

University of Minnesota
American Registry of Radiologic Technologists
National Institutes of Health

If you have any questions, please call or write:

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Please use a No. 2. lead
pencil when completing
this form.

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

Instructions for completing questionnaire:

Please be sure to mark a response for every question, unless you have been instructed to skip a question.

Your responses will be read by an optical reader. It is important to follow the instructions below when recording your answers.

- Use black lead pencil only (No. 2 or softer).
- Do NOT use ink or ballpoint pens.
- Make heavy black marks that fill the circle completely.
- Erase cleanly any answer you wish to change.
- Make no stray marks on the answer sheet.

EXAMPLES

Proper Mark



Improper Marks



EXAMPLES

To record a year:
(example 1916)

19	16
0	0
●	1
2	2
3	3
4	4
5	5
6	●
7	7
8	8
9	9

To record a two digit number:
(example 27)

27	
0	0
1	1
●	2
3	3
4	4
5	5
6	6
7	●
8	8
9	9

To record a one digit number:
(example 3)

03	
●	0
1	1
2	2
3	●
4	4
5	5
6	6
7	7
8	8
9	9

A. GENERAL INFORMATION

1. Please record TODAY'S MONTH AND YEAR.

Month	
<input type="radio"/> Jan	<input type="radio"/> Jul
<input type="radio"/> Feb	<input type="radio"/> Aug
<input type="radio"/> Mar	<input type="radio"/> Sep
<input type="radio"/> Apr	<input type="radio"/> Oct
<input type="radio"/> May	<input type="radio"/> Nov
<input type="radio"/> Jun	<input type="radio"/> Dec

Year		
1	9	9
	4	
	5	
	6	
	7	
	8	
	9	

2. What is your BIRTH DATE?

Month
<input type="radio"/> Jan
<input type="radio"/> Feb
<input type="radio"/> Mar
<input type="radio"/> Apr
<input type="radio"/> May
<input type="radio"/> Jun
<input type="radio"/> Jul
<input type="radio"/> Aug
<input type="radio"/> Sep
<input type="radio"/> Oct
<input type="radio"/> Nov
<input type="radio"/> Dec

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

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

3. What is your SEX?

- Male
- Female

4. What is your CURRENT MARITAL STATUS?

- Never married
- Married
- Living together but not married
- Divorced
- Widowed
- Separated

5. Were you or are you now married to a medical radiation worker?

- No
- Yes

6. Which of these categories best describes you?

- White
- Black
- Asian or Pacific Islander
- American Indian or Alaskan Native
- Other, specify _____

7. Are you of Hispanic origin?

- No
- Yes

8. In what RELIGION were you raised?

- None
- Assembly of God
- Baptist
- Christian
- Christian Science
- Church of Christ
- Congregational
- Episcopal
- Jehovah's Witness
- Jewish
- Lutheran
- Methodist
- Mormon or Latter Day Saint
- Pentecostal
- Presbyterian
- Roman Catholic
- Seventh Day Adventist
- Unitarian Universalist
- Other, specify _____

9. About how TALL are you without shoes?

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

10. About how much do you usually WEIGH without clothes or shoes?

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

11. Have you ever SMOKED cigarettes regularly for a period of one year or more?

- No (GO TO QUESTION 16, PAGE 4)
- Yes

12. Excluding any periods of time during which you did not smoke, how many total years have you smoked regularly?

TOTAL YEARS SMOKED	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

13. During the time you smoked regularly, about how many cigarettes per day did you smoke?

NO. OF CIGARETTES PER DAY	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

14. How old were you when you started smoking regularly?

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

15. How old were you when you stopped smoking?

- Currently smoking (GO TO QUESTION 16, PAGE 4)

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

B. WORKING EXPERIENCE

In this section we are interested in your exposure to radiation while TRAINING and/or WORKING with medical radiation, such as x-ray, radionuclide, radiotherapy, ultra sound or MRI procedures.

16. In what years did you begin TRAINING and WORKING with medical radiation procedures?

Never trained

Never worked

YEAR BEGAN TRAINING

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

YEAR BEGAN WORKING

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

17. In total, how many years have you TRAINED and/or WORKED with medical radiation procedures? Exclude years when you were not personally working or assisting with medical radiation procedures for patient care. If none, record "00" and go to Question 28 on Page 6.

NUMBER OF YEARS

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

(Record information about other occupational radiation exposures in comments section on back page of questionnaire).

18. For each of the following time periods, please indicate how many years you TRAINED and/or WORKED with medical radiation procedures. If none, record "00".

