OMB #: 0925-0656
Expiration Date: 04/30/2015

U.S. Radiologic Technologists Study
Fourth Survey

A collaborative effort between the University of Minnesota School of Public Health, National Cancer Institute, and American Registry of Radiologic Technologists

(ADDRESS BLOCK FOR WINDOW ENVELOPE)

PARTICIPANT NAME
ADDRESS
CITY STATE ZIP

Instructions:
- Use blue or black ink.
- Print legible numbers: 1 2 3
- Mark an X in the box: Right ☒ Wrong ☑ ☒
- Do not make any stray marks on this form. If you have comments, please write them on a separate piece of paper.

GENERAL QUESTIONNAIRE

Whether you are retired or still working, please complete this questionnaire to update us about your health, radiation exposure, and other factors. We realize that some information from the past may be difficult to recall. Just do your best. Even if not exact, your best estimates are valuable to the study.

1. **What is TODAY'S DATE?** M M (MONTH) D D (DAY) 2 0 Y Y (YEAR)

2. **What is your DATE OF BIRTH?** M M (MONTH) D D (DAY) 1 9 Y Y (YEAR)

3. **How tall are you without shoes?** ____ FEET ____ INCHES

4. **How much do you weigh without shoes and clothes?** ____ POUNDS

5. **Do you currently smoke cigarettes?**

☒ No ☒ Yes →

How many CIGARETTES do you usually smoke per day? ..... ____ NUMBER PER DAY

How soon after you wake up do you usually smoke your first cigarette of the day? .....
☒ Within 5 minutes ☒ 31-60 minutes
☒ 6-30 minutes ☒ More than 60 minutes

How many DAYS per week do you usually smoke cigarettes? ..... ____ DAYS PER WEEK

Are you an ex-cigarette smoker?

☒ No ☒ Yes **What year did you last smoke cigarettes?** ____ YEAR LAST SMOKED

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN
Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0656). Do not return the completed form to this address.

SERIAL #

HEALTH HISTORY

Please answer the next questions to let us know if you have been diagnosed with cancer or any of the conditions listed.

6. Did a doctor ever tell you that you had any type of skin cancer? ☒ No (Go to 7) ☒ Yes

Please mark YES for each type of skin cancer you had and provide your age when first diagnosed.

How many skin cancers did you have at each body location?
(If lesion was located on a "side", choose nearest location)

TYPE OF SKIN CANCER (mark all that apply)	YES	AGE FIRST DIAGNOSED	FRONT OF HEAD OR NECK	BACK OF HEAD OR NECK	FRONT OF TORSO	BACK OF TORSO	FRONT OF LEGS	BACK OF LEGS	ARMS OR HANDS
Basal cell carcinoma	☒ →								
Squamous cell carcinoma	☒ →								
Melanoma	☒ →								
Other or type unknown	☒ →								

7. Did a doctor ever tell you that you had any other type of cancer? ☒ No (Go to 8) ☒ Yes

Please mark YES for each type of cancer you had and provide your age when you were first diagnosed.

TYPE OF CANCER (mark all that apply)	YES	AGE FIRST DIAGNOSED
Bladder	☒ →	
Bone	☒ →	
Brain or nervous system	☒ →	
Breast:	☒	

If YES:

Which breast? Left	Which breast? Right	What type was it? Invasive Cancer	What type was it? Ductal Carcinoma *In Situ*	What type was it? Other Or Type Unknown	AGE FIRST DIAGNOSED
☒	☒	☒	☒	☒ →	
☒	☒	☒	☒	☒ →	

TYPE OF CANCER (mark all that apply)	YES	AGE FIRST DIAGNOSED
Cervix (excluding *in situ*)	☒ →	
Colon	☒ →	
Esophagus	☒ →	
Kidney	☒ →	
Leukemia		
Acute myelocytic (AML)	☒ →	
Acute lymphocytic (ALL)	☒ →	
Chronic myelocytic (CML)	☒ →	
Chronic lymphocytic (CLL)	☒ →	
Liver	☒ →	
Lung, trachea, or bronchus	☒ →	
Lymphoma:		
Hodgkin's disease	☒ →	
Non-Hodgkin's lymphoma (NHL)	☒ →	
Multiple myeloma	☒ →	
Ovary	☒ →	
Pancreas	☒ →	
Prostate	☒ →	
Rectum	☒ →	
Salivary gland	☒ →	
Stomach	☒ →	
Testis	☒ →	
Thyroid	☒ →	
Uterus (endometrium)	☒ →	
Other or unknown cancer	☒ →	

Specify: _____

8. Did a doctor ever tell you that you had any of the following medical conditions?

For each medical condition you mark YES, please provide your age when you were first diagnosed.

