Introductory Script for Questionnaire

REGISTRY ID: ☐☐☐☐☐☐☐☐☐☐☐☐☐ FORM CODE: ISQA VERSION:A 10/10/11 Event ☐☐ SEQ # ☐☐

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Read the script to the patient. Record questions the patient asks.

The goal of this study is to collect information that may help us to better understand how genes, lifestyle and our environment may lead to disease. Let me start today by telling you a little bit about how this interview will work. I am going to read you a set of questions exactly as they are worded so that everybody in the study will be answering the same questions. In some cases you will answer in your own words. In other cases, I will give you a list of choices and ask you to pick the one that fits best. Some of these questions ask you to think back to events that may have occurred many years ago. Although the answers may be hard to remember, please do the best you can. Some questions may seem like we are asking the same thing more than once and this is because we are trying to decide the best way to ask the question. There are no right or wrong answers to any of these questions. You should just report what you have experienced in your life. Before we start, I want to remind you that your participation in this study is voluntary, and all the information collected will be kept completely confidential. If we should come to any question that you do not want to answer, just let me know and we'll go on to the next question.

1. Do you have any questions before we begin?.......................... ☐ Y →Notelog Yes ☐ N →Begin Interview No

2. *Enter time interview began:* ☐☐:☐☐ (1-12) (0-59)

   Enter AM or PM: ☐ A, P
   - *AM* A
   - *PM* P

Demographics

REGISTRY ID: | | | | | | | | | | | | |

FORM CODE: DEMA
VERSION: A 03/21/12

Event | | |

SEQ # | | |

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐

0b. Staff ID: ☐☐☐

0c. Language of Interview: ☐ E or S

0d. Consent Date: ☐☐/☐☐/☐☐☐☐

0e. New or Return Status: ☐ N or R

Instructions: Enter the answer given by the participant for each response.

Thank you for agreeing to be interviewed. I would like to ask you to update or verify some information you may have provided when you enrolled in this study.

1. What is your first name? ____

2. What is your middle initial? ____

3. What is your last name? ____

4. *[If female]* What is your maiden name? ___________________________________

5. What is your date of birth? a. MM: ☐☐ b. DD: ☐☐ c. YYYY: ☐☐☐☐

6. What is your sex? .... ☐
   - Male .... M
   - Female .... F

7. Are you Hispanic or Latino(a)? .... ☐
   - Yes .... Y
   - No .... N
   - Unknown .... U
   - Refused .... R

8. Which of the following best describes your racial background?

a. Race #1: .... ☐

- White .... W
- Black or African American .... B
- Asian .... A
- American Indian/Native American .... N
- Native Hawaiian/Pacific Islander I
- Other .... O
- Unknown .... U
- Refused .... R

b. Race #2: .... ☐

- White .... W
- Black or African American .... B
- Asian .... A
- American Indian/Native American .... N
- Native Hawaiian/Pacific Islander I
- Other .... O
- Unknown .... U
- Refused .... R

c. Race #3: .... ☐

- White .... W
- Black or African American .... B
- Asian .... A
- American Indian/Native American .... N
- Native Hawaiian/Pacific Islander I
- Other .... O
- Unknown .... U
- Refused .... R

9. What is your primary spoken language? ☐

- English .... E
- Spanish .... S
- Other .... O
- Refused .... R

10. What is the highest grade or year of school you completed? .... ☐

- Eighth grade or less .... E
- Some high school .... S
- High school graduate or GED Certificate .... H
- Some college or Technical School C
- College graduate (Bachelor's Degree) .... B
- Postgraduate or professional degree .... P
- Refused .... R

11. What is your current marital status? .... ☐

- Married .... M
- Living with partner L
- Divorced .... D
- Separated .... S
- Widowed .... W
- Single, never married .... N
- Refused .... R

12 Do you currently work for pay? .... ☐

- Yes .... Y
- No .... N →Skip to Item 14
- Refused .... R →Skip to Item 14

13 On average, how many hours do you work each week? .... ☐

- 1-20 hours .... A
- 21-30 hours .... B
- 31-39 hours C
- 40 or more hours .... D
- Refused .... R

14. What is your current address?

a. Street Address 1: ____

b. Street Address 2: ____

c. City: ____

d. State: ____

e. Zip Code: ____

15. What is your home phone number? ☐☐☐-☐☐☐-☐☐☐☐

16. What is your work phone number? ☐☐☐-☐☐☐-☐☐☐☐

17. What is your cell phone number? ☐☐☐-☐☐☐-☐☐☐☐

18. What is your current email address? ______________________________

19. Which of these methods is the best way to contact you? .... ☐

    Home Phone .... H
    Cell Phone C
    Work Phone .... W
    Email .... E
    Postal Mail .... P

20. In case we have difficulty contacting you, can you give me the name, address and phone number of someone who would most likely help or take care of you if needed?

    a. First Name: ______________________________

    b. Last Name: ______________________________

    c. Address: ______________________________

    d. City: ______________________________

    e. State: ______________________________

    f. Zip Code: ______________________________

    g. Primary Telephone: ☐☐☐-☐☐☐-☐☐☐☐

    h. Alternate Telephone: ☐☐☐-☐☐☐-☐☐☐☐

    i. Email Address: ______________________________

Physician Referral Form

REGISTRY ID:		FORM CODE: PRFA VERSION: A 06/01/11	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

1. Was the participant a self-referral ? ☐ Yes →Skip to Item 3 ☐ No

2. What is the name, address and contact information for the health care provider who referred you to the North Carolina Cancer Hospital at UNC?

   a. Name: ______________________________

   b. Name of his/her clinic or practice: ______________________________

   c. Address 1: ______________________________

   d. Address 2: ______________________________

   e. City: ______________________________

   f. State: ______________________________

   g. Zip Code: ______________________________

   h. Phone number for the doctor: ☐☐☐-☐☐☐-☐☐☐☐

   i. Email address for the doctor: ______________________________

3. Some people have a primary care doctor or health care provider. This provider may be your family doctor, a general doctor, a nurse practitioner or another type of health care provider.

   Do you have a primary health care provider?............................ ☐ Yes ☐ No →Skip to End

4. What is the name, address and contact information for the primary care provider?

a. Name: ____

b. Name of his/her clinic or practice: ______________________________

c. Address 1: ____

d. Address 2: ____

e. City: ____

f. State: ____

g. Zip Code: ____

h. Phone number for the primary care provider: ☐☐☐-☐☐☐-☐☐☐☐

i. Email address for the primary care provider: _________________________

Living Arrangements

REGISTRY ID:													FORM CODE: LAFA VERSION:A 06/21/11	Event			SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

I would like to ask you about your ***current*** *living arrangements.*

1. Are you **currently** living in a nursing home or other group care facility? This does not include living with family members who take care of you. .... ☐ Y Yes ☐ N →Skip to Item 3 No

2. About how many years have you lived in a nursing home or other group care facility?........ ☐ A-D →Skip to Next Form

   Allow the participant to say how long they have lived in a nursing home and then categorize the response.

   Less than 1 year .... A
   1-2 years........ B
   3-5 years........ C
   Greater than 5 years .... D

3. How many people, other than yourself, live in your home with you?........ ☐☐ 0-30

4. Of these, how many children less than 18 years of age live in your household?........ ☐☐ 0-30

Historical Height and Weight

REGISTRY ID:									FORM CODE: HHWA VERSION:A 06/21/11	Event			SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

*Now, I have some questions to ask about your height, weight, and body size during **different periods** of your life.*

1. *Select the participant's current age group*: ☐ 1-5
   - 18-19 1
   - 20-39 2
   - 40-49 3
   - 50-59 4
   - 60+ 5

(For participants aged 20 or older):
At age 20, how tall were you without shoes? If you don't know your exact height, please make your best guess.

2a. Enter feet: .... ☐ 2-8

2b. Enter inches: .... ☐☐ 0-11

2c. Height at 20 years old in inches: .... ☐☐ 24-99

How tall are you currently, without shoes? If you don't know your exact height, please make your best guess.

3a. Enter feet: .... ☐ 2-8

3b. Enter inches: .... ☐☐ 0-11

3c. Current height in inches: .... ☐☐ 24-99

4. *(For participants aged 20 or older):*
How much did you weigh at age 20, without shoes? If you don't know your exact weight, please make your best guess. *{**WOMEN:** If you were pregnant at age 20, how much did you weigh before your pregnancy?}* Enter weight in pounds:.. ☐☐☐

5. *(For participants aged 40 or older):*
How much did you weigh at age 40, without shoes? *{**WOMEN:** If you were pregnant at age 40, how much did you weigh before your pregnancy?}* Enter weight in pounds:.. ☐☐☐

6. *(For participants aged 50 or older):*
How much did you weigh at age 50, without shoes? Enter weight in pounds:... ☐☐☐

7. *(For participants aged 60 or older):*
How much did you weigh at age 60, without shoes? Enter weight in pounds:... ☐☐☐

8. How much do you currently weigh, without shoes? Enter weight in pounds:... ☐☐☐

9. What was your weight 1 year ago, without shoes? Enter weight in pounds:... ☐☐☐

Global Quality of Life

REGISTRY ID:	FORM CODE: PGSA VERSION:A 02/07/11	Event	SEQ #

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐

0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response by marking one box per row.

Next, I would like to ask some questions about your general health. Some questions may seem like we are asking the same thing more than once and this is because we are trying to decide the best way to ask the question. I will first read a question about your general health status, and then I will read the response options.