NUMBER OF YEARS

Before 1950	1950's	1960's	1970's	1980's	1990 or later
					0
0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

19. In what year did you stop TRAINING and/or WORKING with medical radiation procedures?

Currently working (GO TO QUESTION 20)

YEAR STOPPED

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

20. What is your LIFETIME TOTAL RADIATION EXPOSURE received while working in the field of medical radiation? (1000 mrad = 1 rad = 1 rem = 1 cGy = 10 mSv)

- None (GO TO QUESTION 22)
- < 1,000 mrad
- 1,000 - 4,999 mrad
- 5,000 - 9,999 mrad
- 10,000 - 24,999 mrad
- 25,000 - 49,999 mrad
- ≥ 50,000 mrad
- Don't know (GO TO QUESTION 22)

21. Is your answer estimated or taken from your dosimetry reports?

- Estimated
- From dosimetry reports
- Combination of both

22. While working in the field of medical radiation, about how many times were you removed from receiving additional radiation exposure for any length of time because you reached your exposure limit?

- None
- 1
- 2 - 4
- 5 - 9
- 10+
- Don't know

23. About how many times has your WHITE BLOOD CELL COUNT been depressed below normal as a result of working in the field of medical radiation?

- None
- 1
- 2 - 4
- 5 - 9
- 10+
- Don't know
- Never tested

24. Please indicate how frequently you worked or assisted on a regular basis with each of the following procedures during the specified calendar years. If you never worked with a particular procedure, mark the circle for "Never worked with" and leave all other columns blank for that procedure.

PROCEDURES YOU WORKED WITH	Never worked with	BEFORE 1980 FREQUENCY				1980 - 1989 FREQUENCY				1990 OR LATER FREQUENCY			
		Never or rarely	Monthly	Weekly	Daily	Never or rarely	Monthly	Weekly	Daily	Never or rarely	Monthly	Weekly	Daily
Fluoroscopy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Dental X-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Routine Diagnostic X-rays	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Multi-film Procedures (e.g., IVP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Other Angiography	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Portable X-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
CAT or CT Scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Interventional Radiography	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Diagnostic Radionuclide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Diagnostic Ultrasound	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
External Beam Therapy (MeV)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Orthovoltage Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Brachytherapy (radium or other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Radioactive Iodine Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Other Radionuclide Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Microwave or Ultrasound Diathermy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Mammography	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
MRI, Magnetic Resonance Imaging	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									
Any other procedures, specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									

25. Please indicate how frequently you HELD PATIENTS during any x-ray, radionuclide, or radiotherapy procedures listed above during the specified calendar years. If you never held a patient during any procedure, mark the circle for "Never held" and leave all other columns blank.

HELD PATIENTS	Never held	BEFORE 1980 FREQUENCY				1980 - 1989 FREQUENCY				1990 OR LATER FREQUENCY			
		Never or rarely	Monthly	Weekly	Daily	Never or rarely	Monthly	Weekly	Daily	Never or rarely	Monthly	Weekly	Daily
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									

26. Please indicate how often you wore a LEAD APRON or stood behind a LEAD SHIELD while working or assisting with any procedure listed above during the specified calendar years. If you never used a lead apron or shield, mark the circle for "Never used" and leave all other columns blank.

USED LEAD APRON OR SHIELD	Never used	BEFORE 1980 FREQUENCY				1980 - 1989 FREQUENCY				1990 OR LATER FREQUENCY			
		Never or rarely	Monthly	Weekly	Daily	Never or rarely	Monthly	Weekly	Daily	Never or rarely	Monthly	Weekly	Daily
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									

27. Please indicate how often you developed or processed X-RAY FILM during the specified calendar periods. If you never developed or processed x-ray film, mark the circle for "Never processed" and leave all other columns blank.

X-RAY FILM PROCESSING	Never processed	BEFORE 1980 FREQUENCY				1980 - 1989 FREQUENCY				1990 OR LATER FREQUENCY			
		Never or rarely	Monthly	Weekly	Daily	Never or rarely	Monthly	Weekly	Daily	Never or rarely	Monthly	Weekly	Daily
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>									

C. PERSONAL MEDICAL EXPOSURES

In this section we are interested in radiation exposure YOU RECEIVED AS A PATIENT, NOT procedures performed BY YOU.

28. Please indicate how frequently you had any of the following DIAGNOSTIC PROCEDURES during the specified calendar years. If you never had a particular procedure, mark the circle for "Never had" and leave all other columns blank for that procedure. Please count the number of times you had a procedure, NOT the number of individual films taken.