MEDICAL CONDITION (mark all that apply)	YES	AGE FIRST DIAGNOSED
Benign tumor of brain or nervous system:		
Meningioma	☒ →	
Schwannoma or neuroma	☒ →	
Other	☒ →	
Specify: _____		
Thyroid conditions:		
Thyroid nodule	☒ →	
Goiter (enlarged thyroid)	☒ →	
Benign thyroid tumor (adenoma)	☒ →	
Thyroiditis (Hashimoto's Disease)	☒ →	
Hypothyroidism (underactive thyroid)	☒ →	
Did you take medication *(e.g., synthroid, levothyroxine)* for hypothyroidism?	☒ No ☒ Yes	
Graves' Hyperthyroidism or Graves' Disease	☒ →	
Were you treated *(e.g., surgery, I-131 drugs)* for hyperthyroidism?	☒ No ☒ Yes	
Eye conditions:		
Macular degeneration	☒ →	
Glaucoma	☒ →	
Cataract	☒ →	
Did you have any cataracts removed?	☒ No ☒ Yes	
Age first removed	AGE	
Cardiovascular conditions:		
Angina pectoris	☒ →	
Was it confirmed by ECG, angiogram, or other diagnostic test?	☒ No ☒ Yes	

MEDICAL CONDITION (mark all that apply)	YES	AGE FIRST DIAGNOSED
Cardiovascular conditions continued:		
Ischemic heart disease	☒ →	
Was it confirmed by ECG, angiogram, or other diagnostic test?	☒ No ☒ Yes	
Heart attack (myocardial infarct)	☒ →	
Stroke	☒ →	
High blood pressure	☒ →	
Do you currently take blood pressure medication?	☒ No ☒ Yes	
Other conditions:	Yes	
Sleep apnea	☒ →	
Osteoporosis	☒ →	
Hip fracture	☒ →	
Multiple sclerosis	☒ →	
Parkinson's Disease	☒ →	
Lupus	☒ →	
Osteoarthritis	☒ →	
Rheumatoid arthritis	☒ →	
Scleroderma	☒ →	
Chronic bronchitis	☒ →	
Emphysema	☒ →	
Asthma	☒ →	
Diabetes	☒ →	
Do you currently take insulin?	☒ No ☒ Yes	

9. **How much did you weigh when you were born?** ☐☐ POUNDS ☐☐ OUNCES

10. **Were you breastfed as a baby?** ☒ No ☒ Yes ☒ Don't know

11. **Were you born premature?** ☒ No ☒ Yes ☒ Don't know

12. **Have any of your blood-related parents, siblings, or children had any of the following primary cancers?**

	No	Yes	YOUNGEST age any of these relatives were first diagnosed					
			Under age 40	Ages 40-49	Ages 50-59	Ages 60-69	Age 70 or older	Age Unknown
Brain cancer	☒	☒ →	☒	☒	☒	☒	☒	☒
Breast cancer	☒	☒ →	☒	☒	☒	☒	☒	☒
Thyroid cancer	☒	☒ →	☒	☒	☒	☒	☒	☒
Leukemia, lymphoma, or multiple myeloma	☒	☒ →	☒	☒	☒	☒	☒	☒
Lung cancer	☒	☒ →	☒	☒	☒	☒	☒	☒

13. **How many TIMES did you visit a medical facility or clinic for a ROUTINE EXAM within each age range?** For example, if you had one exam each year when you were 40-49, report 10 exams for that age range.

