National Lung Screening Trial (NLST)

MEDICAL HISTORY QUESTIONNAIRE FOR PARTICIPANTS (MHQ)

Participant ID Label

Thank you for participating in the National Lung Screening Trial (NLST). Your participation is helping to answer some very important questions about the effects of lung cancer screening on overall health. As a part of the study, we would like to obtain some baseline information about your personal medical history. Please take a few minutes to answer the following questions and then return this questionnaire to the Screening Center.

General Instructions:

Print your answers in the spaces provided, or place a “check” or “X” in the boxes where appropriate.

Please provide the following information and then proceed to page 2, beginning with "Today's Date," to complete the remainder of the questionnaire:

Your Name: _____
First Middle Initial Last

Your Date of Birth: MO DAY YEAR

Your Telephone Number: (_____)-_____
Area Code

MEDICAL HISTORY QUESTIONNAIRE (MHQ)

For Office Use Only

Screening Center ID: |___|___|

Screening Center Staff ID: |___|___|___|___|

Study Year: T|__|

Initials Complete: _____

Initials QC: _____

Participant ID Label

Today's Date: |___|___| |___|___| |___|___|___|___|
MO DAY YEAR

Who is completing this questionnaire?

☐ Study participant

☐ Someone else (Specify relationship to study participant)

_____

General Information about You

1. Are you of Hispanic or Latino origin?

   ☐ Yes ☐ No

2. Which of these groups describe you? (Check all that apply.)

   ☐ White
   ☐ Black or African-American
   ☐ Asian
   ☐ American Indian or Alaska Native
   ☐ Native Hawaiian or Other Pacific Islander

3. What is the highest grade or level of schooling you completed?

   ☐ 8th grade or less
   ☐ 9th-11th grade
   ☐ High school graduate/GED
   ☐ Post high school training, other than college (for example, vocational or technical school)
   ☐ Associate degree/some college
   ☐ Bachelor's degree
   ☐ Graduate school
   ☐ Other, specify:_____

4. What is your current marital status?

   ☐ Married or living as married
   ☐ Widowed
   ☐ Divorced
   ☐ Separated
   ☐ Never married

5. What is your current weight?

   Pounds: _____

6. How tall are you?

   Feet: _____ Inches: _____

Your Work Experience

7. Did you ever work for 12 months or more in any of the following industries or occupations?

Asbestos work	Cotton or jute processing	Hard rock mining
Baking	Farming	Painting
Butchering or meat packing	Fire fighting	Sandblasting
Chemicals or plastics manufacturing	Flour, feed, or grain milling	Welding
Coal mining	Foundry or steel milling	

☐ Yes ☐ No (***If No, check box for "No" and please skip to question 9.)***

8. Please fill in the appropriate information for **each** industry or occupation.

Industry or Occupation	Do you or did you work in this industry or occupation for 12 months or more? Please check the appropriate box for each industry or occupation listed. If you mark Yes for any industry or occupation, answer → → →	Write the total number of years you worked in this industry or occupation in the space provided, answer → → →	Do you or did you usually wear a facemask or other equipment to protect your lungs while working?
Asbestos work	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Baking	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Butchering or meat packing	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Chemicals or plastics manufacturing	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Coal mining	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Cotton or jute processing	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Farming	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Fire fighting	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Flour, feed, or grain milling	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Foundry or steel milling	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Hard rock mining	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Painting	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Sandblasting	☐Yes ☐No	No. of years _____	☐ Yes ☐ No
Welding	☐Yes ☐No	No. of years _____	☐ Yes ☐ No

Your Smoking Habits (Other than Cigarettes)

9. Has there ever been a time in your life when you regularly smoked at least one cigar a month?

☐ Yes ☐ No ***(If No, check box for "No" and please skip to question 12.)***

10. For how many years did you regularly smoke at least one cigar a month?

___ # of years (If less than 1 year, please enter 0.)

11. During these years, how many cigars did you smoke in a typical month?

___Number of cigars smoked in a typical month

12. Has there ever been a time in your life when you regularly smoked at least one pipeful of tobacco a month?

☐ Yes ☐ No ***(If No, check box for "No" and please skip to question 15.)***

13. For how many years did you regularly smoke at least one pipeful of tobacco a month?

___ # of years (If less than 1 year, please enter 0.)

14. During these years, how many pipesful of tobacco did you smoke in a typical month?

___ Number of pipesful of tobacco smoked in a typical month

Your Passive Smoke Exposure

15. Have you ever lived with a smoker?

☐ Yes
☐ No

16. Have you ever worked in a room or closed space where people were often smoking?

☐ Yes
☐ No

Your Alcohol Habits (Questions 17-18 refer to your recent drinking behavior.)

