Version Date: 10/99 **Expiration Date: 10/02** **Form Approved OMB No.: 0925-0407**

Participant ID Number

Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

BASELINE QUESTIONNAIRE FOR FEMALE PARTICIPANTS (BQF3)

PLEASE COMPLETE:

Participant Name: _____
First Middle Last

Participant Date of Birth: _____
Month Day Year

Participant Telephone Number: (_____)_____

INSTRUCTIONS

- **Do not fold, staple or tear the pages of this form.**
- **Use a #2 PENCIL to mark your answers.**
- **Make heavy black marks that fill the circle completely.**
- **If you need to change an answer, be sure to erase completely.**
- **Mark only one response for each question, unless the instructions tell you otherwise.**
- **Some questions ask you to write your answer in the space provided.**
- **Some questions also have additional instructions next to certain answers. These instructions may either ask you to skip questions that do not apply to you or ask you to provide additional information. First darken the appropriate circle, then follow the instructions as directed. Unless instructed otherwise, go to the next question.**

CORRECT MARK ● **INCORRECT MARKS** ✓ ⊙ ◉ ⊗

STATEMENT OF CONFIDENTIALITY

Collection of this information is authorized by The Public Health Service Act, Section 412 (42 USC 285 a-1). Rights of study participants are protected by the Privacy Act of 1974. Participation is voluntary and there are no penalties for not participating or withdrawing from the study at any time. Participation will not influence a person's relationship with any provider of medical care or any federal program such as Social Security or Medicare. The information collected in this study will be kept confidential and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Names and other identifiers will be separated from information provided and will not appear in any report of the study. Information provided will be combined for all study participants and reported as statistical summaries. Study records will be kept for approximately 2 years past the end of the study, and then destroyed.

The following questions ask about your general background, work history, and smoking history.

1. In what state or foreign country were you born?

State/Foreign Country: _____

2. Which of these groups best describes you? (Choose One)

○ White ○ Pacific Islander

○ Black ○ American Indian or Alaska Native

○ Asian

2a. Are you of Hispanic origin? (Choose One)

○ No

○ Yes

3. What is the highest grade or level of schooling you completed? (MARK ONLY ONE RESPONSE)

○ Less than 8 years

○ 8 through 11 years

○ 12 years or completed high school

○ Post high school training other than college (for example, vocational or technical training)

○ Some college

○ College graduate

○ Postgraduate

4. What is your current marital status? (Choose One)

○ Married or living as married ○ Separated

○ Widowed ○ Never married

○ Divorced

5. Which of these categories best describes your current working situation? (Choose One)

○ Homemaker ○ Extended sick leave

○ Working ○ Disabled

○ Unemployed ○ Other (SPECIFY)

○ Retired

6. What has been your usual adult occupation? That is, at what type of occupation have you worked the longest during your adult life?

Usual adult occupation: _____

IF HOMEMAKER, GO TO QUESTION 10.

7. What were your usual activities and duties in this occupation?

Usual activities or duties: _____

8. In what type of business or industry were you usually employed in this occupation?

Business or industry: _____

9. How many years have you worked in this occupation?

_____ Number of years worked in occupation

10. Have you ever smoked cigarettes regularly for six months or longer? (Choose One)

○ No (GO TO OUESTION 16)

○ Yes

11. At what age did you start smoking cigarettes regularly? (Enter age first started smoking)

Age In Years: _____

12. Do you smoke cigarettes regularly now? (Choose One)

○ No

○ Yes (GO TO QUESTION 14)

13. At what age did you last stop smoking cigarettes regularly? (Enter age last stopped smoking)

Age In Years: _____

14. During periods when you smoked, how many cigarettes did or do you usually smoke per day? (Choose One)

○ 1-10
○ 11-20
○ 21-30
○ 31-40
○ 41-60
○ 61-80
○ 81 or more

15. During periods when you smoked, did or do you more often smoke filter or non-fitter cigarettes? (Choose One)

○ Filter more often

○ Non-filter more often

○ Both about equally

16. Do you now or did you ever smoke a pipe regularly for a year or longer? (Choose One)

○ Never smoked a pipe

○ Did smoke a pipe but currently do not smoke

○ Currently do smoke a pipe

17. Do you now or did you ever smoke cigars regularly for a year or longer? (Choose One)

○ Never smoked cigars

○ Did smoke cigars but currently do not smoke

○ Currently do smoke cigars

The following questions ask about your family medical history and your personal medical history.