I have not had any of the procedures listed below (GO TO QUESTION 29)

PROCEDURES PERFORMED ON YOU	NEVER HAD	BEFORE 1980 NUMBER TIMES				1980 - 1989 NUMBER TIMES				1990 OR LATER NUMBER TIMES			
		0	1	2-4	5+	0	1	2-4	5+	0	1	2-4	5+
Upper gastrointestinal series	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Barium swallow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Barium enema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cholecystogram or cholangiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Retrograde or intravenous pyelogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Renal arteriogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urethrogram or cystogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Multi-film procedure, other than above	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angiogram, other than above	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fluoroscopic procedure, other than above	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CAT or CT scan	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MRI procedure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skull x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cervical spine x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinus x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Head/neck x-ray, other than above	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Collar bone x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rib x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoracic spine x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lumbar spine x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lumbosacral spine x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdomen x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney/ureter/bladder x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pelvis x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extremities (arms, legs) x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mammography x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. Please indicate how frequently you had DENTAL OR CHEST X-RAYS during the specified calendar years. If you never had a particular procedure, mark the circle for "Never had" and leave all other columns blank for that procedure. Please count the number of times you had a procedure, NOT the number of individual films taken.

PROCEDURES PERFORMED ON YOU	NEVER HAD	BEFORE 1980 NUMBER TIMES				1980 - 1989 NUMBER TIMES				1990 OR LATER NUMBER TIMES			
		0	1-9	10-24	25+	0	1-9	10-24	25+	0	1-9	10-24	25+
Dental x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chest x-ray	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. As a PATIENT, have you undergone any RADIOTHERAPY procedures, including radium implants or other brachytherapy? Here we are interested in procedures performed ON YOU, not those performed BY YOU.

- No (GO TO QUESTION 31)
 Yes → Please indicate whether you received radiotherapy to any of the following body areas for cancer or any other condition during the specified calendar years. If you did not receive radiotherapy during a specific time period, leave items under that column blank. If you never received radiotherapy to a particular body area, mark the circle for "Never received" and leave all other columns blank for that body area.

BODY AREA TREATED WITH RADIOTHERAPY	Never Received	Before 1980		1980 - 1989		1990+	
		For Cancer	For Not for Cancer	For Cancer	For Not for Cancer	For Cancer	For Not for Cancer
Head or neck	<input type="radio"/>						
Shoulder	<input type="radio"/>						
Chest or spine	<input type="radio"/>						
Abdomen	<input type="radio"/>						
Pelvis	<input type="radio"/>						
Extremities	<input type="radio"/>						
Other, specify: _____	<input type="radio"/>						

31. As a PATIENT, have you undergone any NUCLEAR MEDICINE procedures? Here we are interested in procedures performed ON YOU, not those performed BY YOU.

- No (GO TO QUESTION 32)
 Yes → Please indicate whether you received any of the following radionuclides for a diagnostic or therapeutic reason during the specified calendar years. If you did not receive radionuclides during a specific time period, leave items under that column blank. If you never received a particular radionuclide, mark the circle for "never received" and leave all other columns blank for that radionuclide.

TYPE OF RADIONUCLIDE	Never Received	Before 1980		1980 - 1989		1990+	
		For Diagnosis	For Therapy	For Diagnosis	For Therapy	For Diagnosis	For Therapy
¹³¹ Iodine	<input type="radio"/>						
¹²⁵ Iodine	<input type="radio"/>						
^{99m} Technecium	<input type="radio"/>						
²⁰¹ Thallium	<input type="radio"/>						
Other, specify: _____	<input type="radio"/>						
Type unknown	<input type="radio"/>						

D. HISTORY OF ILLNESS

32. Have you ever been told by a doctor that you had any type of CANCER?

- No (GO TO QUESTION 33, PAGE 8)
 Yes → Please mark "YES" for each type of cancer you have had diagnosed by a doctor and specify the year of first diagnosis. Include only primary cancers, not those that originated from a different site (i.e., do not list metastases).

