FEMALE VERSION **STRICTLY CONFIDENTIAL**

DEPARTMENT OF PUBLIC HEALTH AND EPIDEMIOLOGY

UNIVERSITY OF BIRMINGHAM

STUDY OF PEOPLE TREATED FOR CANCER, LEUKAEMIA, TUMOUR OR SIMILAR ILLNESS IN CHILDHOOD

WE WOULD PREFER YOU TO FILL IN THE FORM, BUT IF THIS WOULD BE DIFFICULT BECAUSE OF SOME DISABILITY, IMPAIRMENT OR HANDICAP THEN WE ARE HAPPY FOR A CLOSE RELATIVE OR FRIEND TO FILL IN THE FORM WITH YOU.

PLEASE ANSWER THE QUESTIONS AS FULLY AS YOU CAN, BUT IF YOU CANNOT ANSWER A QUESTION PLEASE JUST GO ON TO THE NEXT QUESTION. IF THERE IS NOT ENOUGH SPACE TO FULLY ANSWER A QUESTION, THEN PLEASE CONTINUE ON A SEPARATE SHEET AND ATTACH TO THIS FORM.

PLEASE ANSWER EACH QUESTION BY TICKING A BOX AND BY GIVING FURTHER DETAILS WHEN ASKED. WHEN YOU HAVE FILLED IN THE FORM PLEASE RETURN IT TO US IN THE ENVELOPE ENCLOSED – NO STAMP IS NEEDED.

PLEASE WRITE CLEARLY.

If you have any questions about the form or the study then please telephone the Birmingham Study Centre, free of charge, on

☎ 0800 328 9419 ☎

A member of the study team will answer your call between 9am and 6.30pm (Monday to Friday). An answerphone will record your message at other times.

If you would like to speak with someone either inside or outside of our office hours, but you are unable to call between 9am and 6.30pm, then please leave your telephone number together with some preferred days and times on the answerphone and a member of the study team will call you back.

A

The following questions ask for your views about your health, how you feel and how well you are able to do your usual activities. If you are unsure about how to answer any questions please give the best answer you can and make any of your own comments if you like. Do not spend too much time in answering as your immediate response is likely to be the most accurate.

1. **In general**, would you say your health is:

(*Please tick **one** box*)

Excellent	☐
Very good	☐
Good	☐
Fair	☐
Poor	☐

2. **Compared to one year ago**, how would you rate your health in general now?

(*Please tick **one** box*)

Much better than one year ago	☐
Somewhat better than one year ago	☐
About the same	☐
Somewhat worse now than one year ago	☐
Much worse now than one year ago	☐

HEALTH AND DAILY ACTIVITIES

3. The following questions are about activities you might do during a typical day. Does your health limit you in these activities? If so, how much?

(*Please tick **one** box on each line*)

		Yes, limited a lot	Yes, limited a little	No, not limited at all
a)	**Vigorous activities,** such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b)	**Moderate activities,** such as moving a table, pushing a vacuum, bowling or playing golf	☐	☐	☐
c)	Lifting or carrying groceries	☐	☐	☐
d)	Climbing **several** flights of stairs	☐	☐	☐
e)	Climbing **one** flight of stairs	☐	☐	☐
f)	Bending, kneeling or stooping	☐	☐	☐
g)	Walking **more than a mile**	☐	☐	☐
h)	Walking **half a mile**	☐	☐	☐
i)	Walking **100 yards**	☐	☐	☐
j)	Bathing and dressing yourself	☐	☐	☐

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

(*Please answer **Yes** or **No** to each question*)

		Yes	No
a)	Cut down on the **amount of time** you spent on work or other activities	☐	☐
b)	**Accomplished less** than you would like	☐	☐
c)	Were limited in the **kind** of work or other activities	☐	☐
d)	Had **difficulty** performing the work or other activities (eg it took more effort)	☐	☐

C

5 During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

(*Please answer **Yes** or **No** to each question*)

		Yes	**No**
a)	Cut down on the **amount of time** you spent on work or other activities	☐	☐
b)	**Accomplished less** than you would like	☐	☐
c)	Didn't do work or other activities as **carefully** as usual	☐	☐

6. During the **past 4 weeks**, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups?

(*Please tick **one** box*)

- Not at all ☐
- Slightly ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

7. How much **bodily pain** have you had during the **past 4 weeks**?

(*Please tick **one** box*)

- None ☐
- Very mild ☐
- Mild ☐
- Moderate ☐
- Severe ☐
- Very severe ☐

8. During the **past 4 weeks** how much did **pain** interfere with your normal work (including work both outside the home and housework)?

(*Please tick **one** box*)

- Not at all ☐
- A little bit ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

YOUR FEELINGS

9. These questions are about how you feel and how things have been with you **during the past month.** (For each question, please indicate the one answer that comes closest to the way you have been feeling).