	TOTAL NUMBER OF EXAMS WITHIN EACH AGE RANGE				
	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Age 70 or older
Pap smear (women only)	☐☐	☐☐	☐☐	☐☐	☐☐
Breast exam (women only)	☐☐	☐☐	☐☐	☐☐	☐☐
Prostate exam (men only)	☐☐	☐☐	☐☐	☐☐	☐☐
Sigmoidoscopy or colonoscopy	☐☐	☐☐	☐☐	☐☐	☐☐
General physical exam	☐☐	☐☐	☐☐	☐☐	☐☐

14. **During the PAST YEAR, did you take any of the following supplements?**

Multivitamins ☒ No ☒ Yes →
How many DAYS PER WEEK did you take? ☐ DAYS

Other supplements taken separately from a multi-vitamin:

Calcium (including Tums®) ☒ No ☒ Yes →
How many DAYS PER WEEK did you take? ☐ DAYS
What was the total dosage (mg) of calcium per day?
☒ Less than 500 mg ☒ 500-899 ☒ 900-1299 ☒ 1300-1599 ☒ 1600 or more

Vitamin D (alone or in a calcium supplement) ☒ No ☒ Yes →
How many DAYS PER WEEK did you take? ☐ DAYS
Time of year taken? ☒ All year ☒ Winter only
What was the total dosage (IU) of Vitamin D per day?
☒ Less than 400 IU ☒ 400-799 ☒ 800-1399 ☒ 1400-1999 ☒ 2000-3999 ☒ 4000 or more

WOMEN ONLY - Men go to Page 6, Question 21

15. Have you ever given birth? ☒ No (Go to 17) ☒ Yes

For each birth please complete the following questions. Include still births but do not include step- or adopted children.

Birth Order	Year of Birth	Did you breast feed this baby?	How many months?
First		☒ No ☒ Yes →	
Second		☒ No ☒ Yes →	
Third		☒ No ☒ Yes →	
Fourth		☒ No ☒ Yes →	
Fifth		☒ No ☒ Yes →	
Sixth		☒ No ☒ Yes →	
Seventh		☒ No ☒ Yes →	
Eighth		☒ No ☒ Yes →	

Please list any additional births on a separate piece of paper and return with this form.

16. Did a doctor ever tell you that you had postpartum mastitis?

☒ No
☒ Yes → **Age when first diagnosed?** AGE **Age when last diagnosed?** AGE **Number of times?** NO. TIMES

17. Have your menstrual periods stopped permanently (i.e., no period for at least six months)**?**

☒ No, still having periods
☒ Yes → AGE STOPPED
☒ No, menstrual periods are irregular or using hormones
☒ Never menstruated

18. Did you have surgery to remove your uterus or ovaries? (Mark all that apply)

☒ No
☒ Yes, uterus removed → AGE WHEN REMOVED?
☒ Yes, one or both ovaries removed → AGE FIRST OVARY REMOVED AGE SECOND OVARY REMOVED

19. Did you ever take prescription hormone replacement therapy for symptoms of menopause?

☒ No
☒ Yes → **Age started taking?** AGE STARTED **Total number of years taken?** YEARS **Currently taking?** ☒ No ☒ Yes

20. Did you ever have a breast biopsy (or aspiration)?

☒ No ☒ Yes → **Age at time of first biopsy/aspiration?** AGE **Number of biopsies/aspirations?** NUMBER

Did any biopsy or aspiration lead to a diagnosis of. . .

	NO	YES	AGE FIRST DIAGNOSED
Breast cancer or ductal carcinoma *in situ*	☒	☒ →	
Lobular carcinoma *in situ*	☒	☒ →	
Atypia or atypical hyperplasia	☒	☒ →	
Hyperplasia without atypia	☒	☒ →	
Fibroadenoma, cystic, or other benign breast disease	☒	☒ →	

WOMEN and MEN Complete Remainder of Questionnaire.

WORK HISTORY

In this questionnaire, the term "radiologic technologist" includes people working in radiology, nuclear medicine, radiation therapy or any other diagnostic imaging or therapeutic radiation jobs.

21. Are you currently working as a radiologic technologist? ☒ Yes ☒ No → **Year last worked as a radiologic technologist?** Y Y Y Y

Answer the following questions separately for each time period. If unsure, estimate as best you can.

	Before 1970	1970-1979	1980-1989	1990-1999	2000-2009
22. Did you work as a radiologic technologist during these time periods?	☒ No ☒ Yes	☒ No ☒ Yes	☒ No ☒ Yes	☒ No ☒ Yes	☒ No ☒ Yes
23. How many HOURS PER WEEK did you usually work as a radiologic technologist during each time period?					

24. Have you performed or assisted with the following procedures? If YES, please provide the number of procedures within a typical WEEK?