18. How many full and half-sisters do you have, both living and deceased? (Choose One)

○ 0	○ 3	○ 6	○ 9
○ 1	○ 4	○ 7	○ 10
○ 2	○ 5	○ 8	○ 11 or more

19. How many full and half-brothers do you have, both living and deceased? (Choose One)

○ 0	○ 3	○ 6	○ 9
○ 1	○ 4	○ 7	○ 10
○ 2	○ 5	○ 8	○ 11 or more

20. Have your parents, children, brothers, sisters, half-brothers, or half-sisters ever been diagnosed as having any type of cancer? (DO NOT INCLUDE BASAL-CELL SKIN CANCER) (Choose One)

○ No (GO TO QUESTION 22)

○ Yes

21. Please complete this chart for each relative (mother, father, children, brothers, sisters, half-brothers, half-sisters) diagnosed with cancer. (DO NOT INCLUDE BASAL-CELL SKIN CANCER.) (If you have more than four relatives diagnosed with cancer, please include a separate page with this information.)

Who was diagnosed as having cancer, that is, what is his or her relationship to you?		**What type of cancer did he or she have?**	**How old was your relative when he or she was diagnosed as having cancer?**
1st RELATIVE	_____ **Relationship**	_____ **Type of cancer**	_____ **Age**
2nd RELATIVE	_____ **Relationship**	_____ **Type of cancer**	_____ **Age**
3rd RELATIVE	_____ **Relationship**	_____ **Type of cancer**	_____ **Age**
4th RELATIVE	_____ **Relationship**	_____ **Type of cancer**	_____ **Age**

22. What is or was your weight at these ages? (Enter the weight in pounds.)

Weight at Age 50? _____

Weight at Age 20? (Exclude weight during pregnancy.) _____

Current Weight? _____

23. How tall are you? (Record your height in feet and inches.)

Feet _____ Inches _____

24. During the last 12 months, have you <u>regularly</u> used aspirin or aspirin-containing products, such as Bayer, Bufferin, or Anacin? (Please do not include aspirin-free products such as Tylenol and Panadol.) (Choose One)

○ No (GO TO QUESTION 26)

○ Yes

25. During the last 12 months, how many pills of aspirin or aspirin-containing products did you usually take per day, per week, or per month? (Choose One)

○ 1 per day ○ 3-4 per week

○ 2 or more per day ○ Less than 2 per month

○ 1 per week ○ 2-3 per month

○ 2 per week

26. During the last 12 months, have you regularly used ibuprofen-containing products, such as Advil, Nuprin, or Motrin? (Choose One)

○ No (GO TO QUESTION 28)

○ Yes

27. During the last 12 months, how many pills of ibuprofen-containing products did you usually take per day, per week, or per month? (Choose One)

○ 1 per day ○ 3-4 per week

○ 2 or more per day ○ Less than 2 per month

○ 1 per week ○ 2-3 per month

○ 2 per week

28. Has a doctor ever told you that you have any of the following conditions? (MARK YES OR NO FOR EACH CONDITION)

NO	YES	
○	○	High blood pressure (hypertension)
○	○	Coronary heart disease/heart attack
○	○	Stroke
○	○	Emphysema
○	○	Chronic bronchitis
○	○	Diabetes
○	○	Colorectal polyp(s)
○	○	Ulcerative colitis
○	○	Crohn's Disease
○	○	Familial polyposis
○	○	Arthritis
○	○	Osteoporosis
○	○	Gardner's Syndrome

NO	YES	
○	○	Hepatitis
○	○	Cirrhosis
○	○	Diverticulitis/diverticulosis
○	○	Gall bladder stones or inflammation

29. Have you ever been diagnosed as having cancer? (DO NOT INCLUDE BASAL-CELL SKIN CANCER) (Choose One)

○ No (GO TO OUESTION 31)

○ Yes

30. Please complete this chart for each cancer. (DO NOT INCLUDE BASAL-CELL SKIN CANCER.) (If you have been diagnosed with more than 3 types of cancer, please include a separate page to record this information.)