(*Please tick **one** box on each line*)

	How much time during **the last month:**	**All of the time**	**Most of the time**	**A good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
a)	Did you feel full of life?	☐	☐	☐	☐	☐	☐
b)	Have you been a very nervous person?	☐	☐	☐	☐	☐	☐
c)	Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐	☐
d)	Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
e)	Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
f)	Have you felt downhearted and low?	☐	☐	☐	☐	☐	☐
g)	Did you feel worn out?	☐	☐	☐	☐	☐	☐
h)	Have you been a happy person?	☐	☐	☐	☐	☐	☐
i)	Did you feel tired?	☐	☐	☐	☐	☐	☐
j)	Has your **health limited your social activities** (like visiting friends or close relatives)?	☐	☐	☐	☐	☐	☐

HEALTH IN GENERAL

10. Please choose the answer that best describes how **true** or **false** each of the following statements is for you.

(*Please tick **one** box on each line*)

		Definitely true	**Mostly true**	**Not sure**	**Mostly false**	**Definitely false**
a)	I seem to get ill more easily than other people	☐	☐	☐	☐	☐
b)	I am as healthy as anybody I know	☐	☐	☐	☐	☐
c)	I expect my health to get worse	☐	☐	☐	☐	☐
d)	My health is excellent	☐	☐	☐	☐	☐

1) What is your current height without shoes?

……. feet ……. inches **OR** ..... metres

2) What is your current weight without shoes?

..... stones ..... pounds **OR** ..... kilograms

3a) During the 2 WEEKS ENDING YESTERDAY, apart from any visit to a hospital, did you talk to a doctor about yourself, either in person or by telephone?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 4a) BELOW**

YES ☐

IF YES **3b) How many times did you talk to a doctor about yourself in those 2 WEEKS?**

..... **Number of times**

4a) During the LAST 3 MONTHS (ENDING ON THE LAST DAY OF LAST MONTH) did you attend, as a patient, the casualty or out-patient department of a hospital?

PLEASE DO NOT INCLUDE STRAIGHTFORWARD ANTE-NATAL OR POST-NATAL VISITS

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 5a) ON PAGE 2**

YES ☐

IF YES **4b) Please write in the names of the last 3 complete calendar months (for example, JULY, JUNE, MAY) and then how many times you attended in that month. If you did not attend in a particular month then please put 'NONE'.**

last month ..... number of times attended .....

the month before last

..... number of times attended .....

two months before last

..... number of times attended .....

5a) During the LAST YEAR, THAT IS SINCE THE DATE EXACTLY A YEAR AGO, have you been in hospital for treatment as a day patient - that is admitted to a hospital bed or day ward but not required to remain overnight?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 6a) BELOW**

YES ☐

⬇

IF YES	**5b)**	**How many separate days in hospital have you had as a day patient for having a baby since the date exactly a year ago?**
		Number of days…….. IF NONE, PLEASE SPECIFY 'NONE'
	5c)	**Apart from any maternity stays how many separate days in hospital have you had as a day patient since the date exactly a year ago?**
		Number of days…….. IF NONE, PLEASE SPECIFY 'NONE'

6a) During the LAST YEAR, THAT IS SINCE THE DATE EXACTLY A YEAR AGO, have you been in hospital as an in-patient, overnight or longer?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 7) ON PAGE 3**

YES ☐

⬇

IF YES	**6b)**	**How many separate stays in hospital as an in-patient in order to have a baby have you had since the date exactly a year ago?**
		Number of stays…….. IF NONE, PLEASE SPECIFY 'NONE'
	6c)	**Apart from any maternity stays how many separate stays in hospital as an in-patient have you had since the date exactly a year ago?**
		Number of stays…….. IF NONE, PLEASE SPECIFY 'NONE'

We would like to know all of the drugs and medications that you have taken during THE LAST 2 YEARS, THAT IS SINCE THE DATE EXACTLY 2 YEARS AGO. We are interested in only those tablets, pills, syrups, injections, patches and creams that were prescribed by a doctor, and which you took regularly for MORE THAN ONE MONTH, or for a total of 30 DAYS OR MORE IN A YEAR.

PLEASE INDICATE BELOW WHICH TYPES OF DRUGS YOU HAVE BEEN PRESCRIBED AND GIVE THE NAMES OF THE DRUGS.
PLEASE ALSO INDICATE EACH TYPE OF DRUG YOU HAVE NOT BEEN PRESCRIBED BY TICKING THE NO BOX.