	Mark here for "Yes" →	YEAR OF FIRST DIAGNOSIS
PRIMARY CANCER		
Bladder	<input type="radio"/>	→ 19 _____
Bone	<input type="radio"/>	→ 19 _____
Brain or Central Nervous System	<input type="radio"/>	→ 19 _____
Breast	<input type="radio"/>	→ 19 _____
Cervix (invasive)	<input type="radio"/>	→ 19 _____
Colon	<input type="radio"/>	→ 19 _____
Connective Tissue (Soft Tissue Sarcoma)	<input type="radio"/>	→ 19 _____
Esophagus	<input type="radio"/>	→ 19 _____
Hodgkin's Disease	<input type="radio"/>	→ 19 _____
Kaposi's Sarcoma	<input type="radio"/>	→ 19 _____
Kidney	<input type="radio"/>	→ 19 _____
Larynx	<input type="radio"/>	→ 19 _____
Leukemia, Acute Lymphocytic ...	<input type="radio"/>	→ 19 _____
Leukemia, Chronic Lymphocytic ..	<input type="radio"/>	→ 19 _____
Leukemia, Acute Myeloid or Granulocytic	<input type="radio"/>	→ 19 _____
Leukemia, Chronic Myeloid or Granulocytic	<input type="radio"/>	→ 19 _____
Leukemia, other than above or type unknown	<input type="radio"/>	→ 19 _____
Liver	<input type="radio"/>	→ 19 _____
Lung or Bronchus	<input type="radio"/>	→ 19 _____
Lymphoma, Non-Hodgkin's	<input type="radio"/>	→ 19 _____
Lymphoma, type unknown	<input type="radio"/>	→ 19 _____
Melanoma	<input type="radio"/>	→ 19 _____
Multiple Myeloma	<input type="radio"/>	→ 19 _____
Oral Cavity or Pharynx	<input type="radio"/>	→ 19 _____
Ovary	<input type="radio"/>	→ 19 _____
Pancreas	<input type="radio"/>	→ 19 _____
Prostate	<input type="radio"/>	→ 19 _____
Rectum	<input type="radio"/>	→ 19 _____
Stomach	<input type="radio"/>	→ 19 _____
Testis	<input type="radio"/>	→ 19 _____
Thyroid	<input type="radio"/>	→ 19 _____
Uterus (endometrium)	<input type="radio"/>	→ 19 _____
Skin, Basal Cell Carcinoma	<input type="radio"/>	→ 19 _____
Skin, Squamous Cell Carcinoma	<input type="radio"/>	→ 19 _____
Other cancer, specify below ...	<input type="radio"/>	→ 19 _____

33. Have you had any of the following conditions or procedures listed below diagnosed by a physician?

No (FEMALES GO TO QUESTION 34; MALES GO TO QUESTION 53, PAGE 9)

Yes → Please mark "YES" for each condition you've had diagnosed by a physician and indicate the time period when you were first diagnosed with that condition.

YEAR OF FIRST DIAGNOSIS

1990+
1985 - 1989
1980 - 1984
<1980

Mark here for "Yes"

MEDICAL CONDITION

Angina Pectoris	<input type="radio"/>	→	<input type="radio"/>				
Asthma	<input type="radio"/>	→	<input type="radio"/>				
Arthritis, Rheumatoid	<input type="radio"/>	→	<input type="radio"/>				
Arthritis, Other	<input type="radio"/>	→	<input type="radio"/>				
Breast Disease (Fibrocystic or Other Benign)	<input type="radio"/>	→	<input type="radio"/>				
Breast Implant, Silicone	<input type="radio"/>	→	<input type="radio"/>				
Bronchitis, Chronic	<input type="radio"/>	→	<input type="radio"/>				
Cataracts	<input type="radio"/>	→	<input type="radio"/>				
Cataract Extraction	<input type="radio"/>	→	<input type="radio"/>				
Cholecystectomy	<input type="radio"/>	→	<input type="radio"/>				
Cholesterol, Elevated (240 or greater) ..	<input type="radio"/>	→	<input type="radio"/>				
Coronary Bypass	<input type="radio"/>	→	<input type="radio"/>				
Diabetes Mellitus	<input type="radio"/>	→	<input type="radio"/>				
Emphysema	<input type="radio"/>	→	<input type="radio"/>				
Fracture of Hip or Forearm	<input type="radio"/>	→	<input type="radio"/>				
Glaucoma	<input type="radio"/>	→	<input type="radio"/>				
Hypertension (High Blood Pressure) ..	<input type="radio"/>	→	<input type="radio"/>				
Hip Replacement	<input type="radio"/>	→	<input type="radio"/>				
Macular Degeneration of Retina	<input type="radio"/>	→	<input type="radio"/>				
Myocardial Infarction (Heart Attack) ..	<input type="radio"/>	→	<input type="radio"/>				
Osteoporosis	<input type="radio"/>	→	<input type="radio"/>				
Pulmonary Embolus	<input type="radio"/>	→	<input type="radio"/>				
Scleroderma	<input type="radio"/>	→	<input type="radio"/>				
Stroke (CVA)	<input type="radio"/>	→	<input type="radio"/>				
Thyroid Conditions:							
Adenoma	<input type="radio"/>	→	<input type="radio"/>				
Goiter	<input type="radio"/>	→	<input type="radio"/>				
Hyperthyroidism	<input type="radio"/>	→	<input type="radio"/>				
Hypothyroidism	<input type="radio"/>	→	<input type="radio"/>				
Nodule	<input type="radio"/>	→	<input type="radio"/>				
Other benign thyroid condition, specify below ...	<input type="radio"/>	→	<input type="radio"/>				
Ulcer, Gastric or Duodenal	<input type="radio"/>	→	<input type="radio"/>				

