The purpose of this questionnaire is to gather demographic and health-related information which will be used to study cancer risk. All personal and identifying information collected will be restricted to only the Stanford Cancer Genetics Clinic staff. ONLY general demographic, environmental and health information will be used for research purposes. If, in the future, any of the details you share with us is found to be associated with a significantly increased risk of developing cancer, your personal information will be used to locate and notify you of these findings.

INSTRUCTIONS
This questionnaire takes approximately 15 minutes to complete. Take the time to be accurate and fill in as much information as you can. Please feel free to not answer questions that you may find objectionable for personal, cultural or religious reasons. If you choose not to answer a specific question, however, please circle the number so it can be identified as an intentionally missed question. Please do not write in the shaded boxes.
Last Name  First Name  MI  Soc Sec No

Home Address  Maiden Name (if applicable)

Home Phone  Work Phone  Fax No.

Email address

Referral Source:  
- Self inquiry
- Family Member
- Primary care physician
- Specialist
- Genetic education/counseling program
- Brochure
- TV/Radio
- Cancer support group
- Other______________

Date of Birth

Sex:  M   F

Marital Status
- Never Married
- Married
- Partnered
- Divorced
- Other

1. Have you ever lived in another region or city for longer than 3 years?   Yes   No

If so, please complete the following:

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<tr>
<th>City</th>
<th>State</th>
<th>Country</th>
<th>No. of years in residence</th>
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2. What is the highest level of education you have completed?

- Elementary School
- Middle School
- High School
- Some College
- College Degree
- Graduate Degree
- Professional Training
3. What is your current employment status?
- [ ] Full Time
- [ ] Part Time
- [ ] Unemployed
- [ ] Disabled
- [ ] Retired
- [ ] Stay at home parent
- [ ] Other

4. What is your total family income?
- [ ] Less than $19,999
- [ ] $20,000 - $39,999
- [ ] $40,000 - $59,999
- [ ] $60,000 - $79,999
- [ ] $80,000 - $99,999
- [ ] $100,000 or greater

5. Please list your current occupation(s) detailing the length of time and average hours worked per week.

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<tr>
<th>Occupation</th>
<th>From</th>
<th>To</th>
<th>No. of hours/wk</th>
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6. Please list any past occupation(s) you have had along with the length of time and average number of hours worked per week.

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<th>Occupation</th>
<th>From</th>
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<th>No. of hours/wk</th>
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7. Please list the occupation(s) of anyone you have lived with for greater than 5 years along with the length of time they worked in that occupation while you cohabitated (include: your mother, father, spouse/partner, working children, boarders, etc.)

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<thead>
<tr>
<th>Occupation</th>
<th>Length of time (in years)</th>
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General Health Questions

8. How many hours of strenuous aerobic exercise (running, jogging, swimming, cycling, etc.) do you do on average each week (please circle one)?
   .5  1  2  3  4  5  6  7  >7

9. How many hours of strenuous anaerobic exercise (weight training, etc.) do you do on average each week (please circle one)?
   .5  1  2  3  4  5  6  7  >7

10. How many hours of other physical activity (occupation, hobbies, housework, etc.) do you do on average each week (please circle one)?
    .5  1  2  3  4  5  6  7  >7

11. How many servings of fish do you eat on average per week?
    1  2  3  4  5  6  7  >7

12. How many servings of red meat do you eat on average per week?
    1  2  3  4  5  6  7  >7

13. How many servings of poultry do you eat on average each week (please circle one)?
    1  2  3  4  5  6  7  >7

14. How many servings of fruits do you eat on average each week (please circle one)?
    1  2  3  4  5  6  7  >7

15. How many servings of vegetables do you eat on average each week (please circle one)?
    1  2  3  4  5  6  7  >7

16. How many servings of high fiber food products do you eat on average each week (bran, etc.)?
    1  2  3  4  5  6  7  >7

17. How many servings of smoked, dried, cured or salted meats do you eat on average per week (bacon, smoked salmon, salted cod, beef jerky, etc.)
    0  1  2  3  4  5  6  7  >7

18. How would you generally characterize your diet (please check one)?
   ☐ High fat (lots of fatty meats, nuts, oils, butter/margarine, etc.)
   ☐ Medium fat (try to eat low fat, but indulge weekly on some fatty foods like bacon, potato chips, etc.)
   ☐ Low fat (only eat lean meats, no or limited oil, butter, nuts, etc.)