		YES	NO	NOT SURE
7a)	**Antibiotics** such as amoxycillin, penicillin, erythromycin, cephalexin or others **NAMES OF DRUGS**	☐	☐	☐
7b)	**Birth control pills** such as Logynon, Microgynon, Brevinor, Ovranette, Cilest or others **NAMES OF DRUGS**	☐	☐	☐
7c)	**Oestrogens or Progesterones (female hormones)** such as Premarin, Prempak-C, Hormonin, Climaval, Estraderm patch, Provera, Primolut N (noresthisterone) or others **NAMES OF DRUGS**	☐	☐	☐
7d)	**Thyroid medications** such as Thyroxine or others **NAMES OF DRUGS**	☐	☐	☐
7e)	**Other medications to replace body hormones** such as growth hormone, steroid hormones (hydrocortisone), DDAVP or others **NAMES OF DRUGS**	☐	☐	☐
7f)	**Medication for Diabetes** such as insulin, metformin (Glucophage), glibenclamide, gliclazide or others **NAMES OF DRUGS**	☐	☐	☐

		YES	NO	NOT SURE
7g)	**Muscle relaxants** such as baclofen (Lioresal), dantrolene (Dantrium) or others **NAMES OF DRUGS**	☐	☐	☐
7h)	**Prescribed pain killers** such as Solpadol, Tylex, diclofenac, naproxen, dihydrocodeine, morphine or others **NAMES OF DRUGS**	☐	☐	☐
7i)	**Prescribed nutritional supplements** such as iron tablets, magnesium, potassium, sodium bicarbonate, vitamin D or others **NAMES OF DRUGS**	☐	☐	☐
7j)	**Anti-epileptic (anti-seizure) drugs** such as phenytoin (Epanutin), carbamazepine (Tegretol), sodium valproate (Epilim), lamotrigine (Lamictal), ethosuximide (Zarontin), phenobarbitone or others **NAMES OF DRUGS**	☐	☐	☐
7k)	**Drugs for high blood pressure or for your heart** such as atenolol, captopril, enalapril, digoxin, frusemide or others **NAMES OF DRUGS**	☐	☐	☐
7l)	**Prescribed antacids (for excess stomach acid or ulcers)** such as cimetidine (Tagamet), ranitidine (Zantac), omeprazole (Losec) or others **NAMES OF DRUGS**	☐	☐	☐
7m)	**Chemotherapy or Immune suppressants** such as prednisolone, azathioprine, cyclosporin or others **NAMES OF DRUGS**	☐	☐	☐
7n)	**Antidepressants or other prescribed drugs for depression or other mood disorders** such as dothiepin (Prothiaden), amitriptyline, fluoxetine (Prozac), lithium or others **NAMES OF DRUGS**	☐	☐	☐
7o)	**Other prescribed drugs** **NAMES OF DRUGS**	☐	☐	☐

MEDICAL CONDITIONS

The questions in this section ask about medical conditions you might have had which were confirmed by a doctor, nurse or other medical professional.

PLEASE INDICATE WHICH CONDITIONS YOU HAVE EVER HAD AND WHICH YOU HAVE NEVER HAD. FOR EACH CONDITION YOU HAVE HAD, PLEASE GIVE YOUR APPROXIMATE AGE (IN YEARS) WHEN THE CONDITION STARTED.

Has a doctor, nurse or other medical professional ever confirmed you have, or have had:

		YES	NO	NOT SURE	IF YES: PLEASE GIVE AGE WHEN IT STARTED (in years)
BRAIN and NERVOUS SYSTEM					
8a)	Cerebral palsy?	☐	☐	☐	.....
8b)	Paralysis of any kind?	☐	☐	☐	.....
	Please describe.....				
8c)	Mental retardation?	☐	☐	☐	.....
8d)	Epilepsy?	☐	☐	☐	.....
8e)	Repeated seizures, fits, convulsions, or blackouts?	☐	☐	☐	.....
8f)	Migraine?	☐	☐	☐	.....
8g)	Other frequent headaches?	☐	☐	☐	.....
8h)	Problems with balance, equilibrium or ability to reach for, or manipulate, objects?	☐	☐	☐	.....
8i)	Tremors or problems with movements?	☐	☐	☐	.....
8j)	Weakness or inability to move your arm(s)?	☐	☐	☐	.....
8k)	Weakness or inability to move your leg(s)?	☐	☐	☐	.....
8l)	Decreased sense of touch or feeling in your hands, fingers, arms or legs?	☐	☐	☐	.....
8m)	Prolonged pain or abnormal sensation in arms, legs or back?	☐	☐	☐	.....
8n)	Problems chewing or swallowing solids or liquids?	☐	☐	☐	.....
8o)	Any other brain or nervous system problems?	☐	☐	☐	.....
	Please describe.....				

Has a doctor, nurse or other medical professional ever confirmed you have, or have had:

		YES	NO	NOT SURE	IF YES: PLEASE GIVE AGE WHEN IT STARTED (in years)
KIDNEYS, BLADDER and OTHER URINARY CONDITIONS					
9a)	Kidney stones?	☐	☐	☐	.....
9b)	REPEATED kidney infections?	☐	☐	☐	.....
9c)	REPEATED bladder infections?	☐	☐	☐	.....
9d)	Dialysis?	☐	☐	☐	.....
9e)	Any other kind of kidney or urinary tract disorder?	☐	☐	☐	.....
	Please describe.....				
DIGESTIVE SYSTEM					
10a)	Gallstones?	☐	☐	☐	.....
10b)	Any other gallbladder trouble?	☐	☐	☐	.....
	Please describe.....				
10c)	Cirrhosis of the liver?	☐	☐	☐	.....
10d)	Hepatitis?	☐	☐	☐	.....
10e)	Jaundice?	☐	☐	☐	.....
10f)	Any other liver trouble?	☐	☐	☐	.....
	Please describe.....				
10g)	An ulcer?	☐	☐	☐	.....
10h)	Any disease of the oesophagus?	☐	☐	☐	.....
	Please describe.....				
10i)	FREQUENT indigestion?	☐	☐	☐	.....
10j)	FREQUENT heartburn?	☐	☐	☐	.....
	IF YES, do you take medication for it more than once a month?	☐	☐	☐	
10k)	Any other stomach trouble?	☐	☐	☐	.....
	Please describe.....				
10l)	Intestinal polyps?	☐	☐	☐	.....
10m)	Diverticular disease?	☐	☐	☐	.....
10n)	Colitis?	☐	☐	☐	.....
10o)	FREQUENT constipation?	☐	☐	☐	.....
10p)	Chronic diarrhoea?	☐	☐	☐	.....
10q)	Rectal or anal fistula?	☐	☐	☐	.....
10r)	Rectal or anal stricture (narrowing or scarring)?	☐	☐	☐	.....
10s)	Any other digestive problems?	☐	☐	☐	.....
	Please describe.....				

Has a doctor, nurse or other medical professional ever confirmed you have, or have had:

		YES	NO	NOT SURE	IF YES: PLEASE GIVE AGE WHEN IT STARTED (in years)
HORMONAL SYSTEM					
11a)	An **over**active thyroid gland (hyperthyroid)?	☐	☐	☐	.....
11b)	An **under**active thyroid gland (hypothyroid)?	☐	☐	☐	.....
11c)	Thyroid nodules?	☐	☐	☐	.....
11d)	Other thyroid enlargements?	☐	☐	☐	.....
11d)	Diabetes - controlled with diet?	☐	☐	☐	.....
11e)	Diabetes - controlled with pills or tablets?	☐	☐	☐	.....
11f)	Diabetes - controlled with insulin injections?	☐	☐	☐	.....
11g)	Lack of growth hormone?	☐	☐	☐	.....
11h)	Have you ever received injections of growth hormone?	☐	☐	☐	.....
11i)	Osteoporosis, brittle, weak or fragile bones?	☐	☐	☐	.....
11j)	Did you need medication to go into puberty?	☐	☐	☐	.....
11k)	Any other hormonal problems?	☐	☐	☐	.....
	Please describe.....				
11l)	Has a doctor ever told you that you might have problems becoming pregnant?	☐	☐	☐	.....
11m)	Have you ever had medical tests (such as a blood test or ultrasound) to see whether or not you might have problems becoming pregnant?	☐	☐	☐	.....
LUNGS and BREATHING					
12a)	Bronchitis?	☐	☐	☐	.....
12b)	Hay fever?	☐	☐	☐	.....
12c)	Recurrent sinus infections?	☐	☐	☐	.....
12d)	Tonsillitis or enlargement of the tonsils or adenoids?	☐	☐	☐	.....
12e)	Pleurisy (inflammation of the lining of the lung)?	☐	☐	☐	.....
12f)	Asthma?	☐	☐	☐	.....
12g)	Abnormal chest wall?	☐	☐	☐	.....
12h)	Chronic cough or shortness of breath for more than a month?	☐	☐	☐	.....
12i)	Have you ever had a need for extra oxygen?	☐	☐	☐	.....
	IF YES, are you currently using extra oxygen?	☐	☐	☐	
12j)	Pneumonia 3 or more times in the past 2 years?	☐	☐	☐	.....
12k)	Emphysema?	☐	☐	☐	.....
12l)	Lung fibrosis or “scarring” of the lung?	☐	☐	☐	.....
12m)	Any other breathing or lung problems?	☐	☐	☐	.....
	Please describe.....				

Has a doctor, nurse or other medical professional ever confirmed you have, or have had:

		YES	NO	NOT SURE	IF YES — PLEASE GIVE AGE WHEN IT STARTED (in years)
HEART and CIRCULATORY SYSTEM					
13a)	Rheumatic heart disease?	☐	☐	☐	.....
13b)	Hardening of the arteries or arteriosclerosis?	☐	☐	☐	.....
13c)	Irregular heart beat or palpitations, (Arrhythmia) requiring medication or follow-up by a doctor?	☐	☐	☐	.....
13d)	Congestive heart failure or cardiomyopathy (weak heart muscle)?	☐	☐	☐	.....
13e)	A myocardial infarction (heart attack)?	☐	☐	☐	.....
13f)	Coronary heart disease?	☐	☐	☐	.....
13g)	A heart murmur?	☐	☐	☐	.....
13h)	Hypertension (high blood pressure) **not** requiring medication?	☐	☐	☐	.....
13i)	Hypertension (high blood pressure) requiring medication?	☐	☐	☐	.....
13j)	A stroke or a cerebrovascular accident?	☐	☐	☐	.....
13k)	Angina pectoris (chest pains due to lack of oxygen to heart requiring medication such as Glyceryl Trinitrate sometimes known as GTN)?	☐	☐	☐	.....
13l)	Pericarditis or fluid around the heart?	☐	☐	☐	.....
13m)	Pericardial constriction (scarring or tightness of the sac around the heart)?	☐	☐	☐	.....
13n)	Stiff or leaking heart valves?	☐	☐	☐	.....
13o)	Heart catheterisation?	☐	☐	☐	.....
13p)	Biopsy of the heart muscle?	☐	☐	☐	.....
13q)	Blood clot in head, lung, arm, leg or pelvis?	☐	☐	☐	.....
13r)	Does exercise cause severe chest pain, shortness of breath, or irregular heart beat?	☐	☐	☐	.....
13s)	Heart failure during pregnancy or after delivery?	☐	☐	☐	.....
13t)	Have you seen a cardiologist (heart specialist)?	☐	☐	☐	.....
13u)	Has anyone in your immediate family (biological mother, father, brothers, sisters) had a heart attack before the age of 55?	☐	☐	☐	.....
13v)	Any other heart or circulatory problems?	☐	☐	☐	.....

Please describe.....

Has a doctor, nurse or other medical professional ever confirmed you have, or have had:

		YES	NO	NOT SURE	IF YES: PLEASE GIVE AGE WHEN IT STARTED (in years)
HEARING, VISION, SPEECH and TASTE					
14a)	Hearing loss requiring a hearing aid?	☐	☐	☐	.....
14b)	Deafness in one or both ears not completely corrected by a hearing aid?	☐	☐	☐	.....
14c)	Complete deafness in either ear?	☐	☐	☐	.....
14d)	Tinnitus or ringing in the ears?	☐	☐	☐	.....
14e)	Persistent dizziness or vertigo?	☐	☐	☐	.....
14f)	Problems hearing sounds, words, or language in crowds?	☐	☐	☐	.....
14g)	Any other hearing problems?	☐	☐	☐	.....
	Please describe.....				
14h)	Registered blind in one or both eyes?	☐	☐	☐	.....
14i)	Cataracts?	☐	☐	☐	.....
14j)	Glaucoma (excess pressure in the eyeball)?	☐	☐	☐	.....
14k)	Problems with double vision?	☐	☐	☐	.....
14l)	A detached retina or any other condition of the retina?	☐	☐	☐	.....
	Please describe.....				
14m)	Any other trouble seeing with one or both eyes even when wearing glasses?	☐	☐	☐	.....
14n)	Very dry eyes requiring eye drops or ointment?	☐	☐	☐	.....
14o)	Short-sightedness (Myopia)	☐	☐	☐	.....
14p)	Long-sightedness (Hypermetropia)	☐	☐	☐	.....
14q)	Any other eye problems?	☐	☐	☐	.....
	Please describe.....				
14r)	Stammering or stuttering?	☐	☐	☐	.....
14s)	Any other speech defects?	☐	☐	☐	.....
	Please describe.....				
14t)	Abnormal sense of taste?	☐	☐	☐	.....
14u)	Loss of taste or smell which lasted for 3 months or more?	☐	☐	☐	.....
	Please describe.....				

HISTORY OF PERIODS (MENSTRUAL BLEEDS)

It is important to know whether some forms of medical treatment in childhood have an effect on women's natural periods (natural menstrual bleeds). NATURAL PERIODS are periods which do not need birth control pills, female hormones or medication to bring them on.

15a) Have you ever had a NATURAL period?

NO ☐ → **IF NO PLEASE GO TO QUESTION 16 ON THE NEXT PAGE**

YES ☐

↓

IF YES

15b) At what age did you have your FIRST NATURAL period?

…….. years old

15c) At what age did you have your MOST RECENT NATURAL period?

…….. years old

15d) Which of the following statements best describes you?

SELECT ONLY ONE

I am pregnant. ☐

I am having **regular** periods and **I am not** taking birth control pills or female hormones. ☐

I am having **irregular** periods and **I am not** taking birth control pills or female hormones. ☐

I am taking birth control pills to prevent a pregnancy. ☐

I am taking birth control pills or female hormones to make my periods regular. ☐

I am having periods and **I am** taking birth control pills or female hormones as hormone replacement therapy (HRT). ☐

→ **PLEASE GO TO QUESTION 16 ON PAGE 11**

I have stopped having periods and **I am not** taking birth control pills or female hormones as hormone replacement therapy (HRT). ☐

I have stopped having periods and **I am** taking birth control pills or female hormones as hormone replacement therapy (HRT). ☐

Other ☐

→ **PLEASE GO TO QUESTION 15e) BELOW**

Please describe ……..

15e) What caused your periods to stop?