	YES	NUMBER OF PROCEDURES PER WEEK				
		Before 1970	1970-1979	1980-1989	1990-1999	2000-2009
Diagnostic x-ray	☒					
Routine fluoroscopy (upper GI series, small bowel series, barium enema, cholecystogram, urethrogram, etc.)	☒					
Intravascular procedures (using catheters) with fluoroscopy in the operating room	☒					
Orthopedic and other non-vascular procedures (no catheters) with fluoroscopy in the operating room	☒					
Diagnostic radioisotope	☒					
Brachytherapy	☒					
Other therapeutic radioisotope	☒					

25. Did you perform or assist with FLUOROSCOPICALLY-GUIDED DIAGNOSTIC OR INTERVENTIONAL procedures at least once a month for a year or more?

Include ONLY fluoroscopically-guided interventional procedures (cardiac, cardiac electrophysiology, interventional radiology, endovascular, interventional neurosurgery, and GI/GU endoscopic procedures with fluoroscopic guidance for diagnosis or intervention). Do NOT include routine fluoroscopy exams (such as upper GI series, esophagram, barium enema). → ☒ No ☒ Yes

26. Did you perform or assist with DIAGNOSTIC OR THERAPEUTIC RADIOISOTOPE procedures at least once a month for a year or more?

☒ No ☒ Yes

	Before 1960	1960-1969	1970-1979	1980-1989	1990-2009
27. When performing diagnostic x-ray procedures, did you usually have to go into a control booth or shielded area to turn on the x-ray beam?	☒ No ☒ Yes	☒ No ☒ Yes	☒ No ☒ Yes	☒ No ☒ Yes	☒ No ☒ Yes

28. Did you ever work as a radiologic technologist in a military hospital or clinic?

☒ No (Go to 29) ☒ Yes → **How many YEARS did you work in a military facility?**

Before 1960	1960-1969	1970-1979	1980-1989	1990-2009

29. Were you ever removed from working as a radiologic technologist because your radiation exposure exceeded the allowable limit?

☒ No ☒ Yes → **How many TIMES did this happen?**

Before 1960	1960-1969	1970-1979	1980-1989	1990-2009

30. What is your approximate lifetime total radiation dose received while working as a radiologic technologist (in mrem)**?**

☒ Zero	☒ 1,000-4,999	☒ 10,000-24,999	☒ 50,000+
☒ 1-999 mrem	☒ 5,000-9,999	☒ 25,000-49,999	☒ Unknown

PERSONAL DIAGNOSTIC RADIATION EXAMS (performed ON YOU)

31. Have you ever had the following personal diagnostic radiation exams? If YES, please provide your age(s) at first and last exam, and the approximate number of exams that you had within each age range. Count the number of exams that you had, NOT the number of films taken.

X-RAY exams performed ON YOU	YES	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Dental, bite-wing	☒								
Dental, panoramic x-ray	☒								
Skull	☒								
Sinus	☒								
Neck	☒								
Spine, full	☒								
Spine, cervical	☒								
Spine, thoracic	☒								
Spine, lumbar or lumbosacral	☒								
Ribs	☒								
Pelvis or sacrum	☒								
Mammogram, routine	☒								
Mammogram, diagnostic	☒								

FLUOROSCOPY exams performed ON YOU *with or without* X-Ray films	YES	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Cerebral arteriogram	☒								
Carotid arteriogram	☒								
Cardiac angiogram or catheterization	☒								
Cardiac angioplasty or stent placement	☒								
Pulmonary arteriogram	☒								
Upper GI series	☒								
Esophagram (barium swallow)	☒								
Liver, gallbladder, or bile ducts	☒								
Small bowel series	☒								
Lower GI series (barium enema)	☒								

TOMOGRAPHY or CT scans performed ON YOU *without* PET scan. Count scans twice if taken both with and without contrast.	YES	AGE 1ST SCAN	AGE LAST SCAN	NUMBER OF SCANS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Head	☒								
Neck	☒								
Chest	☒								
Spine	☒								
Abdomen with pelvis	☒								
Abdomen without pelvis	☒								
CT angiography	☒								

RADIONUCLIDE tests performed ON YOU *without* PET scan	YES	AGE 1ST TEST	AGE LAST TEST	NUMBER OF TESTS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Brain scan	☒								
Thyroid scan	☒								
Thyroid uptake or function	☒								
Cardiac scan	☒								
Lung scan	☒								
Liver scan	☒								
Renogram	☒								
Bone scan	☒								

PET scans performed ON YOU *with or without CT*	YES	AGE 1ST SCAN	AGE LAST SCAN	NUMBER OF SCANS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Brain scan	☒								
Cardiac scan	☒								
Whole body scan or tumor localization	☒								
Other	☒								

Specify: _____

PERSONAL THERAPEUTIC RADIATION PROCEDURES

32. Have you ever had radionuclide therapy procedures performed ON YOU for the selected medical conditions below? If YES, please provide your age(s) at first and last treatment, and the approximate number of treatments that you had within each age range.