E. FEMALE GYNECOLOGICAL HISTORY

(MALES GO TO QUESTION 53, PAGE 9)

34. How old were you when you first started having MENSTRUAL PERIODS?

AGE PERIODS STARTED

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

35. Have your MENSTRUAL PERIODS stopped permanently?

- Yes, menstrual periods stopped.
- Had menopause, but now have periods due to hormone replacement therapy.
- No, still menstruating (GO TO QUESTION 39)
- Not sure (GO TO QUESTION 39)

36. How old were you when your natural MENSTRUAL PERIODS stopped?

AGE NATURAL PERIODS STOPPED

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

37. What is the reason your natural MENSTRUAL PERIODS stopped?

- Surgery →
- Natural menopause (change of life)
- Undernourishment
- Excessive exercise
- Other, specify _____

38. How many ovaries were removed?

- Both
- One
- None
- Don't Know

39. Have you ever taken BIRTH CONTROL PILLS (oral contraceptives) on a regular basis?

- No (GO TO QUESTION 41)
- Yes

40. Altogether, what was the total number of years you took BIRTH CONTROL PILLS (oral contraceptives) on a regular basis?

- <1 years
- 1 - 2 years
- 3 - 4 years
- 5 - 9 years
- 10+ years

41. Have you ever taken oral or other ESTROGENS for symptoms or conditions related to MENOPAUSE?

- No (GO TO QUESTION 46, PAGE 9)
- Yes

42. How old were you when you first took ESTROGENS for a reason related to MENOPAUSE? AGE STARTED

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

43. Altogether, what was the total number of years you regularly took ESTROGENS for symptoms related to MENOPAUSE?

- <1 years 5 - 9 years
 1- 2 years 10+ years
 3 - 4 years

44. Are you currently taking ESTROGENS for symptoms related to MENOPAUSE?

- No Yes

45. Have you ever taken oral PROGESTINS (such as Provera) in combination with estrogens for symptoms or conditions associated with MENOPAUSE?

- No Yes

46. Did you ever take DES (diethylstilbestrol) to prevent miscarriage during any of your pregnancies?

- No Don't know
 Yes

47. Did your mother take DES while she was pregnant with you?

- No Don't know
 Yes

48. Have you ever had a BREAST BIOPSY or aspiration (needle inserted to remove fluid)?

- No (GO TO QUESTION 53) Yes, biopsy only
 Yes, biopsy and aspiration Yes, aspiration only

49. How old were you when you had your first BREAST BIOPSY or aspiration? AGE

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

50. How many BREAST BIOPSIES or aspirations resulted in a diagnosis of breast cancer?

- None 1 or more

51. How many BREAST BIOPSIES and/or aspirations DID NOT result in a diagnosis of breast cancer?

- None 2 5 - 6
 1 3 - 4 7+

52. Please indicate the results of all breast biopsies and/or aspirations. For each result marked, record the year the first biopsy or aspiration was done for that condition. MARK ALL THAT APPLY.

Results of Biopsies/Aspirations	Mark here for "yes"	Year of first biopsy or aspiration for condition
No abnormality detected	<input type="radio"/>	19__
Cyst	<input type="radio"/>	19__
Fibrocystic disease	<input type="radio"/>	19__
Fibroadenoma	<input type="radio"/>	19__
Hyperplasia	<input type="radio"/>	19__
Atypical hyperplasia	<input type="radio"/>	19__
Lobular carcinoma in situ	<input type="radio"/>	19__
Ductal carcinoma in situ	<input type="radio"/>	19__
Breast cancer (invasive)	<input type="radio"/>	19__
Don't know	<input type="radio"/>	19__
Other, specify: _____	<input type="radio"/>	19__

F. MALE AND FEMALE REPRODUCTIVE HISTORY

(Both MALES and FEMALES should complete this section.)