Question	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is:	☐	☐	☐	☐	☐
2. In general, would you say your quality of life is:	☐	☐	☐	☐	☐
3. In general, how would you rate your physical health?	☐	☐	☐	☐	☐
4. In general, how would you rate your mental health, including your mood and your ability to think?	☐	☐	☐	☐	☐
5. In general, how would you rate your satisfaction with your social activities and relationships?	☐	☐	☐	☐	☐
6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐	☐	☐	☐	☐

7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

☐	☐	☐	☐	☐
Completely	Mostly	Moderately	A little	Not at All

8. **In the past 7 days**, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

☐	☐	☐	☐	☐
Never	Rarely	Sometimes	Often	Always

9. **In the past 7 days**, how would you rate your fatigue on average?

☐	☐	☐	☐	☐
None	Mild	Moderate	Severe	Very Severe

10. **In the past 7 days**, how would you rate your pain on average?

No Pain										Worst Imaginable Pain
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Quality of Life-Cancer

REGISTRY ID:		FORM CODE: FGPA VERSION:A 07/22/11	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

Next, I would like to ask some questions about your general well-being over the ***past 7 days****. I will read you a statement and would like you to tell me how this applies to you by answering 'not at all', 'a little bit', 'somewhat', 'quite a bit', or 'very much.' Please remember when answering, we are interested in the* ***past 7 days****.*

A. Physical Well-Being

During the past 7 days,…

	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. You had a lack of energy	☐	☐	☐	☐	☐
2. You had nausea	☐	☐	☐	☐	☐
3. Because of your physical condition, you had trouble meeting the needs of your family	☐	☐	☐	☐	☐
4. You had pain	☐	☐	☐	☐	☐
5. You felt ill	☐	☐	☐	☐	☐
6. You were forced to spend time in bed	☐	☐	☐	☐	☐

B. Social/Family Well-Being

During the past 7 days,…

	Not at all	A little bit	Somewhat	Quite a bit	Very much
7. You felt close to your friends	☐	☐	☐	☐	☐
8. You got emotional support from your family	☐	☐	☐	☐	☐
9. You got support from your friends	☐	☐	☐	☐	☐

	Not at all	A little bit	Somewhat	Quite a bit	Very much
10. You felt close to your partner or the person who is your main support	☐	☐	☐	☐	☐

11. *Regardless of your current level of sexual activity, please answer the following question.*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
In the past 7 days, you were satisfied with your sex life	☐	☐	☐	☐	☐

C. Emotional Well-Being

During the past 7 days, …

	Not at all	A little bit	Somewhat	Quite a bit	Very much
12. You felt sad...	☐	☐	☐	☐	☐
13. You felt nervous..	☐	☐	☐	☐	☐
14. You worried about dying	☐	☐	☐	☐	☐
15. You worried that your condition will get worse ...	☐	☐	☐	☐	☐

D. Functional Well-Being

During the past 7 days, …

	Not at all	A little bit	Somewhat	Quite a bit	Very much
16. You were able to work, including work at home .	☐	☐	☐	☐	☐
17. Your work, including work at home, was fulfilling	☐	☐	☐	☐	☐
18. You were able to enjoy life................................	☐	☐	☐	☐	☐
19. You were sleeping well	☐	☐	☐	☐	☐
20. You were enjoying the things you usually do for fun	☐	☐	☐	☐	☐
21. You were content with the quality of your life right now	☐	☐	☐	☐	☐

Cognitive Function

REGISTRY ID:		FORM CODE: FCFA VERSION:A 07/22/11	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

*Next, I am going to ask you questions about your concentration and memory over the **past 7 days**. I will read you a statement and would like you to tell me if this has happened to you never, about once a week, two to three times a week, nearly every day, or several times a day. Please remember when answering, we are interested in the **past 7 days**.*

A. Perceived Cognitive Impairments

During the past 7 days,…

	Never	About once a week	2-3 times a week	Nearly every day	Several times a day
1. You had trouble forming thoughts	☐	☐	☐	☐	☐
2. Your thinking was slow	☐	☐	☐	☐	☐
3. You had trouble concentrating	☐	☐	☐	☐	☐
4. You had trouble finding your way to a familiar place	☐	☐	☐	☐	☐
5. You had trouble remembering where you put things, like your keys or your wallet	☐	☐	☐	☐	☐
6. You had trouble remembering new information, like phone numbers or simple instructions	☐	☐	☐	☐	☐
7. You had trouble recalling the name of an object while talking to someone	☐	☐	☐	☐	☐

8. You had trouble finding the right words to express yourself.. ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

9. You used the wrong word when you referred to an object... ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

10. You had trouble saying what you mean in conversations with others.............................. ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

11. You walked into a room and forgot what you meant to get or do there............................. ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

12. You had to work really hard to pay attention or you would make a mistake............. ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

13. You forgot names of people soon after being introduced... ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

14. Your reactions in everyday situations were slow... ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

15. You had to work harder than usual to keep track of what you were doing.................... ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

16. Your thinking was slower than usual................. ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

17. You had to work harder than usual to express yourself clearly .... ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

18. You had to use written lists more often than usual so you would not forget things………………….... .... ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

19. You had trouble keeping track of what you were doing if you were interrupted .... ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

20. You had trouble shifting back and forth between different activities that required thinking .... ☐ Never ☐ About once a week ☐ 2-3 times a week ☐ Nearly every day ☐ Several times a day

Cancer Symptoms

REGISTRY ID:		FORM CODE: RSCA VERSION:A 01/09/12	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

Now, I will ask you about any symptoms you may be experiencing. Please, for all symptoms, indicate to what extent you have been bothered by it by using the responses not at all, a little, quite a bit, or very much. Please remember when answering, we are interested in the ***past week****.*

A. Symptoms List

Have you during the **past week**, been **bothered** by:

1. Lack of appetite	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
2. Tiredness	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
3. Sore Muscles	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
4. Lack of Energy	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
5. Low Back Pain	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
6. Nausea	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
7. Difficulty Sleeping	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
8. Headaches	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
9. Vomiting	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much
10. Dizziness	☐ Not at all	☐ A little	☐ Quite a bit	☐ Very much

11. Decreased Sexual Interest ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

12. Abdominal, or stomach, aches ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

13. Constipation ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

14. Diarrhea ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

15. Acid Indigestion ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

16. Shivering ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

17. Tingling in Hands or Feet ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

18. Numbness in Hands or Feet ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

19. Difficulty Concentrating ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

20. Sore Mouth or Pain when Swallowing ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

21. Loss of Hair ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

22. Burning or Sore Eyes ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

23. Shortness of Breath ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

24. Dry Mouth ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

25. Rash ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

26. Problems with Tasting Food or Drink ☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much

27. Have you had problems with leakage of stool (accidents or soiling)? ☐ Y Yes ☐ N No →GO to Item 30

28. How bothersome is the stool leakage? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Quite a bit

29. In what month and year did the stool leakage start for you (MM/YYYY)? .... ☐☐/☐☐☐☐

Many people leak urine some of the time. We are trying to find out how many people leak urine and how much this bothers them. Answer the following questions thinking about how you have been on average over the **past four weeks.**

30. How often do you leak urine?

☐	☐	☐	☐	☐	☐
Never *→Skip to next form*	About once a week or less	Two or three times a week	About once a day	Several times a day	All the time

31. In what month and year did you first start to leak urine (MM/YYYY)? .... ☐☐/☐☐☐☐

32. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)?

☐	☐	☐
A small amount	A moderate amount	A large amount

33. Overall, how much does leaking urine interfere with your everyday life?

Not at all										A great deal
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

34. When does urine leak? (Please indicate all that apply to you.)

- Leaks before you can get to the toilet.. ☐
- Leaks when you cough or sneeze.. ☐
- Leaks when you are asleep.. ☐
- Leaks when you are physically active/exercising.. ☐
- Leaks when you have finished urinating and are dressed .... ☐
- Leaks for no obvious reason .... ☐
- Leaks all the time .... ☐

Physical Activity

REGISTRY ID:		FORM CODE: PAFA VERSION:A 07/22/11	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

Next I am going to ask you about the time you spend doing different types of physical activity in a ***typical week****. Please answer these questions even if you do not consider yourself to be a physically active person.*

A. Activity at Work

Think first about the time you spend doing work. Think of work as the things that you have to do such as paid or unpaid work, household chores (like housework and yardwork), farming, hunting or fishing. In answering the following questions 'vigorous-intensity activities' are activities that require hard physical effort and cause large increases in breathing or heart rate, 'moderate-intensity activities' are activities that require moderate physical effort and cause small increases in breathing or heart rate.

1. Does your work involve vigorous-intensity activity that causes large increases in breathing or heart rate like *[carrying or lifting heavy loads, digging or construction work*] for at least 10 minutes continuously? .... ☐ Y Yes ☐ N →Skip to Item 4 No
2. In a **typical week**, on how many days do you do vigorous-intensity activities as part of your work? *Enter the number of days*: .... ☐ 1-7
3. How much time do you spend doing vigorous-intensity activities at work on a **typical day**?

   Enter the time: .... ☐☐ 0-60

   Enter the time unit:.......... ☐ M, H

   Minutes M
   Hours H
4. Does your work involve moderate-intensity activity that causes small increases in breathing or heart rate such as brisk walking *[or carrying light loads*] for at least 10 minutes continuously?.......... ☐ Y Yes ☐ N →Skip to Item 7 No
5. In a **typical week**, on how many days do you do moderate-intensity activities as part of your work? *Enter the number of days:* .... ☐ 1-7

6. How much time do you spend doing moderate-intensity activities at work on a **typical day**?

   Enter the time: .... [ ][ ] 0-60

   Enter the time unit:.. [ ] M, H

Minutes	M
Hours	H

B. Travel to and from Places

The next questions do not include the physical activities at work that you have already mentioned. Now I would like to ask you about the usual way you travel to and from places. For example: to work, for shopping, to market, to places of worship.