17. How often do you have a drink containing alcohol?

☐ Never ***(If Never, check box for "Never" and please skip to question 19.)***
☐ Monthly or less often
☐ Two to four times a month
☐ Two to three times a week
☐ Four or more times a week

18. How many drinks containing alcohol do you have on a typical day when you are drinking? *(One drink is defined as a 12-ounce beer, a 5-ounce glass of wine, or a 1.5-ounce shot of liquor, either alone or in mixed drinks)*

☐ 1
☐ 2-3
☐ 4
☐ 5-7
☐ 8 or more

Your Medical History

19. Has a doctor ever told you that you had or have any of the conditions or illnesses listed below? Please mark all that apply and indicate the age at which you were diagnosed. If you have had the same illness or condition more than once, please record your age the first time you were diagnosed.

☐ Yes ☐ No ***(If No, check box for "No" and skip to question 20.)***

↓

☐ Asbestosis	|__|__| Age at diagnosis
☐ Asthma - first diagnosed as a *child*	|__|__| Age at diagnosis
☐ Asthma - first diagnosed as an *adult*	|__|__| Age at diagnosis
☐ Bronchiectasis	|__|__| Age at diagnosis
☐ Chronic Bronchitis	|__|__| Age at diagnosis
☐ Chronic Obstructive Pulmonary Disease (COPD)	|__|__| Age at diagnosis
☐ Diabetes	|__|__| Age at diagnosis
☐ Emphysema	|__|__| Age at diagnosis
☐ Fibrosis of the lung	|__|__| Age at diagnosis
☐ Heart Disease or Heart Attack	|__|__| Age at diagnosis
☐ Pneumonia	|__|__| Age at diagnosis
☐ Sarcoidosis	|__|__| Age at diagnosis
☐ Silicosis	|__|__| Age at diagnosis
☐ Tuberculosis (TB)	|__|__| Age at diagnosis
☐ High Blood Pressure (Hypertension)	|__|__| Age at diagnosis
☐ Stroke	|__|__| Age at diagnosis

20. Have you ever had a chest x-ray? (Not including a chest x-ray for NLST.)

☐ Yes ☐ No ***(If No, check box for "No" and please skip to question 23.)***

21. What was the year of your last chest x-ray?

|___|___|___|___|
Year

22. What was the reason for your last chest x-ray? (***Please mark only one.****)*

☐ Because of a specific health problem
☐ Follow-up to a previous health problem
☐ Part of a routine physical exam or as a screening exam *(A screening exam is a medical test used to detect disease before symptoms have occurred.)*

23. Have you ever had a "whole body" CT exam or a CT exam of your chest or lungs? (Not including a CT exam for NLST.)

☐ Yes ☐ No **(*If No, check box for "No" and please skip to question 26.*)**

24. In what year did you have your last "whole body" CT exam, or CT exam of your chest or lungs?

|___|___|___|___|
Year

25. What was the reason for your last "whole body" CT exam, or CT exam of your chest or lungs? (***Please mark only one.***)

- ☐ Because of a specific health problem
- ☐ Follow-up to a previous health problem
- ☐ Part of a routine physical exam or as a screening exam *(A screening exam is a medical test used to detect disease before symptoms have occurred.)*

26. Have you ever been diagnosed as having any of the cancers listed below?

☐ Yes ☐ No ***(If No, check box for "No" and then skip to question 27.)***

↓

Please mark all that apply and indicate the age at which you were diagnosed. If you have had the same type of cancer more than once, please record your age the first time you were diagnosed.

☐ Bladder cancer	|__|__| Age at diagnosis
☐ Breast cancer	|__|__| Age at diagnosis
☐ Cervical cancer	|__|__| Age at diagnosis
☐ Colorectal cancer	|__|__| Age at diagnosis
☐ Cancer of the esophagus	|__|__| Age at diagnosis
☐ Kidney cancer	|__|__| Age at diagnosis
☐ Cancer of the larynx	|__|__| Age at diagnosis
☐ Lung cancer	|__|__| Age at diagnosis
☐ Mouth (oral) cancer	|__|__| Age at diagnosis
☐ Nasal cancer	|__|__| Age at diagnosis
☐ Pancreatic cancer	|__|__| Age at diagnosis
☐ Cancer of the pharynx	|__|__| Age at diagnosis
☐ Stomach cancer	|__|__| Age at diagnosis
☐ Thyroid cancer	|__|__| Age at diagnosis
☐ Transitional cell cancer	|__|__| Age at diagnosis

27. Have any of the following blood relatives ever had lung cancer? ***(Please write the appropriate response code in the space provided next to each relative.)***

01 No
02 Yes
98 Does not apply
99 Unknown / I prefer not to answer

|__|__| Father

|__|__| Mother

|__|__| Brother(s), including half-brothers

|__|__| Sister(s), including half-sisters

|__|__| Child (biological)

Thank you for taking the time to fill out this questionnaire.