53. Have you and your spouse (or partner) ever tried to become PREGNANT for more than two years without success?

- No (GO TO QUESTION 55)

Yes → 54. What was the cause? MARK ALL THAT APPLY

- Ovulatory/hormonal problem
 Tubal obstruction or scarring
 Male infertility
 Endometriosis
 Other reason, specify: _____
 Cause not investigated
 Cause not found

55. For each time you (or your spouse or partner) became pregnant, please mark the outcome of the PREGNANCY. Male technologists, include only those pregnancies for which you were the biologic father.

- No pregnancies (GO TO QUESTION 58)

	PREGNANCY OUTCOME			
	Live birth	Stillbirth	Miscarriage	Abortion
1st Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2nd Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3rd Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12th Pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Currently pregnant				

56. For each of your LIVE BORN CHILDREN, please record (a) the sex and year of birth, (b) whether the child ever had cancer, year of diagnosis, and type of cancer, and (c) whether the child is deceased, year of death, and cause of death. Do not include adopted, foster, step-children or those who were stillborn. Start with the oldest live born child and record in birth order for all live born children.

I have not had any live born children (GO TO QUESTION 58)

FIRST CHILD (born alive)																																																														
<p>a. Sex of child</p> <input type="radio"/> Male <input type="radio"/> Female	<p>b. Was this child ever diagnosed with cancer?</p> <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes	<p>c. Is this child deceased?</p> <input type="radio"/> No (next child) <input type="radio"/> Yes <input type="radio"/> Don't know																																																												
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THIRD CHILD (born alive)																																																														
<p>a. Sex of child</p> <input type="radio"/> Male <input type="radio"/> Female	<p>b. Was this child ever diagnosed with cancer?</p> <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes	<p>c. Is this child deceased?</p> <input type="radio"/> No (next child) <input type="radio"/> Yes <input type="radio"/> Don't know																																																												
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SECOND CHILD (born alive)																																																														
<p>a. Sex of child</p> <input type="radio"/> Male <input type="radio"/> Female	<p>b. Was this child ever diagnosed with cancer?</p> <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes	<p>c. Is this child deceased?</p> <input type="radio"/> No (next child) <input type="radio"/> Yes <input type="radio"/> Don't know																																																												
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FOURTH CHILD (born alive)																																																														
<p>a. Sex of child</p> <input type="radio"/> Male <input type="radio"/> Female	<p>b. Was this child ever diagnosed with cancer?</p> <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes	<p>c. Is this child deceased?</p> <input type="radio"/> No (next child) <input type="radio"/> Yes <input type="radio"/> Don't know																																																												
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FIFTH CHILD (born alive)

<p>a. Sex of child</p> <input type="radio"/> Male <input type="radio"/> Female	<p>b. Was this child ever diagnosed with cancer?</p> <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes	<p>c. Is this child deceased?</p> <input type="radio"/> No (next child) <input type="radio"/> Yes <input type="radio"/> Don't know																																																												
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SEVENTH CHILD (born alive)

<p>a. Sex of child</p> <input type="radio"/> Male <input type="radio"/> Female	<p>b. Was this child ever diagnosed with cancer?</p> <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes	<p>c. Is this child deceased?</p> <input type="radio"/> No (next child) <input type="radio"/> Yes <input type="radio"/> Don't know																																																												
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SIXTH CHILD (born alive)

<p>a. Sex of child</p> <input type="radio"/> Male <input type="radio"/> Female	<p>b. Was this child ever diagnosed with cancer?</p> <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes	<p>c. Is this child deceased?</p> <input type="radio"/> No (next child) <input type="radio"/> Yes <input type="radio"/> Don't know																																																												
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EIGHTH CHILD (born alive)

<p>a. Sex of child</p> <input type="radio"/> Male <input type="radio"/> Female	<p>b. Was this child ever diagnosed with cancer?</p> <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes	<p>c. Is this child deceased?</p> <input type="radio"/> No (next child) <input type="radio"/> Yes <input type="radio"/> Don't know																																																												
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If you have had more than eight live born children, please record answers to Question 56 for the additional children on a separate sheet of paper and return it with your completed questionnaire.

57. If any of your live born children had a **BIRTH DEFECT**, please record the type of defect in the appropriate column for that child. Mark all that apply for each child. Leave the columns blank for those children who had no birth defects.

None of my children have had a birth defect (GO TO QUESTION 58)

BIRTH DEFECT	BIRTH ORDER OF LIVE BORN CHILDREN							
	1st	2nd	3rd	4th	5th	6th	7th	8th
Cataracts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cleft lip or palate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Club foot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Down's Syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extra fingers, shortened limbs, or any other skeletal abnormality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hole in the heart or other congenital heart defect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hydrocephalus (excess water around or within the brain)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Small head size (microcephaly)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spina bifida or other neural tube defect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Undescended testicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other birth defects Specify type of defect(s) →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you have had more than eight live born children with a birth defect, please record answers to Question 57 for the additional children on a separate sheet of paper and return it with your completed questionnaire.