7. Do you walk or use a bicycle (*pedal cycle*) for at least 10 minutes continuously to get to and from places? .... [ ] Y Yes [ ] N →Skip to Item 10 No

8. In a **typical week**, on how many days do you walk or bicycle for at least 10 minutes continuously to get to and from places? *Enter the number of days:*.. [ ] 1-7

9. How much time do you spend walking or bicycling for travel on a **typical day**?

   Enter the time: .... [ ][ ] 0-60

   Enter the time unit:.. [ ] M, H

Minutes	M
Hours	H

C. Recreational Activities

The next questions do not include the work and transport activities that you have already mentioned. Now I would like to ask you about sports, fitness and recreational activities (leisure).

10. Do you do any vigorous-intensity sports, fitness or recreational (*leisure*) activities that cause large increases in breathing or heart rate *[like running or football]* for at least 10 minutes continuously? .... [ ] Y Yes [ ] N →Skip to Item 13 No

11. In a **typical week**, on how many days do you do vigorous-intensity sports, fitness or recreational (*leisure*) activities? *Enter the number of days:*.. [ ] 1-7

12. How much time do you spend doing vigorous-intensity sports, fitness or recreational activities on a **typical day**?

    Enter the time: .... [ ][ ] 0-60

    Enter the time unit:.. [ ] M, H

Minutes	M
Hours	H

13. Do you do any moderate-intensity sports, fitness or recreational *(leisure*) activities that cause a small increase in breathing or heart rate, such as brisk walking (*easy cycling or swimming)*, for at least 10 minutes continuously? .... ☐ Y Yes ☐ N →Skip to Item 16 No

14. In a **typical week**, on how many days do you do moderate-intensity sports, fitness or recreational (*leisure*) activities? *Enter the number of days:*.. ☐ 1-7

15. How much time do you spend doing moderate-intensity sports, fitness or recreational (*leisure*) activities on a **typical day**?

    Enter the time: .... ☐☐ 0-60

    Enter the time unit:.. ☐ M, H

Minutes	M
Hours	H

16. Do you do any mild-intensity sports, fitness or recreational *(leisure*) activities that require minimal effort and no perspiration (*like easy walking or yoga*), for at least 10 minutes continuously? .... ☐ Y Yes ☐ N →Skip to Item 19 No

17. In a **typical week**, on how many days do you do mild-intensity sports, fitness or recreational (*leisure*) activities? *Enter the number of days:*.. ☐ 1-7

18. How much time do you spend doing mild-intensity sports, fitness or recreational (*leisure*) activities on a **typical day**?

    Enter the time: .... ☐☐ 0-60

    Enter the time unit:.. ☐ M, H

Minutes	M
Hours	H

D. Sedentary Behavior

The following question is about sitting or reclining at work, at home, getting to and from places, or with friends including time spent sitting at a desk, sitting with friends, travelling by car, bus, or train, reading, playing cards or watching television, but do not include time spent sleeping.

19. How much time do you usually spend sitting or reclining on a **typical day**?

    Enter the time: .... ☐☐ 0-60

    Enter the time unit:.. ☐ M, H

Minutes	M
Hours	H

Performance Assessment

REGISTRY ID:		FORM CODE: SGAA VERSION:A 07/21/11	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: __ __ / __ __ / __ __ __ __   0b. Staff ID: __ __ __

Instructions: Enter the answer given by the participant for each response.

1. Over the **past month**, how would you generally rate your activity? [ ] A-E
   - Normal activity with no limitations..A
   - Not your normal self, but able to be up and about with fairly normal activities ....B
   - Not feeling up to most things, but in bed or chair less than half the day C
   - Able to do little activity and spend most of the day in bed or chair ....D
   - Pretty much bedridden, rarely out of bed..E

Reproductive History

REGISTRY ID:	FORM CODE: RHFA VERSION:A 10/12/11	Event	SEQ #

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

A. Menstrual Cycle

The next series of questions is about your reproductive history. I will begin by asking some questions about your period or menstrual cycle.

1. How old were you when you had your first menstrual period? *Enter age in years:* .... ☐☐ 06-20

2. Have you had at least one menstrual period in the **past year**? Please do not include bleedings caused by medical conditions, hormone therapy, or surgeries............ ☐ Y, N
   - Yes .... Y →Skip to Item 5
   - No .... N

3. What is the reason that you have not had a period in the **past year**? .... ☐ A-E
   - Pregnancy............ A
   - Breast Feeding............ B
   - Menopause/Hysterectomy C
   - Medical Conditions/Treatments............ D
   - Other............ E
   - Other reason for not having had a period:______________________________

4. About how old were you when you had your last menstrual period? *Enter age in years:* .... ☐☐ 10-90

B. Pregnancy and Uterine Health History

The next questions are about your pregnancy history.

5. Have you ever been pregnant? Please include any current pregnancy, live births, miscarriages, stillbirths, tubal pregnancies and abortions. ☐ Y, N, D, R
   - Yes .... Y
   - No .... N →Skip to Item 11
   - Don't Know .... D →Skip to Item 11
   - Refused .... R →Skip to Item 11

6. How many times have you been pregnant? Be sure to count all your pregnancies including any current pregnancy, live births, miscarriages, stillbirths, tubal pregnancies, or abortions. *Enter number of pregnancies:* .... ☐☐ 01-20

7. How many of your deliveries resulted {did your delivery result} in live births? *Enter number of live birth deliveries:* .... ☐☐ 00-20 (If 0 →Skip to item 11) (If 1 →Skip to item 9)

8. How old were you at the time of your first live birth? *Enter age in years:* .... ☐☐ 10-70

9. How old were you at the time of your {last} live birth? *Enter age in years:* .... ☐☐ 10-70

10. Did you breast feed {your child} any of your children for at least one month? .... ☐ Y, N
    - Yes .... Y
    - No .... N

11. Have you had a hysterectomy, including a partial hysterectomy, that is, surgery to remove your uterus or womb? .... ☐ Y, N, D, R
    - Yes .... Y
    - No .... N →Skip to Item 13
    - Don't Know .... D →Skip to Item 13
    - Refused .... R →Skip to Item 13

12. How old were you when you had your {hysterectomy/uterus removed/womb removed}? *Enter age in years:* .... ☐☐ 10-90

13. Have you had both of your ovaries removed, either when you had your uterus removed, or at another time? .... ☐ Y, N, D, R

    Yes .... Y
    No .... N → Skip to Item 15
    Don't Know .... D → Skip to Item 15
    Refused .... R → Skip to Item 15

14. How old were you when you had your ovaries removed or your last ovary removed if they were removed at different times? *Enter age in years:* .... ☐☐ 10-90

C. Birth Control History

Now I am going to ask you about your birth control history.

15. Have you ever taken birth control pills for any reason? *[If the participant took birth control pills for less than 1 month, enter "No."]* .... ☐ Y, N, D, R

    Yes .... Y
    No .... N → Skip to Item 18
    Don't Know .... D → Skip to Item 18
    Refused .... R → Skip to Item 18

16. Are you taking birth control pills now? .... ☐ Y, N

    Yes .... Y
    No .... N

17. Not counting any time when you stopped taking them, for how long altogether {have you taken/did you take} birth control pills?

17a. Enter number: .... ☐☐ 0-99

17b. Enter time period altogether participant took birth control pills .... ☐ A, B

    Month(s) .... A
    Year(s) .... B

18. Have you ever used other forms of hormonal birth control such as birth control patches, injections, birth control implants, or Nuva Ring? .... ☐ Y, N, D, R

    Yes .... Y
    No .... N → Skip to Item 22
    Don't Know .... D → Skip to Item 22
    Refused .... R → Skip to Item 22

Which forms of other hormonal birth control have you used?

19a. Birth control patches? .... ☐ Y ☐ N

Yes No

19b. Injections or implants for birth control? .... ☐ Y Yes ☐ N No

19c. Nuva Ring? .... ☐ Y Yes ☐ N No

19d. Other? .... ☐ Y Yes ☐ N No

Other hormonal birth control:______________________________

20. Are you using {birth control patches/injections or implants for birth control/Nuva Ring} now? .... ☐ Y, N
- Yes .... Y
- No .... N

21. Not counting any time when you stopped taking them, for how long altogether {have you used/did you use} {birth control patches/injections or implants for birth control/Nuva Ring}?

21a. Enter number: .... ☐☐ 0-99

21b. Enter time period altogether participant took birth control patches/injections or implants for birth control/Nuva Ring. .... ☐ A, B
- Month(s) .... A
- Year(s) .... B

D. Hormone Replacement History

Sometimes women take female hormones, such as estrogen or progesterone, at menopause (the change of life) for hormone replacement therapy. We are interested in any hormone replacement pills that you took, as well as skin patches that you may have used for reasons other than birth control.

22. Have you ever used female hormone replacement such as estrogen and progesterone? Please include any forms of female hormone replacement treatments, such as pills, cream, patch, or injectables; do not include birth control methods or use for infertility. .... ☐ Y, N, D, R
- Yes .... Y
- No .... N →Skip to Next Form
- Don't Know .... D →Skip to Next Form
- Refused .... R →Skip to Next Form

Which forms of female hormones have you used?

23a. Pills? .... ☐ Y Yes ☐ N No

23b. Patches? .... ☐ Y Yes ☐ N No

23c. Cream/Suppository/Injection? .... ☐ Y Yes ☐ N No

Instructions to Data Collector:

If only pills were used answer questions 24 through 32 and skip to next form.

If only patches were used then skip to question 33 and answer questions 33-38.

If only cream/suppository/injection was used then skip to next form.

If all of question 23 is answered as 'don't know' or refused then skip to next form.