What type of cancer did you have?		How old were you when you were diagnosed with this cancer?
1st CANCER	_____ **Type of cancer**	_____ **Age**
2nd CANCER	_____ **Type of cancer**	_____ **Age**
3rd CANCER	_____ **Type of cancer**	_____ **Age**

31. How old were you when you had your first menstrual period? (Choose One)

○ Less than 10 ○ 14-15

○ 10-11 ○ 16 or older

○ 12-13

32. How old were you when you had your last period? (Choose One)

○ Less than 40 ○ 50-54

○ 40-44 ○ 55 or older

○ 45-49

33. Did your periods stop because of natural menopause, surgery, radiation, or drug therapy? (Choose One)

○ Natural Menopause ○ Radiation

○ Surgery ○ Drug therapy

34. Have you ever tried to become pregnant for a year or more without success? (Choose One)

○ No

○ Yes

35. Have you ever been pregnant? (Choose One)

- ○ No (GO TO QUESTION 43)
- ○ Yes
- ○ Don't know (GO TO QUESTION 43)

36. How old were you when you first became pregnant? (Choose One)

- ○ Less than 15
- ○ 15-19
- ○ 20-24
- ○ 25-29
- ○ 30-34
- ○ 35-39
- ○ 40-44
- ○ 45 or older

37. How many times have you been pregnant? Please include stillbirths, miscarriages, abortions, tubal or ectopic pregnancies, and live births. (Choose One)

- ○ 1
- ○ 2
- ○ 3-4
- ○ 5-9
- ○ 10 or more

38. How many of your pregnancies resulted in a stillbirth? (Choose One)

- ○ 0
- ○ 1
- ○ 2 or more

39. How many of your pregnancies resulted in a miscarriage or an abortion? (Choose One)

- ○ 0
- ○ 1
- ○ 2 or more

40. How many of your pregnancies resulted in a pregnancy in one of your tubes, that is, a tubal or ectopic pregnancy? (Choose One)

- ○ 0
- ○ 1
- ○ 2 or more

41. How many of your pregnancies resulted in a live birth? (If none, record "00" In the space provided and go to Question 43.)

Pregnancies resulting in a live birth _____

42. What was your age at the birth of your first child? (Choose One)

- ○ Less than 16
- ○ 16-19
- ○ 20-24
- ○ 25-29
- ○ 30-34
- ○ 35-39
- ○ 40 or older

43. Did you ever take birth control pills for birth control or to regulate menstrual periods? (Choose One)

- ○ No (GO TO QUESTION 46)
- ○ Yes

44. How old were you when you first started taking birth control pills? (Choose One)

- ○ Less than 30
- ○ 30-39
- ○ 40-49
- ○ 50-59
- ○ 60 or older

45. For how many total years did you take birth control pills? (Choose One)

- ○ 10 years or more
- ○ 6-9 years
- ○ 4-5 years
- ○ 2-3 years
- ○ One year or less

46. Have you had a tubal ligation, that is, have you had your tubes tied? (Choose One)

- ○ No
- ○ Yes
- ○ Don't know

47. Have you had a hysterectomy, that is, have you had your uterus or womb removed? (Choose One)

- ○ No (GO TO QUESTION 49)
- ○ Yes
- ○ Don't know (GO TO QUESTION 49)

48. What was your age when you had your uterus or womb removed? (Choose One)

- ○ Less than 40
- ○ 40-44
- ○ 45-49
- ○ 50-54
- ○ 55 or older

49. Have you ever had one or both of your ovaries removed? (Choose One)

- ○ No (GO TO QUESTION 51)
- ○ Yes
- ○ Don't know (GO TO QUESTION 51)