G. FAMILY HISTORY

58. Please indicate whether any of the following **blood related FAMILY MEMBERS** have had **CANCER**. If yes, please specify the **primary site** where the **first cancer** started and the age at diagnosis. Do not list metastases, or basal or squamous cell skin cancer.

FAMILY MEMBER	Don't Know			PRIMARY CANCER SITE	AGE AT DIAGNOSIS
	No	Know	Yes		
Father	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Mother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Maternal Grandfather	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Maternal Grandmother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Paternal Grandfather	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Paternal Grandmother	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____

59. Have any of your **blood related BROTHERS OR SISTERS** had **CANCER**?

No DON'T KNOW (GO TO QUESTION 60)

Yes → If yes, please specify the **primary site** where the **first cancer** started. Do not list metastases, or basal or squamous cell skin cancer.

SIBLING	Don't Know			PRIMARY CANCER SITE	AGE AT DIAGNOSIS
	Sister	Brother	Know		
Sister	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Sister	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____
Sister	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	_____

60. Please indicate below if any of your female blood relatives, including those previously reported, have had **BREAST CANCER**? Mark **all** that apply.

- None
 Mother
 Sister
 Daughter
 Grandmother, maternal
 Grandmother, paternal
 Aunt, maternal
 Aunt, paternal
 Don't know

61. Are you a **TWIN**?

- No Don't know
 Yes, identical
 Yes, fraternal, same sex
 Yes, fraternal, opposite sex
 Yes, type unknown, same sex

62. How many blood related **SISTERS** and **BROTHERS**, living and dead, do you have? If none or don't know, record "00."

NO. OF SISTERS

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

NO. OF BROTHERS

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

64. Which of the following **INDIVIDUAL SUPPLEMENTS** are you currently taking on a regular basis? Multivitamins contain many of these vitamins or minerals, but here we are interested in supplements that are taken in addition to a multivitamin. **MARK ALL THAT APPLY.**

- None
- Brewer's yeast
- Thiamine
- Riboflavin
- Niacin
- Vitamin B-6
- Folic acid or folate
- Iron
- Magnesium
- Selenium
- Zinc
- Omega fatty acids

MALES GO TO QUESTION 66)

65. During how many pregnancies did you take **prescription prenatal vitamins** for at least 3 months?

- None or never pregnant
- 1 pregnancy
- 2 pregnancies
- 3 pregnancies
- 4 pregnancies
- 5 OR MORE pregnancies

66. During the past year, on average, how many days each month did you take the following **MEDICATIONS**? Please mark one column for each medication.

**AVERAGE
DAYS PER MONTH**

22+

15 - 21

5 - 14

1 - 4

<1

MEDICATION	None
Acetaminophen (e.g., Tylenol)	<input type="radio"/>
Aspirin (e.g., Anacin, Bufferin, Midol, Alka-Seltzer)	<input type="radio"/>
Other anti-inflammatory (e.g., Ibuprofen, Motrin, Naprosyn, Advil)	<input type="radio"/>
Thyroid hormones (e.g., Synthroid)	<input type="radio"/>
Tranquilizers (e.g., Valium)	<input type="radio"/>

67. Have you ever taken **prescription DIURETICS** on a regular basis?

- No (GO TO QUESTION 69)
- Yes

68. On average, how long have you taken **prescription DIURETICS** on a regular basis?

- <6 months
- 6 - 11 months
- 1 - 2 years
- More than 2 years

I. OTHER FACTORS

69. What is the color of your **EYES**?

- Blue
- Brown
- Green
- Hazel
- Grey
- Black
- Other, specify below _____

70. What do you consider your **SKIN** complexion to be?

- Fair
- Medium
- Dark

71. What was your natural **HAIR COLOR** when you were 15 years old?

- Blonde
- Light brown
- Dark brown/brunette
- Red or Auburn
- Black
- Other, specify below _____

72. Have you ever used **permanent or semi-permanent HAIR DYE** regularly? By regular use we mean at least twice a year for 2 consecutive years. Please do **not** include temporary rinses or bleach/highlights.