E. Hormone Replacement – Pills

24. Have you ever taken female hormone replacement pills containing estrogen only, like Premarin, Estrace, or Estratest? (Do not include birth control pills.)
    [If the participant took these pills for less than 1 month, enter "No."]............................ ☐ Y, N, D, R
    - Yes .... Y
    - No .... N →Skip to Item 27
    - Don't Know .... D →Skip to Item 27
    - Refused .... R →Skip to Item 27

25. Are you taking pills containing estrogen only now? .... ☐ Y, N
    - Yes .... Y
    - No .... N

26. Not counting any time when you stopped taking them, for how long altogether {have you taken/did you take} pills containing estrogen only?

26a. Enter number: .... ☐☐ 0-99

26b. Enter time period altogether participant took pills containing estrogen only. .... ☐ A, B
    - Month(s) .... A
    - Year(s) .... B

27. Have you taken female hormone replacement pills containing progestin only, like Provera, Cycrin, or MPA? (Do not include birth control pills.) *[If the participant took these pills for less than 1 month, enter "No."]*..................................... ☐ Y, N, D, R
    - Yes .... Y
    - No .... N →Skip to Item 30
    - Don't Know .... D →Skip to Item 30
    - Refused .... R →Skip to Item 30

28. Are you taking pills containing progestin only now? .... ☐ Y, N
    - Yes .... Y

No .... N

29. Not counting any time when you stopped taking them, for how long altogether {have you taken/did you take} pills containing progestin only?

29a. Enter number: .... [ ][ ] 0-99

29b. Enter time period altogether participant took pills containing progestin only. .... [ ] A, B

Month(s) .... A

Year(s) .... B

30. Have you taken female hormone replacement pills containing both estrogen and progestin, like Prempro, Premphase, or FemHRT? (Do not include birth control pills.) *[If the participant took these pills for less than 1 month, enter "No."]* .... [ ] Y, N, D, R

Yes .... Y

No .... N →Skip to Item 33

Don't Know .... D →Skip to Item 33

Refused .... R →Skip to Item 33

31. Are you taking pills containing both estrogen and progestin now? .... [ ] Y, N

Yes .... Y

No .... N

32. Not counting any time when you stopped taking them, for how long altogether {have you taken/did you take} pills containing both estrogen and progestin?

32a. Enter number: .... [ ][ ] 0-99

32b. Enter time period altogether participant took pills containing both estrogen and progestin. .... [ ] A, B

Month(s) .... A

Year(s) .... B

F. Hormone Replacement – Patches

33. Have you ever used female hormone replacement patches containing estrogen only? *[If the participant used these patches for less than 1 month, enter "No."]* .... [ ] Y, N, D, R

Yes .... Y

No .... N →Skip to Item 36

Don't Know .... D →Skip to Item 36
Refused .... R →Skip to Item 36

34. Are you using patches containing estrogen only now? .... ☐ Y, N
Yes .... Y
No .... N

35. Not counting any time when you stopped using them, for how long altogether {have you used/did you use} patches containing estrogen only?

35a. Enter number: .... ☐☐ 0-99

35b. Enter time period altogether participant used patches containing estrogen only..... ☐ A, B
Month(s) .... A
Year(s) .... B

36. Have you used female hormone replacement patches containing both estrogen and progestin? *[If the participant used these patches for less than 1 month, enter "No."]* .... ☐ Y, N, D, R
Yes .... Y
No .... N →Skip to Next Form
Don't Know .... D →Skip to Next Form
Refused .... R →Skip to Next Form

37. Are you using patches containing both estrogen and progestin now? .... ☐ Y, N
Yes .... Y
No .... N

38. Not counting any time when you stopped using them, for how long altogether {have you used/did you use} patches containing both estrogen and progestin?

38a. Enter number: .... ☐☐ 0-99

38b. Enter time period altogether participant used patches containing both estrogen and progestin .... ☐ A, B
Month(s) .... A
Year(s) .... B

Enter number of months: .... ☐☐☐ 01-500

Sexual Function

REGISTRY ID:		FORM CODE: SFQA VERSION:A 1/05/12	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: __ __/__ __/__ __ __ __ 0b. Staff ID: __ __ __

Instructions: Enter the answer given by the participant for each response by marking one box per row.

Female and Males (Items 1-2)

1. In the past 30 days, how interested have you been in sexual activity?
   ☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very

2. In the past 30 days, how often have you felt like you wanted to have sex?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Female Only (Items 3-7)

3. Over the past 4 weeks, how often did you become lubricated ("wet") during sexual activity or intercourse?
   ☐ No sexual activity ☐ Almost always or always ☐ Most times (more than half the time) ☐ Sometimes (about half the time) ☐ A few times (less than half the time) ☐ Almost never or never

4. In the past 30 days, how difficult has it been for your vagina to get lubricated ("wet") when you wanted it to?
   ☐ Have not tried to get lubricated ☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very

5. In the past 30 days, how would you describe the comfort of your vagina during sexual activity?
   ☐ No sexual activity ☐ Very comfortable ☐ Comfortable ☐ Uncomfortable ☐ Very Uncomfortable

6. In the past 30 days, how often have you had difficulty with sexual activity because of discomfort or pain in your vagina?
   ☐ No sexual activity ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

7. In the past 30 days, how often have you stopped sexual activity because of discomfort or pain in your vagina?

No sexual activity	Never	Rarely	Sometimes	Often	Always
☐	☐	☐	☐	☐	☐

Male Only (Items 8-10)

8. In the past 30 days, how difficult has it been for you to get an erection when you wanted to? (If you use pills, injections, or a penis pump to help you get an erection, please answer this question thinking about the times that you used these aids.)

Have not tried to get an erection	Not at all	A little bit	Somewhat	Quite a bit	Very
☐	☐	☐	☐	☐	☐

9. In the past 30 days, how difficult has it been for you to keep an erection (stay hard) when you wanted to? (If you use pills, injections, or a penis pump to help you get an erection, please answer this question thinking about the times that you used these aids.)

Have not had an erection	Not at all	A little bit	Somewhat	Quite a bit	Very
☐	☐	☐	☐	☐	☐

10. How would you rate your ability to have an erection during the last 4 weeks?

Very poor	Poor	Fair	Good	Very good
☐	☐	☐	☐	☐

Female and Males (Items 11-13)

11. In the past 30 days, how would you rate your ability to have a satisfying orgasm/climax?

Have not tried to have an orgasm or climax	Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐	☐

12. In the past 30 days, when you have had sexual activity, how much have you enjoyed it?

No sexual activity	Not at all	A little bit	Somewhat	Quite a bit	Very
☐	☐	☐	☐	☐	☐

13. In the past 30 days, when you have had sexual activity, how satisfying has it been?

No sexual activity	Not at all	A little bit	Somewhat	Quite a bit	Very
☐	☐	☐	☐	☐	☐

Comorbidities and Medications

REGISTRY ID:		FORM CODE: CAMA VERSION:A 07/13/11	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐   0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

Next I will be asking you some questions about your medical history. If you answer that you have been diagnosed with any of these medical conditions, I will then ask you if you have taken medications for these conditions.

	a. Have you **EVER** been told by a doctor or other health professional that you had any of the following conditions?	**b.** Are any of your current activities limited by this condition?	**c.** Do you currently take any prescription medications for this condition?	**d.** Do you currently take any over-the-counter medications for this condition?
1. Alzheimer's disease	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
2. Arthritis	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
3. Asthma	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
4. Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
5. Diabetes	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No

	a. Have you **EVER** been told by a doctor or other health professional that you had any of the following conditions?	**b.** Are any of your current activities limited by this condition?	**c.** Do you currently take any prescription medications for this condition?	**d.** Do you currently take any over-the-counter medications for this condition?
6. HIV/AIDS	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
7. Hypertension	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
8. Weak or failing kidneys - do not include kidney stones, bladder infections, or incontinence	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
9. Liver Conditions, for example cirrhosis of the liver, chronic liver disease	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
10. Osteoporosis	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
11. Inflammatory bowel disease, such as Crohn's Disease/Ulcerative Colitis	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
12. Ulcer - stomach, duodenal or peptic ulcer	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
13. Anxiety	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
14. Depression	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
15. Bipolar Disorder	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No

	a. Have you **EVER** been told by a doctor or other health professional that you had any of the following conditions?	**b.** Are any of your current activities limited by this condition?	**c.** Do you currently take any prescription medications for this condition?	**d.** Do you currently take any over-the-counter medications for this condition?
16. Schizophrenia	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
17. Congestive heart failure	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
18. Angina/chest pain	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
19. Heart attack/myocardial infarction	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
20. High cholesterol	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
21. Stroke	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
22. Blood clot in a leg or deep vein thrombosis	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No
23. Blood clot in your lungs or a pulmonary embolus	Yes No → Next Don't Know → Next Refused → Next	Yes No	Yes No	Yes No

24. Have you **EVER** been told by a doctor or other health professional that you had **cancer or a malignancy of any kind?** .... ☐ Y Yes ☐ N ➔ **Next Form** No

a. How many different types of cancer have you had? .... ☐ 1-4

One .... 1➔ **Answer Item 25 entirely**
Two .... 2➔ **Answer Items 25-26 entirely**
Three.. 3➔ **Answer Items 25-27 entirely**
Four.. 4➔ **Answer Items 25-28 entirely**

25. What was your first type of cancer or malignancy? ______________________________

25a. At what age were you told that you had this cancer?................................ ☐☐☐

25b. Did you **ever** have any <u>surgery</u> as part of this cancer treatment? ......☐ Y Yes ☐ N➔ **GO TO 25c** No
.... ☐ D➔ **GO TO 25c** Don't Know
.... ☐ R➔ **GO TO 25c** Refused

Please DO NOT consider any biopsy you had or insertion of medication ports such as a Hickman catheter to be surgery.