19. What is your current weight in pounds?        lbs

20. What is your current height?        ft        in
General Stress Level Questions

Please answer the following questions by circling the number on the associated 0 to 4 scale that most closely describes your response to the question where 0 represents not at all and 4 represents all the time. As an example, for the question “Do you worry a lot?” selecting 0 would mean you never worry while selecting 4 would mean you constantly worry.

21. Do you ever feel tensed up? 0 1 2 3 4
22. Do you worry a lot? 0 1 2 3 4
23. Do you have panic attacks? 0 1 2 3 4
24. Do you feel something awful is about to happen? 0 1 2 3 4
25. Do you take as much interest in things as you used to? 0 1 2 3 4
26. Do you laugh as readily as you used to? 0 1 2 3 4
27. Do you feel cheerful? 0 1 2 3 4
28. Do you feel generally optimistic about the future? 0 1 2 3 4

Previous Environmental Exposures

29. Please indicate with a check mark if you have ever had repeated contact (ie contact everyday for at least 3 months) with any of the following materials in your work, home, hobbies or other activities.

- Animals (other than pets)
- Arsenic (rat poison, weed killers, etc.)
- Asbestos (fireproofing, insulation, brake linings, etc.)
- Benzene, Xylene or other solvents
- Beryllium (copper alloy for springs, electrical contacts)
- Cadmium
- Chemical fertilizers
- Coal
- Dry cleaning chemicals (perchloroethylene)
- Commercial Dyes
- Film developing fluids
- Glue
- Grain dust
- Hair sprays
- Hair dyes
- Insulation materials
- Iron ore
- Lead
- Metal (dust or fumes)
- Mustard gas
- Nitrates or nitrites
- Paint finish remover (methylene chloride)
- Paint products
- Pesticides, insecticides or herbicides
- Petroleum products (excluding auto gas)
- Polychlorinated biphenyls (PCB’s)
- Talc dust
- Trichloroethylene
- Uranium
- Zinc
30. Do you have a history of massive radiation exposure (This refers to exposure from radioactive contamination and leaks, constant occupational exposures, etc., not routine X-rays, CT’s, nuclear medicine imaging, etc.)? Yes No

If so, please complete the following:

<table>
<thead>
<tr>
<th>Radiation type</th>
<th>Date of exposure</th>
<th>Dosage (amount of exposure) In mSv</th>
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Examples of radiation types:
- EMR (electromagnetic), Ultraviolet (sun), Alpha, Beta, Gamma (radiation therapies, nuclear medicine), X-rays (mammography, radiography).

Examples of exposure dosages:
- Chest X-ray = 0.05 mSv
- Chest CT = 7 mSv
- Background levels (from all natural sources) = 2 mSv

31. Do you, or have you ever lived within ½ mile (800 meters) of electrical transmission lines or transformers? Yes No

If so, for how many years? And, how far away (in feet)?

32. Please list any other environmental exposures that you believe to be significant to your health conditions.
Medical History

