marijuana or hashish?

☐☐

- ○ Prefer Not to Answer
- ○ Don't know

MU04 Have you ever smoked marijuana or hashish at least once a month for more than one year?

- ○ Yes
- ○ No → SKP TO ELC_01 (PAGE 37)
- ○ Prefer Not to Answer → SKP TO ELC_01 (PAGE 37)
- ○ Don't know → SKP TO ELC_01 (PAGE 37)

MU05 How old were you when you started smoking marijuana or hashish at least once a month for one year?

☐☐

- ○ Prefer Not to Answer
- ○ Don't know

MU06 How long has it been since you last smoked marijuana or hashish at least once a month for one year? (Please enter answer in the most appropriate box.)

☐☐ Years **OR** ☐☐ Months **OR** ☐☐ Weeks **OR** ☐☐ Days

- ○ Prefer Not to Answer
- ○ Don't know

MU07 During the time that you smoked marijuana or hashish, how often would you usually use it?

- ○ Once per month
- ○ 2-3 times per month
- ○ 4-8 times per month (about 1-2 times per week)
- ○ 9-24 times per month (about 3-6 times per week)
- ○ 25-30 times per month (one or more times per day)
- ○ Prefer Not to Answer
- ○ Don't know

MU08 During the time that you smoked marijuana or hashish, how many joints or pipes would you usually smoke in a day?

- ○ 1 per day
- ○ 2 per day
- ○ 3-5 per day
- ○ 6 or more per day
- ○ Prefer Not to Answer
- ○ Don't know

MU09 How long has it been since you last used marijuana or hashish? (Please enter answer in most appropriate box.)

☐☐ Years **OR** ☐☐ Months **OR** ☐☐ Weeks **OR** ☐☐ Days

- ○ Prefer Not to Answer
- ○ Don't know

MU10 During the past 30 days, on how many days did you use marijuana or hashish?

☐☐ Days

- ○ Prefer Not to Answer
- ○ Don't know

E-cigarette use

ELC_01 Have you ever tried an electronic cigarette, also known as an e-cigarette?

- ○ Yes
- ○ No
- ○ Prefer not to answer
- ○ Don't know

→ SKIP TO EX_01 (NEXT PAGE)

ELC_02 In the past 30 days did you use an electronic cigarette, also known as an e-cigarette?

- ○ Yes
- ○ No
- ○ Prefer not to answer
- ○ Don't know

ELC_03 The last time you used an e-cigarette, did it contain nicotine?

- ○ Yes
- ○ No
- ○ Prefer not to answer
- ○ Don't know

ELC_04 In the past two years, did you ever use the e-cigarette as an aid while attempting to quit smoking?

- ○ Yes
- ○ No
- ○ Prefer not to answer
- ○ Don't know

Exposure to Second-hand Smoke

EX_01 How often are you usually exposed to other people's tobacco smoke?

- ○ Every day
- ○ Almost every day
- ○ At least once a week
- ○ At least once a month
- ○ Less than once a month
- ○ Never
- ○ Prefer not to answer
- ○ Don't know

WORKING STATUS

WS01 Which of the following best describes your current employment status? Choose **ALL** that apply
Full time means 30 hours or more per week. Part time means less than 30 hours per week.

- ○ Full-time employed / self-employed
- ○ Part-time employed / self-employed
- ○ Retired
- ○ Looking after home and/or family
- ○ Unable to work because of sickness or disability
- ○ Unemployed
- ○ Doing unpaid or voluntary work
- ○ Student

HOUSEHOLD INCOME

The next question asks for your household income.

Income influences health in many ways. For this reason, it is important that we ask the following question about household income even though it is sensitive information.

HI01 What was your approximate total household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.

- ○ Less than $10,000
- ○ $10,000 - $24,999
- ○ $25,000 - $49,999
- ○ $50,000 - $74,999
- ○ $75,000 - $99,999
- ○ $100,000 - $149,999
- ○ $150,000 - $199,999
- ○ $200,000 or more
- ○ Don’t know
- ○ Prefer not to answer

ANTHROPOMETRIC MEASUREMENTS

If you are capable to STAND WITHOUT ASSISTANCE, you can continue with some basic physical measurements. Do you wish to continue with some basic physical measurements?

- ○ No, I DON'T WANT TO continue.
- ○ Yes, I WANT TO continue and take my physical measurements.
- ○ Prefer not to answer
- ○ Don't know

Weight

- Adjust your scale to zero;
- Weigh yourself with your clothes off, or wear light clothing. Remember to remove your shoes.
- Step on the scale. Make sure both feet are fully on the scale.
- Record your weight in pounds or kilograms.