50. What exactly was removed? (Choose One)

- ○ One ovary - partial
- ○ One ovary - total
- ○ Both ovaries - partial
- ○ Both ovaries - total
- ○ Don't know

51. Sometimes women take female hormones such as estrogen or progesterone around the time of menopause. Have you ever used female hormones (tablets, pills, or creams) for menopause? (Choose One)

○ No (GO TO QUESTION 54)

○ Yes

○ Don't know (GO TO QUESTION 54)

52. Are you currently using female hormones? (Choose One)

○ No

○ Yes

53. For how many total years did you take female hormones? (Choose One)

○ 10 years or more ○ 2-3 years

○ 6-9 years ○ One year or less

○ 4-5 years

54. Have you ever been told by a doctor that you had any of the following conditions? (MARK YES OR NO FOR EACH CONDITION)

NO	YES	
○	○	Benign or fibrocystic breast disease
○	○	Benign ovarian tumor or cyst
○	○	Endometriosis
○	○	Uterine fibroid tumors

55. During the <u>past three years,</u> have you had a chest x-ray? (Choose One)

○ No ○ Yes, more than once

○ Yes, once ○ Don't know

56. During the <u>past three years</u>, have you had a mammogram? (Choose One)

○ No ○ Yes, more than once

○ Yes, once ○ Don't know

57. During the <u>past three years,</u> have you had a pap smear? (Choose One)

○ No ○ Yes, more than once

○ Yes, once ○ Don't know

58. During the <u>past three years,</u> have you had a pelvic examination? (Choose One)

○ No ○ Yes, more than once

○ Yes, once ○ Don't know

59. During the <u>past three years,</u> have you had an ultrasound or scan of your ovaries? (Choose One)

○ No ○ Yes, more than once

○ Yes, once ○ Don't know

60. During the <u>past three years,</u> have you had a blood test for ovarian cancer, for example CA-125? (Choose One)

○ No ○ Yes, more than once

○ Yes, once ○ Don't know

61. During the <u>past three years,</u> have you had a test for blood in the stool? (Choose One)

○ No ○ Yes, more than once

○ Yes, once ○ Don't know

62. During the <u>past three years</u>, have you had a colonoscopy, sigmoidoscopy, or barium enema to examine the colon and rectum? (Choose One)

○ No ○ Yes, more than once

○ Yes, once ○ Don't know

63. What is the date you completed this questionnaire? (MONTH, DAY, YEAR)

MONTH _____ **DAY** _____ **YEAR** _____

For Office Use Only: ○ Estimated Date

64. Who completed this questionnaire? (Choose One)

○ Completed by study participant

○ Completed by someone else (SPECIFY RELATIONISHP)

_____

Thank you very much for completing this questionnaire. Please check each page carefully to make certain you have answered all the questions that apply to you; then complete the Baseline Locator Form.

For Office Use Only:

SCREENING CENTER ID # ___ ___

SATELLITE CENTER ID # ___ ___

SC STAFF ID#___ ___ ___ ___

METHOD OF ADMINISTRATION (MARK ONE):

- ○ SELF-ADMINISTERED
- ○ SELF-ADMINISTERED WITH ASSISTANCE
- ○ IN-PERSON INTERVIEW-BY SC STAFF
- ○ IN-PERSON INTERVIEW BY OTHER
- ○ TELEPHONE ADMINISTERED

FORM PROCESSING (Choose One)

- ○ Form Receipted into SMS
- ○ Manual Review Completed

Data Retrieval: (Choose One)

- ○ Attempted OR
- ○ None Required

Data Entry of Non-Scannable Items: (Choose One)

- ○ Completed OR
- ○ None Required

Final Disposition: (Choose One)

- ○ Final Complete (FCM) OR
- ○ Final Incomplete (FIC)

ITEM 21. Relationships with Cancer

Please specify SEQNO, RECODE, CACODE, and AGE for each

ITEM 30. Cancer Types

Please specify SEQNO, CACODE, and AGE for each