32. Blood Type (please circle if known)
   Type: A   B   AB   O
   Rh:   +   -

33. Have you ever been diagnosed by a physician with any of the following conditions:
   ❑ ADH
   ❑ Autoimmune syndrome
   ❑ Coronary artery disease
   ❑ Chronic bronchitis
   ❑ Colon polyps
   ❑ Crohn’s disease
   ❑ Blood clots
   ❑ DCIS (ductile carcinoma \textit{in situ})
   ❑ LCIS (lobular carcinoma \textit{in situ})
   ❑ Diabetes
   ❑ Diverticulitis
   ❑ Emphysema
   ❑ Endometriosis
   ❑ Esophagitis
   ❑ Esophageal stricture
   ❑ Fibrocystic breast
   ❑ Gallstones
   ❑ Gastric reflux
   ❑ Gastritis
   ❑ Hepatitis
   ❑ HIV/AIDS
   ❑ Hypertension
   ❑ Thyroid disease
   ❑ H. Pylori
   ❑ IBD (irritable bowel disease)
   ❑ Kidney disease
   ❑ Pancreatitis
   ❑ Peptic ulcers
   ❑ Osteoarthritis
   ❑ Rectal bleeding
   ❑ Repetitive strain injuries
   ❑ Rheumatoid arthritis
   ❑ Stroke or TIA (transient ischemic attack)
   ❑ Ulcerative colitis
   ❑ Other conditions. If so, please describe:

   

34. Was your mother taking DES (an anti-miscarriage medication) at the time of your birth?  Yes   No

35. Was your mother using tobacco products at the time of your birth?  Yes   No

   If so, please complete the following:

   Type of product:
   ❑ Cigarettes
   ❑ Pipe
   ❑ Cigars
   ❑ Chewing tobacco
   ❑ Snuff

   No. of years smoke prior to your birth:

   How would you describe her use?
   ❑ Heavy user
   ❑ Moderate user
   ❑ Light user
36. Was your mother using alcohol while pregnant with you?  Yes  No

If so, at approximately what frequency?
- Heavy use
- Moderate use
- Light use

37. Was your mother using recreational (e.g. marijuana, cocaine, etc.) drugs while pregnant with you?  Yes  No
If so, please complete the following:

Type of drug(s):

How would you describe her use?
- Heavy user
- Moderate user
- Light user

38. What was your birth weight?  lbs  oz

39. Do you, or have you ever, used tobacco products?  Yes  No
If so, please complete the following:

Type of product:
- Cigarettes
- Pipe
- Cigars
- Chewing tobacco
- Snuff

If you have stopped, when?  mm/dd/yyyy
How many packs per day?

40. If you are a non-smoker, have you ever lived in the same house with a smoker?  Yes  No
If so, please complete the following:

How many years did you cohabitate?

How would you characterize their use?
- Heavy user
- Moderate user
- Light user

41. Do you use, or have you used, alcohol?  Yes  No
If so, please complete the following:

What type of alcohol do you drink?
- Beer
- Wine
- Liquor

If you have stopped, please give the date and reason.

Approximately how many drinks per week?
(1 drink = 1 beer, 1 glass of wine or 1 oz of liquor)
42. Do you use, or have you used recreational (e.g. marijuana, cocaine, etc.) drugs?  
Yes  No  
If so, please complete the following: 

Type of drug(s): 

How would you describe your use?  
☐ Heavy user  
☐ Moderate user  
☐ Light user  

Date started: mmddyyyy  If you have stopped, date: mmddyyyy  

43. Have you had any previous blistering sunburns?  
Yes  No  
If so, please complete the following:  

At approximately what age was the first one?  

Approximately how many have you had in total?  

44. Have you ever taken Tamoxifen or other antiestrogen drug?  
Yes  No  
If so, please complete the following:  

<table>
<thead>
<tr>
<th>Drug name/type</th>
<th>Date started</th>
<th>Date ended</th>
<th>Reason for starting</th>
<th>Reason for stopping</th>
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45. Have you ever taken infertility drugs?  
Yes  No  
If so, please complete the following:  

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Date started</th>
<th>Date ended</th>
<th>Months taken</th>
<th>No. of cycles</th>
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46. Have you ever taken DES (an anti-miscarriage medication) during any of your pregnancies?  
Yes  No  
If so, please complete the following:  

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Date started</th>
<th>Date ended</th>
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</table>
47. Please list any medications that you have previously taken for greater than 1 year. Please include the length of time used as well as dosage (in mg/day) if possible.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Length of time used (months)</th>
<th>Dosage (mg/day)</th>
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END OF QUESTIONNAIRE – THANK YOU