SELECT ONLY ONE

Normal or early menopause ☐

Surgery (including hysterectomy) ☐

Pregnancy ☐

Other ☐ **Please describe ……..**

SURGERY

PLEASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING TYPES OF SURGERY AND GIVE YOUR APPROXIMATE AGE WHEN YOU FIRST HAD EACH TYPE OF OPERATION.
PLEASE ALSO INDICATE WHICH TYPES OF SURGERY YOU HAVE NEVER HAD BY TICKING THE NO BOX.

		YES	NO	NOT SURE	IF YES: PLEASE GIVE AGE FIRST HAD THIS SURGERY (in years)
16a)	Amputation of an arm, leg, hand, foot, finger or toe? **Please describe.....**	☐	☐		.....
16b)	Scoliosis surgery (insertion of rods or other methods to straighten the spine)?	☐	☐	☐	.....
16c)	Other surgery of your spinal cord or spine? **Please describe.....**	☐	☐	☐	.....
16d)	Leg lengthening or shortening operations?	☐	☐	☐	.....
16e)	Joint replacement operations? **Please describe.....**	☐	☐	☐	.....
16f)	Other bone surgery? **Please describe.....**	☐	☐	☐	.....
16g)	Coronary artery bypass surgery?	☐	☐	☐	.....
16h)	Pericardiectomy (stripping of the sac around the heart)?	☐	☐	☐	.....
16i)	Angioplasty (enlarging a heart vessel using a balloon)?	☐	☐	☐	.....
16j)	Other heart surgery? **Please describe.....**	☐	☐	☐	.....
16k)	Surgery for intestinal obstruction (blocked intestines)?	☐	☐	☐	.....
16l)	Colostomy or ileostomy (stool going into a bag)?	☐	☐	☐	.....

		YES	NO	NOT SURE	IF YES: PLEASE GIVE AGE FIRST HAD THIS SURGERY (in years)
16m)	Reconnection after a colostomy or ileostomy?	☐	☐	☐	……
16n)	Surgery to remove a blood clot in an artery or vein?	☐	☐	☐	……
	Please describe.....				
16o)	Removal of the thyroid gland in your neck?	☐	☐	☐	……
16p)	Removal of your spleen?	☐	☐	☐	……
16q)	Ventriculoperitoneal shunt (tube from the brain to the abdomen, under the skin, which removes excess spinal fluid)?	☐	☐	☐	……
16r)	Breast surgery for removal or biopsy of a suspicious lump?	☐	☐	☐	……
16s)	A bronchoscopy since your therapy stopped?	☐	☐	☐	……
16t)	Other lung surgery?	☐	☐	☐	……
	Please describe.....				
16u)	A liver biopsy since your therapy stopped?	☐	☐	☐	……
16v)	Reconstructive surgery (surgery to repair damage due to an accident or medical therapy or other surgery)?	☐	☐	☐	……
	Please describe.....				
16w)	A heart transplant?	☐	☐	☐	……
16x)	A lung transplant?	☐	☐	☐	……
16y)	A kidney transplant?	☐	☐	☐	……
16z)	A bone marrow transplant?	☐	☐	☐	……
17a)	Other organ transplant?	☐	☐	☐	……
	Please describe.....				
17b)	Cataract surgery?	☐	☐	☐	……
17c)	Sinus surgery?	☐	☐	☐	……
17d)	Surgery on your jaw?	☐	☐	☐	……
17e)	Any other surgery?	☐	☐	☐	……
	Please describe.....				

CANCER, LEUKAEMIA, TUMOUR OR SIMILAR ILLNESS

18a) Did your childhood cancer, leukaemia, tumour or similar illness ever come back (recur or relapse) after it was first treated?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 18b) BELOW**

YES ☐

⬇

IF YES PLEASE GIVE DETAILS OF THE FIRST TIME IT CAME BACK AFTER FIRST TREATMENT

	Date doctor confirmed illness had come back	Doctor's name	Hospital name	Hospital address
	..DAY./MONTH./.YEAR...	.....	.....	.....
		.....	.....	.....
				.....
				.....

18b) Apart from your original childhood cancer, leukaemia, tumour or similar illness, have you ever been diagnosed with any OTHER cancer, leukaemia or tumour?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 19a) ON PAGE 14**

YES ☐

⬇

IF YES PLEASE GIVE DETAILS OF YOUR FIRST OTHER CANCER, LEUKAEMIA OR TUMOUR

	Illness diagnosed	Date of diagnosis	Doctor's name	Hospital name	Hospital address
	.....	..DAY./MONTH./.YEAR...	.....	.....	.....
			.....	.....	.....
					.....
					.....
					.....

MARRIAGE

19a) Have you ever been married or lived with someone as married?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 20a) BELOW**

YES ☐
↓

IF YES **19b) What is your current legal marital status?**

single and never married ☐

married ☐

separated ☐

divorced ☐

widowed ☐

19c) What was the date of your FIRST marriage, or if you have never been married the date you FIRST lived with someone as married?

date...../...../..... (DAY / MONTH / YEAR)

PREGNANCIES AND CHILDREN

. **20a) Have you been told by a doctor that you are unlikely to ever become pregnant?**

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 21a) ON PAGE 15**
YES ☐
↓

IF YES **PLEASE GIVE DETAILS BELOW**

Please describe the problem.....
.....
.....
.....