25b.1 When was the **last time** you had <u>surgery</u> as part of this cancer treatment (MM/DD/YYYY)?... ☐☐/☐☐/☐☐☐☐

25c. Did you **ever** receive any <u>chemotherapy</u> as part of this cancer treatment? ....☐ Y Yes ☐ N➔ **GO TO 25d** No
.... ☐ D➔ **GO TO 25d** Don't Know
.... ☐ R➔ **GO TO 25d** Refused

Please include both IV (that is, intravenous) and oral forms of chemotherapy.

25c.1 When was the **last time** you had <u>chemotherapy</u> as part of this cancer treatment (MM/DD/YYYY)? ... ☐☐/☐☐/☐☐☐☐

25d. Did you **ever** receive any <u>radiation therapy</u> as part of this cancer treatment? ....☐ Y Yes ☐ N➔ **GO TO 25e** No
.... ☐ D➔ **GO TO 25e** Don't Know
.... ☐ R➔ **GO TO 25e** Refused

25d.1 When was the **last time** you had <u>radiation therapy</u> as part of this cancer treatment (MM/DD/YYYY)? ... ☐☐/☐☐/☐☐☐☐

25e. Did you **ever** receive a <u>bone marrow or stem cell transplant</u> as part of this cancer treatment?..☐ Y Yes ☐ N➔ **GO TO 25f** No
.... ☐ D➔ **GO TO 25f** Don't Know
.... ☐ R➔ **GO TO 25f** Refused

Please DO NOT consider a bone marrow biopsy to be a bone marrow transplant.

25e.1 When was the **last time** you had a bone marrow or stem cell transplant as part of this cancer treatment (MM/DD/YYYY)? .... ☐☐/☐☐/☐☐☐☐

25f. Did you **ever** receive any other type of medical treatments as part of this cancer treatment? ....
☐ Y Yes
☐ N ➔ **GO TO 26 or Next Form** No
☐ D ➔ **GO TO 26 or Next Form** Don't Know
☐ R ➔ **GO TO 26 or Next Form** Refused

If yes, specify type of other treatment ____________________________

25f.1 When was the **last time** you had any other medical treatments as part of this cancer treatment (MM/DD/YYYY)? .... ☐☐/☐☐/☐☐☐☐

26. What was your second type of cancer or malignancy? ________________________________

26a. At what age were you told that you had this cancer? .... ☐☐☐

26b. Did you **ever** have any surgery as part of this cancer treatment? ......
☐ Y Yes
☐ N ➔ **GO TO 26c** No
☐ D ➔ **GO TO 26c** Don't Know
☐ R ➔ **GO TO 26c** Refused

Please DO NOT consider any biopsy you had or insertion of medication ports such as a Hickman catheter to be surgery.

26b.1 When was the **last time** you had surgery as part of this cancer treatment (MM/DD/YYYY)? .... ☐☐/☐☐/☐☐☐☐

26c. Did you **ever** receive any chemotherapy as part of this cancer treatment? ....
☐ Y Yes
☐ N ➔ **GO TO 26d** No
☐ D ➔ **GO TO 26d** Don't Know
☐ R ➔ **GO TO 26d** Refused

Please include both IV (that is, intravenous) and oral forms of chemotherapy.

26c.1 When was the **last time** you had chemotherapy as part of this cancer treatment (MM/ DD/YYYY)? .. ☐☐/☐☐/☐☐☐☐

26d. Did you **ever** receive any <u>radiation therapy</u> as part of this cancer treatment? .... ☐ Y Yes ☐ N➔ **GO TO 26e** No
.... ☐ D➔ **GO TO 26e** Don't Know
.... ☐ R➔ **GO TO 26e** Refused

26d.1 When was the **last time** you had <u>radiation therapy</u> as part of this cancer treatment (MM/ DD/YYYY)? .. ☐☐/☐☐/☐☐☐☐

26e. Did you **ever** receive a <u>bone marrow or stem cell transplant</u> as part of this cancer treatment? .... ☐ Y Yes ☐ N➔ **GO TO 26f** No
.... ☐ D➔ **GO TO 26f** Don't Know
.... ☐ R➔ **GO TO 26f** Refused

Please DO NOT consider a bone marrow biopsy to be a bone marrow transplant.

26e.1 When was the **last time** you had a <u>bone marrow or stem cell transplant</u> as part of this cancer treatment (MM/ DD/YYYY)? .... ☐☐/☐☐/☐☐☐☐

26f. Did you **ever** receive any other type of medical treatments as part of this cancer treatment? .... ☐ Y Yes ☐ N➔ **GO TO 27 or Next Form** No
.... ☐ D➔ **GO TO 26 or Next Form** Don't Know
.... ☐ R➔ **GO TO 26 or Next Form** Refused

If yes, specify type of other treatment ____________________________

26f.1 When was the **last time** you had any other medical treatments as part of this cancer treatment (MM/Y DD/YYY)? .... ☐☐/☐☐/☐☐☐☐

27. What was your third type of cancer or malignancy? ________________________________

27a. At what age were you told that you had this cancer? .... ☐☐☐

27b. Did you **ever** have any surgery as part of this cancer treatment? ......☐ Y Yes ☐ N➔ **GO TO 27c** No
☐ D➔ **GO TO 27c** Don't Know
☐ R➔ **GO TO 27c** Refused

Please DO NOT consider any biopsy you had or insertion of medication ports such as a Hickman catheter to be surgery.

27b.1 When was the **last time** you had surgery as part of this cancer treatment?

(MM/ DD/YYYY) .... ☐☐/☐☐/☐☐☐☐

27c. Did you **ever** receive any chemotherapy as part of this cancer treatment? ......☐ Y Yes ☐ N➔ **GO TO 27d** No
☐ D➔ **GO TO 27d** Don't Know
☐ R➔ **GO TO 27d** Refused

Please include both IV (that is, intravenous) and oral forms of chemotherapy.

27c.1 When was the **last time** you had chemotherapy as part of this cancer treatment (MM/ DD/YYYY)? .. ☐☐/☐☐/☐☐☐☐

27d. Did you **ever** receive any radiation therapy as part of this cancer treatment? ......☐ Y Yes ☐ N➔ **GO TO 27e** No
☐ D➔ **GO TO 27e** Don't Know
☐ R➔ **GO TO 27e** Refused

27d.1 When was the **last time** you had radiation therapy as part of this cancer treatment (MM/ DD/YYYY)? .. ☐☐/☐☐/☐☐☐☐

27e. Did you **ever** receive a bone marrow or stem cell transplant as part of this cancer treatment?......☐ Y Yes ☐ N➔ **GO TO 27f** No
☐ D➔ **GO TO 27f** Don't Know
☐ R➔ **GO TO 27f** Refused

Please DO NOT consider a bone marrow biopsy to be a bone marrow transplant.

27e.1 When was the **last time** you had a bone marrow or stem cell transplant as part of this cancer treatment (MM/ DD/YYYY)? .... ☐☐/☐☐/☐☐☐☐

27f. Did you **ever** receive any other type of medical treatments as part of this cancer treatment? .... ☐ Y Yes ☐ N ➔ **GO TO 28 or Next Form** No
.... ☐ D ➔ **GO TO 28 or Next Form** Don't Know
.... ☐ R ➔ **GO TO 28 or Next Form** Refused

If yes, specify type of other treatment:___________________________

27f.1 When was the **last time** you had any other medical treatments as part of this cancer treatment (MM/ DD/YYYY)? .... ☐☐/☐☐/☐☐☐☐

28. What was your fourth type of cancer or malignancy? ______________________________

28a. At what age were you told that you had this cancer? .... ☐☐☐

28b. Did you **ever** have any surgery as part of this cancer treatment? ...... ☐ Y Yes ☐ N ➔ **GO TO 28c** No
.... ☐ D ➔ **GO TO 28c** Don't Know
.... ☐ R ➔ **GO TO 28c** Refused

Please DO NOT consider any biopsy you had or insertion of medication ports such as a Hickman catheter to be surgery.

28b.1 When was the **last time** you had surgery as part of this cancer treatment?

(MM/ DD/YYYY) .... ☐☐/☐☐/☐☐☐☐

28c. Did you **ever** receive any chemotherapy as part of this cancer treatment? .... ☐ Y Yes ☐ N ➔ **GO TO 28d** No
.... ☐ D ➔ **GO TO 28d** Don't Know
.... ☐ R ➔ **GO TO 28d** Refused

Please include both IV (that is, intravenous) and oral forms of chemotherapy.

28c.1 When was the **last time** you had chemotherapy as part of this cancer treatment (MM/ DD/YYYY)? .. ☐☐/☐☐/☐☐☐☐

28d. Did you **ever** receive any radiation therapy as part of this cancer treatment? .... ☐ Y Yes ☐ N➔ **GO TO 28e** No
.... ☐ D➔ **GO TO 28e** Don't Know
.... ☐ R➔ **GO TO 28e** Refused

28d.1 When was the **last time** you had radiation therapy as part of this cancer treatment (MM/ DD/YYYY)? .. ☐☐/☐☐/☐☐☐☐

28e. Did you **ever** receive a bone marrow or stem cell transplant as part of this cancer treatment? .... ☐ Y Yes ☐ N➔ **GO TO 28f** No
.... ☐ D➔ **GO TO 28f** Don't Know
.... ☐ R➔ **GO TO 28f** Refused

Please DO NOT consider a bone marrow biopsy to be a bone marrow transplant.