RADIONUCLIDE THERAPY procedures performed ON YOU for the following medical conditions:	YES	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Hyperthyroidism	☒								
Thyroid cancer or ablation	☒								
Leukemia	☒								
Non-Hodgkin's lymphoma	☒								
Polycythemia vera	☒								
Other	☒								

Specify: _____

33. Have you ever had radiation therapy (radiotherapy, cobalt therapy, etc.) to any of the following body areas for CANCER or for NON-CANCER conditions? If YES, please provide your age(s) at first and last treatment, and the approximate number of treatments.

If you had a treatment series for a single cancer occurrence, count as one treatment.

RADIATION THERAPY procedures performed ON YOU to the following body areas for CANCER conditions:	YES	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS WITHIN EACH AGE RANGE CANCER (series)					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Head	☒								
Neck	☒								
Chest (including breast)	☒								
Spine	☒								
Abdomen	☒								

For non-cancer conditions, count the number of individual treatment sessions you had.

RADIATION THERAPY procedures performed ON YOU to the following body areas for NON-CANCER conditions:	YES	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS WITHIN EACH AGE RANGE NON-CANCER (sessions)					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Head	☒								
Neck	☒								
Chest (including breast)	☒								
Spine	☒								
Abdomen	☒								

IN YOUR LIFETIME

34. Have you EVER used a SUNLAMP for tanning or to treat a skin condition?

☒ No

☒ Yes →

How old were you the FIRST time you used a sunlamp?

☒ Under 13 years old ☒ 13-19 ☒ 20-39 ☒ 40-64 ☒ Age 65 or older

How old were you the LAST time you used a sunlamp?

☒ Under 13 years old ☒ 13-19 ☒ 20-39 ☒ 40-64 ☒ Age 65 or older

How many times did you use a sunlamp in your life?

☒ 1-2 times ☒ 3-4 ☒ 5-9 ☒ 10-19 ☒ 20 times or more

35. Have you EVER used a TANNING BOOTH or TANNING BED?

☒ No

☒ Yes →

How old were you the FIRST time you used a tanning booth or tanning bed?

☒ Under 13 years old ☒ 13-19 ☒ 20-39 ☒ 40-64 ☒ Age 65 or older

How old were you the LAST time you used a tanning booth or tanning bed?

☒ Under 13 years old ☒ 13-19 ☒ 20-39 ☒ 40-64 ☒ Age 65 or older

How many times did you use a tanning booth or tanning bed in your life?

☒ 1-2 times ☒ 3-4 ☒ 5-9 ☒ 10-19 ☒ 20 times or more

36. How many MONTHS PER YEAR did you usually have a TAN FROM SUN EXPOSURE at each age listed below?

Under 13 years old	Ages 13-19	Ages 20-39	Ages 40-64	Age 65 or older
☒ Never had a tan	☒ Never had a tan	☒ Never had a tan	☒ Never had a tan	☒ Never had a tan
☒ 1-3 months	☒ 1-3 months	☒ 1-3 months	☒ 1-3 months	☒ 1-3 months
☒ 4-6	☒ 4-6	☒ 4-6	☒ 4-6	☒ 4-6
☒ 7-12 months	☒ 7-12 months	☒ 7-12 months	☒ 7-12 months	☒ 7-12 months

37. HOW OFTEN did you protect yourself from the sun by wearing a long-sleeve shirt or long pants, when you were in the sun on a typical day in the summer at each age listed below?

Under 13 years old	Ages 13-19	Ages 20-39	Ages 40-64	Age 65 or older
☒ Never/rarely	☒ Never/rarely	☒ Never/rarely	☒ Never/rarely	☒ Never/rarely
☒ Sometimes	☒ Sometimes	☒ Sometimes	☒ Sometimes	☒ Sometimes
☒ Usually/always	☒ Usually/always	☒ Usually/always	☒ Usually/always	☒ Usually/always

When answering the next two questions about "night shift" work, please include ALL jobs held during your lifetime. By "night shift" we mean working 3 or more hours during 12:00-5:00 AM for 6 months or more.