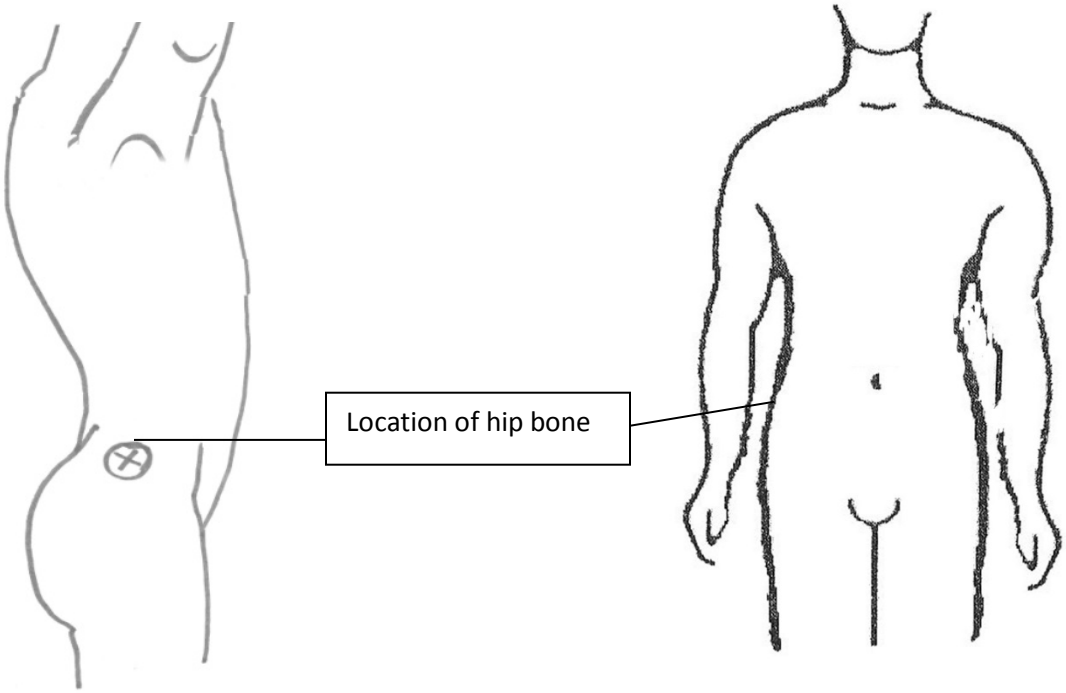
AM01 Weight Measurement ☐ Pounds **OR** ☐ Kilograms

WAIST AND HIPS

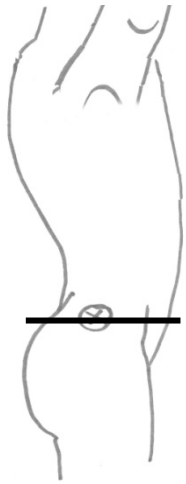
1. Take the next set of measurements either unclothed or in tight fitting underwear.
2. Stand in front of a mirror to help position the measuring tape correctly.
3. Pull the measuring tape tight enough that it does not slide, but not too tight to indent the skin;
4. Record the measurement in inches or centimeters.

Waist

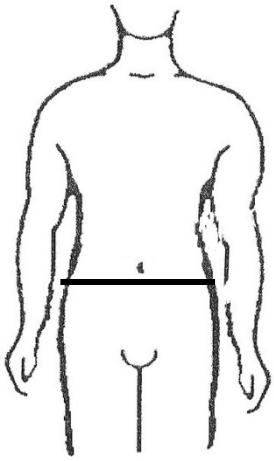
- This measurement is taken at a specific spot found along your side. To find the spot simply place your thumb under your armpit, then slide your thumb straight down until you find the hip bone (see image)



- Place your measuring tape over that spot where your thumb found the bone, then wrap the measuring tape around your middle.



Wrap the measuring tape around your middle

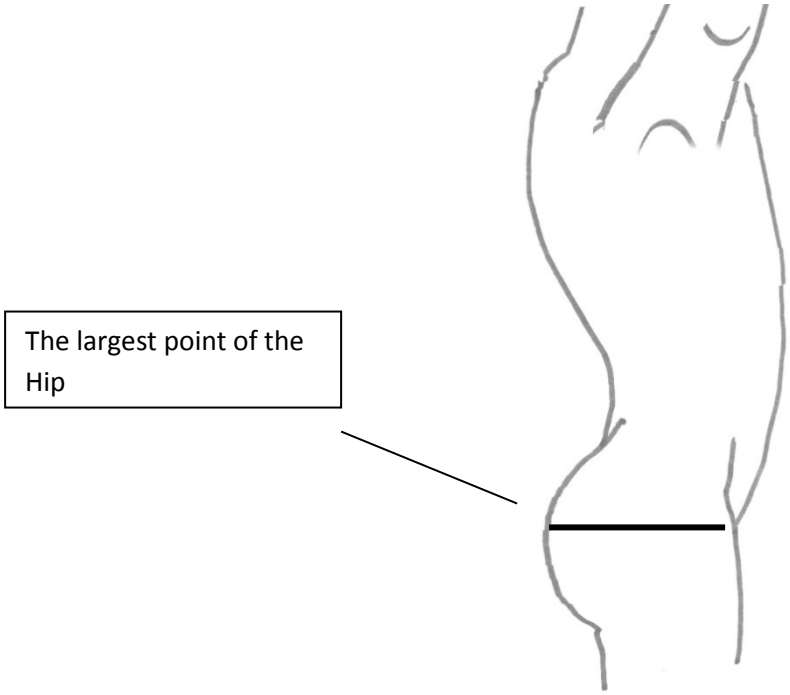


- Look in the mirror and turn in a circle to ensure the measuring tape is level all around and not twisted at any point. Take the measurement, EVEN IF THIS IS NOT YOUR USUSAL WAISTLINE.
- Measure twice. The two measurements should be within a half inch (or one centimetre) of each other. If they are not, take a third measurement and record the closest two measurements.
- Record your measurement to the nearest half inch or centimetre

AM02	First Waist Measurement		Inches	**OR**		Centimeters
AM03	Second Waist Measurement		Inches	**OR**		Centimeters

Hips

- Stand in profile to a mirror with your feet shoulder width apart.
- Look for the largest point of your buttocks and place the measuring tape at that position. (See image)



- Now turn in a full circle in front of the mirror to be certain the measuring tape is level all the way around your body. Take the measurement.
- Measure twice. The two measurements should be within a half inch (or one centimetre) of each other. If not, take a third measurement and record the closest two measurements. .
- Record the size of your buttocks to the nearest half inch or centimetre.

AM04 First Hip Measurement ☐ Inches **OR** ☐ Centimeters

AM05 Second Hip Measurement ☐ Inches **OR** ☐ Centimeters

This is the end of the questionnaire!
Thank you for taking the time to complete this survey.