- No (GO TO QUESTION 76, PAGE 15)
- Yes

73. About how many times per year did you use permanent or semi-permanent **HAIR DYES**?

**TIMES
PER
YEAR**

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

74. For how many years have you used permanent or semi-permanent **HAIR DYES** regularly?

YEARS

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

75. What color permanent or semi-permanent **HAIR DYES** did you use the most?

- Blonde
- Brown/brunette
- Black
- Red or red/brown
- Other, specify _____

76. During the past year, how often did you drink the following BEVERAGES?

BEVERAGE (AVERAGE SERVING)	AVERAGE NUMBER OF SERVINGS CONSUMED DURING PAST YEAR												
	Never	<1/ month	1/ month	2 - 3/ month	1/ week	2/ week	3 - 4/ week	5 - 6/ week	1/ day	2/ day	3/ day	4/ day	5+/ day
100% fruit juice (including fortified) (4 - 6 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fruit <u>drinks</u> fortified with Vitamin C (4 - 6 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Orange juice fortified with calcium (4 - 6 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Whole milk (4%) (8 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lowfat milk (1 - 2%) (8 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skim or nonfat milk (0 - 1/2%) (8 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Meal-replacement beverages, such as Instant Breakfast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low-calorie meal-replacement beverages, such as Slim Fast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cola, regular (12 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cola, decaffeinated (12 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee, regular (6 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee, decaffeinated (6 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tea (6 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beer (12 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wine (4 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liquor (1 shot)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water (8 oz.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

77. During the past year, how often did you eat the following FOODS?

TYPE OF FOOD	AVERAGE NUMBER OF SERVINGS CONSUMED DURING PAST YEAR												
	Never	<1/ month	1/ month	2 - 3/ month	1/ week	2/ week	3 - 4/ week	5 - 6/ week	1/ day	2/ day	3/ day	4/ day	5+/ day
Fresh fruit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Canned fruit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Baked, boiled or mashed potatoes (excluding french fries)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cooked vegetables (excluding potatoes, rice or beans)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beans, such as kidney, pinto, baked or refried	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lettuce salad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Raw vegetables (excluding lettuce)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beef	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pork	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chicken or turkey	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fish (excluding canned fish, such as tuna)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
100% fortified cold cereal, such as Product 19, Total or Just Right	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High-fiber cereal, such as All-Bran, Grape-nuts, Wheaties, Granola	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Any other cold cereal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Whole grain breads or rolls, such as rye, pumpernickel, whole wheat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White bread or rolls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cottage cheese or yogurt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hard or soft cheese (excluding cottage cheese)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fried chicken, fried fish or fried potatoes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cookies, cake or pie	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

78. During the past year, on average how many hours per week did you spend EXERCISING OR WALKING?

HOURS PER WEEK

NONE
 <1 hr.
 1-3 hrs.
 4-9 hrs.
 10-19 hrs.
 20-39 hrs.
 Over 40 hrs.

Exercising strenuously (e.g., aerobics, jogging, swimming)	<input type="radio"/>					
Walking or hiking for exercise	<input type="radio"/>					
Walking at home or at work	<input type="radio"/>					

79. During the past year, on average how many FLIGHTS OF STAIRS (not individual steps) did you climb daily?

- None
- 1 - 2
- 3 - 4
- 5 - 9
- 10 - 14
- 15 or more

80. How would you rate your overall health?

- Excellent
- Good
- Fair
- Poor

81. Are you of Celtic or Gaelic ancestry?

- No
- Don't know
- Yes

82. Sometime in the future, would you be willing to donate a small venous blood sample if we sent you a convenient collection kit? This would involve having someone draw your blood, but would not require any centrifugation or other processing. This would allow researchers to investigate the long-term effects of low-level fractionated radiation exposures.

- No, I would not be willing to donate blood
- Yes, I would be willing to donate blood

Please use this space for any additional comments or information.

83. What is your SOCIAL SECURITY NUMBER?

SOCIAL SECURITY NUMBER

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

Your social security number is being requested under Section 411, Public Health Service Act [42 USC 285a]. The primary use of this information is for researchers to locate you in the future and to search vital records in a follow-up study conducted. Additional disclosures of information may be: to the Department of Health and Human Services contractors, grantees and collaborating researchers and their staff in order to accomplish the research purpose for which the records are collected; to a congressional office in response to a request made by you; and as otherwise required by Law. Furnishing your Social Security Number is voluntary, and you will not be denied any Federal right, benefit, or privilege by your refusal to disclose it.

THANK YOU VERY MUCH FOR YOUR HELP.

Please take a minute or two to recheck your questionnaire to be sure you have not missed any questions or skipped any items on the lists or tables.

FOR OFFICE USE ONLY

A	K
B	L
C	M
D	N
E	O
F	P
G	Q
H	R
I	S
J	T