38. Did you ever work PERMANENT night shifts at this age?

			During how many YEARS did you work PERMANENT night shifts at this age?					On average, how many PERMANENT NIGHT SHIFTS did you work PER MONTH at this age?					
			1	2-3	4-5	6-7	8 or more	1-3	4-5	6-9	10-14	15-19	20 or more
Under age 30	☒ No	☒ Yes →	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Age 30-39	☒ No	☒ Yes →	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Age 40-49	☒ No	☒ Yes →	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Age 50 or older	☒ No	☒ Yes →	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒

39. Did you ever work ROTATING night shifts at this age?

Under age 30	☒ No	☒ Yes
Age 30-39	☒ No	☒ Yes
Age 40-49	☒ No	☒ Yes
Age 50 or older	☒ No	☒ Yes

IN THE PAST YEAR

The following questions will allow us to evaluate physical activity and health in the USRT Study.

40. During the PAST YEAR, how many HOURS per week did you do the following. . .

	NUMBER OF HOURS PER WEEK							
	NONE	1/2 hr	1 hr	1½	2-3	4-6	7-10	11 hrs or more
Walk for exercise *(Do not include walking for daily activities, such as shopping)*.....	☒	☒	☒	☒	☒	☒	☒	☒
Moderate exercise *(e.g., golf, bowling, softball, yoga, pilates, tai chi)*	☒	☒	☒	☒	☒	☒	☒	☒
Strenuous exercise *(e.g., jogging, vigorous bicycling, swimming, soccer, aerobics)*.....	☒	☒	☒	☒	☒	☒	☒	☒
Weight training or resistance exercises *(e.g., weight machines, free weights)*.....	☒	☒	☒	☒	☒	☒	☒	☒

41. During the PAST YEAR, how many HOURS per day did you spend. . .

	NONE	1-2	3-4	5-6	7-8	9-10	11-12	13 hours or more
Sitting watching TV, video or DVD	☒	☒	☒	☒	☒	☒	☒	☒
Sitting or driving in a car, bus, train, plane, etc.	☒	☒	☒	☒	☒	☒	☒	☒
Other sitting *(reading, knitting, using a computer)*	☒	☒	☒	☒	☒	☒	☒	☒

42. During the PAST YEAR, how many HOURS per day did you sleep in a typical 24-hour period on:

TIME	1-4	5	6	7	8	9	10 hours or more
WEEKDAYS	☒	☒	☒	☒	☒	☒	☒
WEEKENDS	☒	☒	☒	☒	☒	☒	☒

43. During the PAST YEAR, how many TIMES in a typical week were your daily activities adversely affected because you got too little sleep?

None	1	2-3	4-5	6-7	8 times or more
☒	☒	☒	☒	☒	☒

44. During the PAST YEAR, how much light was visible in your bedroom while you slept?

☒ Bright light (e.g., to read) ☒ Some light (e.g., night light) ☒ Completely dark

45. During the PAST YEAR, did you go to bed after midnight at least once a week for at least three months?

☒ No ☒ Yes →

What was your usual BEDTIME after midnight?

☒ 12:00 to 1:00 a.m.
☒ After 1:00 to 2:00 a.m.
☒ After 2:00 to 3:00 a.m.
☒ After 3:00 a.m.

About how many TIMES PER MONTH did you go to bed after midnight?

☒ 1-4
☒ 5-8
☒ 9-15
☒ 16+

46. What type of person do you generally consider yourself?

☒ Morning person ☒ Evening person ☒ Neither ☒ Both

In case we need to contact you, please provide a telephone number and best time to reach you.

Phone number ☐☐☐ - ☐☐☐ - ☐☐☐☐
AREA CODE PHONE NUMBER

Best time to call:
☒ WEEK DAY
☒ WEEK NIGHT
☒ WEEKEND

If you worked or assisted with radioisotope or fluoroscopically-guided interventional radiation procedures on a regular basis, you may receive a follow-up questionnaire focused on those types of procedures.

Thank you!

SERIAL #

Data Recognition Corp.-6M2140-13194-54321