Doctors name
.....

Date of consultation ...../...../..... (DAY / MONTH / YEAR)

Hospital name and address
.....
.....
.....

21a) Was there ever a period in your life when you tried for ONE YEAR OR MORE to become pregnant without success?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 22a) BELOW**
YES ☐
↓

IF YES 21b) Did you, or your partner, see a doctor because of this?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 22a) BELOW**

YES ☐
↓

IF YES 21c) Did the doctor find any reason why you could not become pregnant?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 22a) BELOW**

YES ☐ ➔ PLEASE DESCRIBE

.....

.....

.....

22a) Have you ever been pregnant?

NO ☐ ➔ **IF NO PLEASE GO TO PAGE 23**

YES ☐
↓

IF YES 22b) Including any current pregnancy, how many times have you been pregnant including live births, stillbirths, miscarriages and abortions?

Total number of pregnancies .....

22c) Are you pregnant at the moment?

NO ☐
YES ☐

PLEASE FILL IN PAGES 16 TO 22 STARTING WITH YOUR FIRST PREGNANCY AND ENDING WITH THE LAST PREGNANCY FOR WHICH YOU KNOW THE OUTCOME. SO PLEASE FILL IN PREGNANCY PAGES FOR ALL PREGNANCIES EXCEPT A CURRENT PREGNANCY.

FIRST PREGNANCY

a) Was this a multiple pregnancy involving twins or triplets etc.?

NO ☐ **IF NO PLEASE COMPLETE THIS PAGE**

YES ☐ **IF YES PLEASE COMPLETE A PAGE FOR EACH CHILD**

b) Did you, or the father, have any medical assistance to help you become pregnant, for example drugs or some form of in-vitro fertilisation?

NO ☐
YES ☐ **Please describe** ……..

c) What was the date of the birth/ abortion/ termination/ miscarriage? ……/……./…….
DAY MONTH YEAR

d) How many weeks did the pregnancy last? ..... weeks

e) What was the outcome of this pregnancy?

LIVE BIRTH	☐	BIRTHWEIGHT ……lbs/……..oz **OR** …….Kg
ABORTION/TERMINATION	☐	REASON FOR ABORTION/TERMINATION ……..
MISCARRIAGE	☐	DETAILS……
STILLBIRTH	☐	CAUSE OF STILLBIRTH ……..

IF A LIVE BIRTH	**PLEASE GO TO QUESTION f) BELOW**

IF NOT A LIVE BIRTH	**PLEASE GO TO PAGE 17 IF YOU HAVE HAD MORE PREGNANCIES** **PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES**

f) Has this child ever been diagnosed with an illness or condition which was life threatening or involved the child being admitted to hospital or involved the child taking drugs or other medication for a long period?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION g) BELOW**

YES ☐
↓

Illness or condition diagnosed .....……

Child's age at first diagnosis .....years

g) How is this child's health now?

ALIVE AND WELL	☐	
ALIVE WITH ILLNESS	☐	PLEASE DESCRIBE ILLNESS……
THIS CHILD HAS DIED	☐	DATE OF DEATH ……/……./……. DAY MONTH YEAR

PLEASE GO TO PAGE 17 IF YOU HAVE HAD MORE PREGNANCIES
PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES

SECOND PREGNANCY

a) Was this a multiple pregnancy involving twins or triplets etc.?

NO ☐ **IF NO PLEASE COMPLETE THIS PAGE**

YES ☐ **IF YES PLEASE COMPLETE A PAGE FOR EACH CHILD**

b) Did you, or the father, have any medical assistance to help you become pregnant, for example drugs or some form of in-vitro fertilisation?

NO ☐
YES ☐ **Please describe** ……..

c) What was the date of the birth/ abortion/ termination/ miscarriage? ……./……./……..
DAY MONTH YEAR

d) How many weeks did the pregnancy last? ..... weeks

e) What was the outcome of this pregnancy?

LIVE BIRTH	☐	BIRTHWEIGHT ……lbs/……..oz **OR** …….Kg
ABORTION/TERMINATION	☐	REASON FOR ABORTION/TERMINATION ……..
MISCARRIAGE	☐	DETAILS……
STILLBIRTH	☐	CAUSE OF STILLBIRTH ……..

IF A LIVE BIRTH	**PLEASE GO TO QUESTION f) BELOW**

IF NOT A LIVE BIRTH	**PLEASE GO TO PAGE 18 IF YOU HAVE HAD MORE PREGNANCIES** **PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES**

f) Has this child ever been diagnosed with an illness or condition which was life threatening or involved the child being admitted to hospital or involved the child taking drugs or other medication for a long period?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION g) BELOW**

YES ☐
↓
Illness or condition diagnosed .....……

Child's age at first diagnosis .....years

g) How is this child's health now?