28e.1 When was the **last time** you had a bone marrow or stem cell transplant as part of this cancer treatment (MM/ DD/YYYY)? .... ☐☐/☐☐/☐☐☐☐

28f. Did you **ever** receive any other type of medical treatments as part of this cancer treatment? .... ☐ Y Yes ☐ N➔ **Next Form** No
.... ☐ D➔ **Next Form** Don't Know
.... ☐ R➔ **Next Form** Refused

If yes, specify type of other treatments:______________________________

28f.1 When was the **last time** you had any other medical treatments as part of this cancer treatment (MM/DD/YYYY)? .... ☐☐/☐☐/☐☐☐☐

NSAIDs and Multivitamins

REGISTRY ID: | | | | | | | | | | | | |

FORM CODE: NAMA
VERSION:A 05/01/12

Event | | |

SEQ # | | |

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐

0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

We are now interested in obtaining information on certain prescription and over-the-counter pain medications that you may have taken during the ***past year*** *for any reason.*

A. Prescription Medication

1. Have you taken any **prescription** pain medication in the **past year**? .... ☐ Y, N

   Yes .... Y

   No .... N →Skip to Item 8

2. Have you used **prescription** pain medications such as Motrin, Naprosyn, Daypro, Feldene, or any other **NSAIDs**, during the **past year**? .... ☐ Y, N

   Yes .... Y

   No .... N →Skip to Item 5

3. How often in the **past year** did you take these medications? You can answer in times per day, per week, or per month. *[NOTE: If the participant says that he/she took these medications less frequently than once per month, code this as zero times.]*

3a. Enter number: .... ☐☐ 0-99 (If zero→Skip to Item 5)

3b. Select the unit of time for how many times per day/week/month medication was taken: ☐ D, W, M

   Per day .... D

   Per week .... W

   Per month .... M

4. In total, how long did you take these medications in the **past year**? You can answer in days, weeks, or months.

4a. Enter number: .... [ ][ ] 1-52

4b. Select the unit of time for how long medication was taken: .... [ ] D, W, M
- Day(s) .... D
- Week(s) .... W
- Month(s) .... M

5. Have you used **prescription** pain medications such as Celebrex or Celecoxib, or any other **Cox-2 inhibitors**, during the **past year**? .... [ ] Y, N
- Yes .... Y
- No .... N →Skip to Item 8

6. How often in the **past year** did you take these medications? You can answer in times per day, per week, or per month. *[NOTE: If the participant says that he/she took these medications less frequently than once per month, code this as zero times.]*

6a. Enter number: .... [ ][ ] 0-99 (If zero→Skip to Item 8)

6b. Select the unit of time for how many times per day/week/month medication was taken: [ ] D, W, M
- Per day .... D
- Per week .... W
- Per month .... M

7. In total, how long did you take these medications in the **past year**? You can answer in days, weeks, or months.

7a. Enter number: .... [ ][ ] 1-52

7b. Select the unit of time for how long medication was taken: .... [ ] D, W, M
- Day(s) .... D
- Week(s) .... W
- Month(s) .... M

B. Over-the-Counter Medication

Next, I will ask about over-the-counter medication use.

8. Have you taken any **over-the-counter** aspirin during the **past year**? .... [ ] Y, N
- Yes .... Y
- No .... N →Skip to Item 15

9. Have you used **baby or low-dose** aspirin (100 mg/tablet or less) during the **past year**? .... ☐ Y, N
   - Yes .... Y
   - No .... N →Skip to Item 12

10. How often in the **past year** did you take these medications? You can answer in times per day, per week, or per month. *[NOTE: If the participant says that he/she took these medications less frequently than once per month, code this as zero times.]*

10a. Enter number: .... ☐☐ 0-99 (If zero→Skip to Item 12)

10b. Select the unit of time for how many times per day/week/month medication was taken: ☐ D, W, M
   - Per day .... D
   - Per week .... W
   - Per month .... M

11. In total, how long did you take these medications in the **past year**? You can answer in days, weeks, or months.

11a. Enter number: .... ☐☐ 1-52

11b. Select the unit of time for how long medication was taken: .... ☐ D, W, M
   - Day(s) .... D
   - Week(s) .... W
   - Month(s) .... M

12. Have you used **adult-strength** aspirin or aspirin-containing products (325 mg/tablet or more) during the **past year**? .... ☐ Y, N
   - Yes .... Y
   - No .... N →Skip to Item 15

13. How often in the **past year** did you take these medications? You can answer in times per day, per week, or per month. *[NOTE: If the participant says that he/she took these medications less frequently than once per month, code this as zero times.]*

13a. Enter number: .... ☐☐ 0-99 (If zero→Skip to Item 15)

13b. Select the unit of time for how many times per day/week/month medication was taken: ☐ D, W, M
   - Per day .... D
   - Per week .... W
   - Per month .... M

14. In total, how long did you take these medications in the **past year**? You can answer in days, weeks, or months.

14a. Enter number: .... [ ][ ] 1-52

14b. Select the unit of time for how long medication was taken: .... [ ] D, W, M

Day(s) .... D
Week(s) .... W
Month(s) .... M

15. Have you used **over-the-counter** acetaminophen such as Tylenol during the **past year**? .... [ ] Y, N

Yes .... Y
No .... N →Skip to Item 18

16. How often in the **past year** did you take these medications? You can answer in times per day, per week, or per month. *[NOTE: If the participant says that he/she took these medications less frequently than once per month, code this as zero times.]*

16a. Enter number: .... [ ][ ] 0-99 (If zero→Skip to Item 18)

16b. Select the unit of time for how many times per day/week/month medication was taken: [ ] D, W, M

Per day .... D
Per week .... W
Per month .... M

17. In total, how long did you take these medications in the **past year**? You can answer in days, weeks, or months.

17a. Enter number: .... [ ][ ] 1-52

17b. Select the unit of time for how long medication was taken: .... [ ] D, W, M

Day(s) .... D
Week(s) .... W
Month(s) .... M

18. Have you used other **over-the-counter** pain medications, such as ibuprofen (like Advil or Motrin) or naproxen (like Aleve), during the **past year**? .... [ ] Y, N

Yes .... Y
No .... N →Skip to Item 21

19. How often in the **past year** did you take these medications? You can answer in times per day, per week, or per month. *[NOTE: If the participant says that he/she took these medications less frequently than once per month, code this as zero times.]*

19a. Enter number: .... ☐☐ 0-99 (If zero→Skip to Item 21)

19b. Select the unit of time for how many times per day/week/month medication was taken: ☐ D, W, M

Per day .... D
Per week .... W
Per month .... M

20. In total, how long did you take these medications in the **past year**? You can answer in days, weeks, or months.

20a. Enter number: .... ☐☐ 1-52

20b. Select the unit of time for how long medication was taken: .... ☐ D, W, M

Day(s) .... D
Week(s) .... W
Month(s) .... M

21. Have you taken any **vitamins, minerals or other nutrient supplements** during the **past year**? .... ☐ Y, N

Yes .... Y
No .... N →Skip to Item 24

22. How often in the **past year** did you take these supplements? You can answer in times per day, per week, or per month. *[NOTE: If the participant says that he/she took these medications less frequently than once per month, code this as zero times.]*

22a. Enter number: .... ☐☐ 0-99 (If zero→Skip to Item 24)

22b. Select the unit of time for how many times per day/week/month supplements were taken: ☐ D, W, M

Per day .... D
Per week .... W
Per month .... M

23. In total, how long did you take these supplements in the **past year**? You can answer in days, weeks, or months.

23a. Enter number: .... ☐☐ 1-52

23b. Select the unit of time for how long supplements were taken: .... ☐ D, W, M

Day(s) .... D
Week(s) .... W
Month(s) .... M

24. Have you taken any **other dietary supplements** during the **past year**? (By dietary supplements, we mean herbals, and other supplements such as probiotic, melatonin, glucosamine, antioxidants, etc).. ☐ Y, N

Yes...Y
No...N →Skip to Item 27

25. How often in the **past year** did you take these supplements? You can answer in times per day, per week, or per month. *[NOTE: If the participant says that he/she took these medications less frequently than once per month, code this as zero times.]*

25a. Enter number:... ☐☐ 0-99 (If zero→Skip to Item 27)

25b. Select the unit of time for how many times per day/week/month supplements were taken: ☐ D, W, M

Per day...D
Per week...W
Per month...M

26. In total, how long did you take these supplements in the **past year**? You can answer in days, weeks, or months.

26a. Enter number:... ☐☐ 1-52

26b. Select the unit of time for how long supplements were taken:.......... ☐ D, W, M

Day(s)... ……..D
Week(s).. ……..W
Month(s) M

27. Beyond dietary supplements, have you used any other **Complementary and Alternative Medicine** therapies during the **past year**? (By complementary and alternative medicine therapies, we mean acupunture, chiropractic, massage, therapeutic touch/reiki, spiritual healing, special diets - anti–inflammatory, macrobiotic etc) .... ☐ Y, N

Yes...Y
No...N

28.Have you discussed Complementary and Alternative Medicine (CAM) use with any of your healthcare providers (primary care provider, surgeon, radiologist, medical oncologist)?.... ☐ Y, N

Yes,……………………………………………………………………………Y
No……………………………………………………………………………..N → Skip to Item 30

29. Which of the following providers did you discuss use of Complementary and Alternative Medicine?

29a. A primary care provider (doctor, internist, nurse)……………………………… ☐ Y, N

Yes...Y
No...N

29b. A cancer care provider (surgeon, radiologist, medical oncologist)…………… ☐ Y, N

Yes..Y
No...N

30. Have you received advice about CAM from any of these additional sources (including any advice on brands, dosage, side effects, interactions with other medications, etc.)?

30a. CAM provider (Naturopath, Chiropractor, Herbalist, etc..)…………………… ☐ Y, N

Yes..Y
No...N

30b. A pharmacist………………………………………………………………….... ☐ Y, N

Yes..Y
No...N

30c. A nutritionist…………………………………………………………………… ☐ Y, N

Yes..Y
No...N

30d. Staff at health food store……………………………………………………...... ☐ Y, N

Yes..Y
No...N

30e. Internet……………………………………………………………………….... ☐ Y, N

Yes..Y
No...N

30f. Media such as television, magazines, newspapers, or books………………… ☐ Y, N

Yes..Y
No...N

30g. Friends or family……………………………………………………………..... ☐ Y, N

Yes..Y
No...N

30h. Other patients or support group……………………………………………….. ☐ Y, N

Yes..Y
No...N

Cancer Screening

REGISTRY ID:													FORM CODE: CSFA VERSION:A 10/10/11	Event			SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐   0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

Now I would like to ask you about some screening tests you may have received.

A. Females and Males

1. Have you ever had a test for blood in your stool, called a smear test or a hemoccult? (This test is frequently done as part of a routine physical exam or it can be done at home.)............ ☐ Y, N, D, R
   - Yes .... Y
   - No .... N →Skip to Item 4
   - Don't Know .... D →Skip to Item 4
   - Refused .... R →Skip to Item 4

2. How long has it been since you had your last blood stool test?............ ☐ A-E
   - Within the past year (anytime less than 12 months ago) .... A
   - Within the past 2 years (1 year but less than 2 years ago) .... B
   - Within the past 3 years (2 years but less than 3 years ago) C
   - Within the past 5 years (3 years but less than 5 years ago) .... D
   - 5 or more years ago .... E

3. Was the blood stool test done because you had medical problems or symptoms or was it done as part of a regular checkup?............ ☐ A-B
   - Because of symptoms or medical problems .... A
   - Regular checkup .... B

4. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams? .... [ ] Y, N, D, R
   - Yes .... Y
   - No .... N → Skip to Item 7 (F) or 16 (M)
   - Don't Know .... D → Skip to Item 7 (F) or 16 (M)
   - Refused .... R → Skip to Item 7 (F) or 16 (M)

5. How long has it been since you had your last sigmoidoscopy or colonoscopy? .... [ ] A-E
   - Within the past year (anytime less than 12 months ago) .... A
   - Within the past 2 years (1 year but less than 2 years ago) .... B
   - Within the past 3 years (2 years but less than 3 years ago) C
   - Within the past 5 years (3 years but less than 5 years ago) .... D
   - 5 or more years ago .... E

6. Was the sigmoidoscopy/colonoscopy done because you had medical problems or symptoms or was it done as part of a regular checkup? .... [ ] A-B
   - Because of symptoms or medical problems .... A
   - Regular checkup .... B

B. Females Only (Males skip to Item 16)

7. A clinical breast exam is when a doctor, nurse, or other health professional feels the breasts for lumps. Have you ever had a clinical breast exam? .... ☐ Y, N, D, R
   - Yes .... Y
   - No .... N →Skip to Item 10
   - Don't Know .... D →Skip to Item 10
   - Refused .... R →Skip to Item 10

8. How long has it been since your last clinical breast exam? .... ☐ A-E
   - Within the past year (anytime less than 12 months ago) .... A
   - Within the past 2 years (1 year but less than 2 years ago) .... B
   - Within the past 3 years (2 years but less than 3 years ago) C
   - Within the past 5 years (3 years but less than 5 years ago) .... D
   - 5 or more years ago .... E

9. Was the clinical breast exam done because you had medical problems or symptoms or was it done as part of a regular checkup? .... ☐ A-B
   - Because of symptoms or medical problems .... A
   - Regular checkup .... B

10. A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram? .... ☐ Y, N, D, R
    - Yes .... Y
    - No .... N →Skip to Item 13
    - Don't Know .... D →Skip to Item 13
    - Refused .... R →Skip to Item 13

11. How long has it been since you had your last mammogram? .... ☐ A-E
    - Within the past year (anytime less than 12 months ago) .... A
    - Within the past 2 years (1 year but less than 2 years ago) .... B
    - Within the past 3 years (2 years but less than 3 years ago) C
    - Within the past 5 years (3 years but less than 5 years ago) .... D
    - 5 or more years ago .... E

12. Was the mammogram done because you had medical problems or symptoms or was it done as part of a regular checkup? .... ☐ A-B
    - Because of symptoms or medical problems .... A
    - Regular checkup .... B

13. A Pap test is a test for cancer of the cervix. Have you ever had a Pap test? .... [ ] Y, N, D, R

- Yes .... Y
- No .... N →Skip to Next Form
- Don't Know .... D →Skip to Item Next Form
- Refused .... R →Skip to Item Next Form

14. How long has it been since you had your last Pap test? .... [ ] A-E

- Within the past year (anytime less than 12 months ago) .... A
- Within the past 2 years (1 year but less than 2 years ago) .... B
- Within the past 3 years (2 years but less than 3 years ago) C
- Within the past 5 years (3 years but less than 5 years ago) .... D
- 5 or more years ago .... E

15. Was the Pap test done because you had medical problems or symptoms or was it done as part of a regular checkup? .... [ ] A-B

- Because of symptoms or medical problems .... A
- Regular checkup .... B

End of form for females.

C. Males Only (Females skip to Next Form)

16. A Prostate-Specific Antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you ever had a PSA test?................................ ☐ Y, N, D, R

    Yes .... Y
    No .... N →Skip to Item 19
    Don't Know .... D →Skip to Item 19
    Refused .... R →Skip to Item 19

17. How long has it been since you had your last PSA test?.. ☐ A-E

    Within the past year (anytime less than 12 months ago) .... A
    Within the past 2 years (1 year but less than 2 years ago) .... B
    Within the past 3 years (2 years but less than 3 years ago) C
    Within the past 5 years (3 years but less than 5 years ago) .... D
    5 or more years ago .... E

18. Was the PSA done because you had medical problems or symptoms or was it done as part of a regular checkup?.. ☐ A-B

    Because of symptoms or medical problems .... A
    Regular checkup .... B

19. A digital rectal exam is an exam in which a doctor, nurse, or other health professional places a gloved finger into the rectum to feel the size, shape, and hardness of the prostate gland. Have you ever had a digital rectal exam? .... ☐ Y, N, D, R

    Yes .... Y
    No .... N →Skip to Next Form
    Don't Know .... D →Skip to Item Next Form
    Refused .... R →Skip to Item Next Form

20. How long has it been since your last digital rectal exam? .... ☐ A-E

    Within the past year (anytime less than 12 months ago) .... A
    Within the past 2 years (1 year but less than 2 years ago) .... B
    Within the past 3 years (2 years but less than 3 years ago) C
    Within the past 5 years (3 years but less than 5 years ago) .... D
    5 or more years ago .... E

21. Was the rectal exam done because you had medical problems or symptoms or was it done as part of a regular checkup?... ☐ A-B

    Because of symptoms or medical problems .... A
    Regular checkup .... B

Access to Health Care Questionnaire

REGISTRY ID:													FORM CODE: ATHA VERSION:A 07/12/11	Event			SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

Next I am going to ask you about your access to healthcare.

1. What kind of place do you **usually** go to when you are sick or need advice about your health - a free clinic, doctor's office, emergency room, or some other place?.................. ☐ A-D
   - Free Clinic...A
   - Doctor's Office ....B
   - Emergency Room C
   - Other..D
   - Other Specify: ________________________

2. What kind of place do you **usually** go to when you need routine or preventive care, such as a physical examination or check-up - a free clinic, doctor's office, emergency room, or some other place? .... ☐ A-D
   - Free Clinic...A
   - Doctor's Office ....B
   - Emergency Room C
   - Other..D
   - Other Specify: ________________________

3. At any time in the **past year** did you CHANGE the place to which you USUALLY go for health care? .... ☐ Y Yes ☐ N No →Skip to Item 5

4. Was this change for a reason related to health insurance? .... ☐ Y Yes ☐ N No

5. Have you delayed getting care for any of the following reasons in the **past year**?

a. You couldn't get through on the telephone. ☐ Y Yes ☐ N No

b. You couldn't get an appointment soon enough. ☐ Y Yes ☐ N No

c. Once you got there, you had to wait too long to see the doctor. ☐ Y Yes ☐ N No

d. The clinic or doctor's office wasn't open when you could get there. ☐ Y Yes ☐ N No

e. You didn't have transportation. ☐ Y Yes ☐ N No

f. You or a family member could not afford to take time off of work. ☐ Y Yes ☐ N No

g. You did not have childcare. ☐ Y Yes ☐ N No

h. Another family member was ill. (spouse, child, parent) ☐ Y Yes ☐ N No

i. You couldn't communicate with the office or doctor because of speech, hearing or language problems. ☐ Y Yes ☐ N No

j. You could not afford the gas or other travel expenses. ☐ Y Yes ☐ N No

k. You did not know where to get the help you needed. ☐ Y Yes ☐ N No

l. The doctor or clinic did not take your insurance. ☐ Y Yes ☐ N No

m. You did not have health insurance. ☐ Y Yes ☐ N No

n. You did not have the money you needed to pay expenses. ☐ Y Yes ☐ N No

o. You found it difficult to park and/or find your way to the clinic or office. ☐ Y Yes ☐ N No

*During the **past year**, was there any time when you needed any of the following, but didn't get it because you couldn't afford it?*

6a. Prescription medicines. .... ☐ Y Yes ☐ N No

6b. Mental health care or counseling.. ☐ Y Yes ☐ N No

6c. Dental care, including check-ups.. ☐ Y Yes ☐ N No

6d. Doctor's visit. .... ☐ Y Yes ☐ N No

6e. X-ray or other test. .... ☐ Y Yes ☐ N No

6f. Bandage, brace, or other medical supply. .... ☐ Y Yes ☐ N No

6g. Over-the-counter medicine.. ☐ Y Yes ☐ N No

7. How did you usually get to UNC Hospitals or Clinics?.. ☐ A-E

   Public transportation ....A
   Drove yourself..B
   Family member or friend drove you..C
   Taxi..D
   Other..E
   Other Specify: ________________________

8. About how many miles away was UNC Hospitals or Clinics?.. ☐☐☐ 1-999

9. How long did it take you to get to UNC Hospitals or Clinics?

   Enter the time: .... ☐☐ 0-60

   Enter unit: .... ☐ M, H

   Minutes ....M
   Hours ....H

Alcohol

REGISTRY ID:	FORM CODE: AIFA VERSION:A 07/10/11	Event	SEQ #

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

Next I have some questions about your ***lifetime*** *alcohol consumption.*

1. Have you consumed 50 beers or two cases in your lifetime? This includes draft, malt liquor, ale, and home-brew. .... ☐ Y, N, D, R
   - Yes .... Y
   - No .... N →Skip to Item 6
   - Don't Know .... D →Skip to Item 6
   - Refused .... R →Skip to Item 6

2. Do you currently drink beer? .... ☐ Y, N, D, R
   - Yes .... Y →Skip to Item 4
   - No .... N
   - Don't Know .... D →Skip to Item 6
   - Refused .... R →Skip to Item 6

3. How long has it been since you quit drinking beer? You can respond in days, weeks, months, or years.

3a. Enter number: .... ☐☐☐ 1-365

3b. Enter time period since participant quit drinking beer: .... ☐ A-D
   - Day(s) .... A
   - Week(s) .... B
   - Month(s) C
   - Year(s) .... D

4. How much beer {do/did} you usually drink? You can answer in beers per day, per week, per month, or per year. One beer is equivalent to 12 ounces.

4a. Enter number of beers: .... [ ][ ][ ] 1-999

4b. Select the unit of time for the number of beers:.............................. [ ] A-D

Per Day .... A
Per Week .... B
Per Month C
Per Year.. D

5. How old were you when you FIRST started to drink beer fairly regularly? By regularly, we mean at least 1 beer per month. *Enter age in years. (Answer N/A if respondent never drank beer regularly.)* .... [ ][ ] 1-99

6. Have you consumed wine 20 times in your lifetime? This includes store bought wine, sherry, port, wine from a bar or restaurant, and homemade. .... [ ] Y, N, D, R

Yes .... Y
No .... N →Skip to Item 11
Don't Know .... D →Skip to Item 11
Refused .... R →Skip to Item 11

7. Do you currently drink wine? .... [ ] Y, N, D, R

Yes .... Y →Skip to Item 9
No .... N
Don't Know .... D →Skip to Item 11
Refused .... R →Skip to Item 11

8. How long has it been since you quit drinking wine? You can respond in days, weeks, months, or years.

8a. Enter number: .... [ ][ ][ ] 1-365

8b. Enter time period since participant quit drinking wine:.................... [ ] A-D

Day(s) .... A
Week(s) .... B
Month(s) C
Year(s) .... D

9. How much wine {do/did} you usually drink? You can answer in glasses of wine per day, per week, per month, or per year. One glass of wine is equivalent to 5 ounces.

9a. Enter number of drinks of wine:.. ☐☐☐ 1-999

9b. Select the unit of time for the number of drinks: .... ☐ A-D

Per Day .... A
Per Week .... B
Per Month C
Per Year.. D

10. How old were you when you FIRST started to drink wine fairly regularly? By regularly, we mean at least 1 glass of wine per month. *Enter age in years. (Answer N/A if respondent never drank wine regularly.)*.. ☐☐ 1-99

11. Have you consumed hard liquor 20 times in your lifetime? This includes straight and mixed drinks and moonshine. .... ☐ Y, N, D, R

Yes .... Y
No .... N →Skip to Next Form
Don't Know .... D →Skip to Next Form
Refused .... R →Skip to Next Form

12. Do you currently drink liquor? .... ☐ Y, N, D, R

Yes .... Y →Skip to Item 14
No .... N
Don't Know .... D →Skip to Next Form
Refused .... R →Skip to Next Form

13. How long has it been since you quit drinking liquor? You can respond in days, weeks, months, or years.

13a. Enter number:.. ☐☐☐ 1-365

13b. Enter time period since participant quit drinking liquor:................... ☐ A-D

Day(s)... A
Week(s) .... B
Month(s).. C
Year(s).. D

14. How much hard liquor {do/did} you usually drink? You can answer in drinks per day, per week, per month, or per year. One drink is equivalent to a drink with one shot of liquor.

14a. Enter number of drinks of hard liquor: .... ☐☐☐ 1-999

14b. Select the unit of time for the number of drinks of hard liquor:........ ☐ A-D

Per Day .... A
Per Week .... B
Per Month C
Per Year.. D

15. How old were you when you FIRST started to drink hard liquor fairly regularly? By regularly, we mean at least 1 drink per month. *Enter age in years. (Answer N/A if respondent never drank hard liquor regularly.)*.. ☐☐ 1-99

Tobacco

REGISTRY ID:		FORM CODE: TIFA VERSION:A 07/12/11	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

Next I have some questions about your ***lifetime*** *use of tobacco products.*

1. Have you smoked at least 100 cigarettes in your entire life? (*NOTE: 5 packs=100 cigarettes).* .... ☐ Y, N, D, R
   - Yes .... Y
   - No .... N →Skip to Next Form
   - Don't Know .... D →Skip to Next Form
   - Refused .... R →Skip to Next Form

2. Do you now smoke cigarettes every day, some days, or not at all? .... ☐ A-C
   - Every day.......... A →Skip to Item 4
   - Some days.......... B →Skip to Item 4
   - Not at all.......... C

3. How long has it been since you quit smoking cigarettes? You can respond in days, weeks, months, or years.

3a. Enter number: .... ☐☐☐ 1-365

3b. Enter time period since participant quit smoking: .... ☐ A-D
   - Day(s).......... A
   - Week(s) .... B
   - Month(s).......... C
   - Year(s) .... D

4. On average how many cigarettes do{/did} you smoke a day: .... ☐☐☐ 1-999

5. How soon after you wake{/woke} up do{/did} you smoke? .... ☐ A-D

   Within 5 minutes .... A
   From 6 to 30 minutes .... B
   From more than 30 minutes to 1 hour C
   More than 1 hour.. D

6. How old were you when you FIRST started to smoke fairly regularly?
   Enter age in years. (Answer N/A if respondent never smoked regularly.).. ☐☐ 1-99

Work Ability Index

REGISTRY ID: | FORM CODE: WAIA VERSION:A 06/21/11 | Event | SEQ #

ADMINISTRATIVE INFORMATION

0a. Completion Date: __ __ / __ __ / __ __ __ __ 0b. Staff ID: __ __ __

Instructions: Enter the answer given by the participant for each response.

The next few questions are about your ***current*** *employment.*

1. Assume that your ability to work at its best has a value of 10 points and 0 means that you cannot currently work at all. How many points would you give your current ability to work? .... __ __ 0-10

2. How do you rate your current ability to work with respect to the **physical** demands of your work? .... __ A-E
   - Very good .... A
   - Rather good .... B
   - Moderate C
   - Rather poor .... D
   - Very poor .... E

3. How do you rate your current ability to work with respect to the **mental** demands of your work? .... __ A-E
   - Very good .... A
   - Rather good .... B
   - Moderate C
   - Rather poor .... D
   - Very poor .... E

4. How many whole days have you been off work because of a health problem, including being sick or doctor's appointments, during the past year (12 months)?

   Enter number: .... __ __ __ 1-365

Enter time period altogether participant took off work:.................... [ ] A-C

Day(s).. A

Week(s) .... B

Month(s).. C

Patient-Provider Communication

REGISTRY ID:		FORM CODE: PSQA VERSION:A 07/22/11	Event		SEQ #	

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

These next questions are about how you feel about the medical care you receive. These are some things that people say about medical care. Please consider each one carefully keeping in mind the medical care you are receiving ***now****. We are interested in your feelings, good and bad, about the medical care you have received. Please tell us how strongly you agree or disagree with each of the following statements, using the responses strongly agree, agree, uncertain, disagree, or strongly disagree.*

1. Doctors are good about explaining the reason for medical tests. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
2. Your doctor's office has everything needed to provide complete medical care. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
3. The medical care you have been receiving is just about perfect. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
4. Sometimes doctors make you wonder if their diagnosis is correct.. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
5. You feel confident that you can get the medical care you need without being set back financially. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree
6. When you go for medical care, they are careful to check everything when treating and examining you. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

7. You have to pay for more medical care than you can afford. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

8. You have easy access to the medical specialists you need. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

9. Where you get medical care, people have to wait too long for emergency treatment.. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

10. Doctors act too businesslike and impersonal toward you. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

11. Your doctors treat you in a very friendly and courteous manner. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

12. Those who provide your medical care sometimes hurry too much when they treat you. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

13. Doctors sometimes ignore what you tell them. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

14. You have some doubts about the ability of the doctors who treat you. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

15. Doctors usually spend plenty of time with you. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

16. You find it hard to get an appointment for medical care right away. ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

17. You are dissatisfied with some things about the medical care you receive................ ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree

18. You are able to get medical care whenever you need it..................................... ☐ Strongly Agree ☐ Agree ☐ Uncertain ☐ Disagree ☐ Strongly Disagree