ALIVE AND WELL	☐	
ALIVE WITH ILLNESS	☐	PLEASE DESCRIBE ILLNESS……
THIS CHILD HAS DIED	☐	DATE OF DEATH ……./……./……. DAY MONTH YEAR

PLEASE GO TO PAGE 18 IF YOU HAVE HAD MORE PREGNANCIES
PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES

THIRD PREGNANCY

a) Was this a multiple pregnancy involving twins or triplets etc.?

NO ☐ **IF NO PLEASE COMPLETE THIS PAGE**

YES ☐ **IF YES PLEASE COMPLETE A PAGE FOR EACH CHILD**

b) Did you, or the father, have any medical assistance to help you become pregnant, for example drugs or some form of in-vitro fertilisation?

NO ☐
YES ☐ **Please describe** ……..

c) What was the date of the birth/ abortion/ termination/ miscarriage? ...../...../..... DAY MONTH YEAR

d) How many weeks did the pregnancy last? ..... weeks

e) What was the outcome of this pregnancy?

LIVE BIRTH	☐	BIRTHWEIGHT ……lbs/……..oz **OR** …….Kg
ABORTION/TERMINATION	☐	REASON FOR ABORTION/TERMINATION ……..
MISCARRIAGE	☐	DETAILS……
STILLBIRTH	☐	CAUSE OF STILLBIRTH ……..

IF A LIVE BIRTH	**PLEASE GO TO QUESTION f) BELOW**

IF NOT A LIVE BIRTH	**PLEASE GO TO PAGE 19 IF YOU HAVE HAD MORE PREGNANCIES** **PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES**

f) Has this child ever been diagnosed with an illness or condition which was life threatening or involved the child being admitted to hospital or involved the child taking drugs or other medication for a long period?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION g) BELOW**

YES ☐
↓

Illness or condition diagnosed .....……

Child's age at first diagnosis .....years

g) How is this child's health now?

ALIVE AND WELL	☐	
ALIVE WITH ILLNESS	☐	PLEASE DESCRIBE ILLNESS……
THIS CHILD HAS DIED	☐	DATE OF DEATH ...../...../..... DAY MONTH YEAR

PLEASE GO TO PAGE 19 IF YOU HAVE HAD MORE PREGNANCIES
PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES

FOURTH PREGNANCY

a) Was this a multiple pregnancy involving twins or triplets etc.?

NO ☐ **IF NO PLEASE COMPLETE THIS PAGE**

YES ☐ **IF YES PLEASE COMPLETE A PAGE FOR EACH CHILD**

b) Did you, or the father, have any medical assistance to help you become pregnant, for example drugs or some form of in-vitro fertilisation?

NO ☐
YES ☐ **Please describe** ……..

c) What was the date of the birth/ abortion/ termination/ miscarriage? ……./……./…….
DAY MONTH YEAR

d) How many weeks did the pregnancy last? ..... weeks

e) What was the outcome of this pregnancy?

LIVE BIRTH	☐	BIRTHWEIGHT ……lbs/……..oz **OR** …….Kg
ABORTION/TERMINATION	☐	REASON FOR ABORTION/TERMINATION ……..
MISCARRIAGE	☐	DETAILS……
STILLBIRTH	☐	CAUSE OF STILLBIRTH ……..

IF A LIVE BIRTH	**PLEASE GO TO QUESTION f) BELOW**

IF NOT A LIVE BIRTH	**PLEASE GO TO PAGE 20 IF YOU HAVE HAD MORE PREGNANCIES** **PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES**

f) Has this child ever been diagnosed with an illness or condition which was life threatening or involved the child being admitted to hospital or involved the child taking drugs or other medication for a long period?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION g) BELOW**

YES ☐
↓

Illness or condition diagnosed .....……

Child's age at first diagnosis .....years

g) How is this child's health now?

ALIVE AND WELL	☐	
ALIVE WITH ILLNESS	☐	PLEASE DESCRIBE ILLNESS……
THIS CHILD HAS DIED	☐	DATE OF DEATH ……./……./……. DAY MONTH YEAR

PLEASE GO TO PAGE 20 IF YOU HAVE HAD MORE PREGNANCIES
PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES

FIFTH PREGNANCY

a) Was this a multiple pregnancy involving twins or triplets etc.?

NO ☐ **IF NO PLEASE COMPLETE THIS PAGE**

YES ☐ **IF YES PLEASE COMPLETE A PAGE FOR EACH CHILD**

b) Did you, or the father, have any medical assistance to help you become pregnant, for example drugs or some form of in-vitro fertilisation?

NO ☐
YES ☐ **Please describe** ……..

c) What was the date of the birth/ abortion/ termination/ miscarriage? ……./……./……..
DAY MONTH YEAR

d) How many weeks did the pregnancy last? ..... weeks

e) What was the outcome of this pregnancy?

LIVE BIRTH	☐	BIRTHWEIGHT ……lbs/……..oz **OR** …….Kg
ABORTION/TERMINATION	☐	REASON FOR ABORTION/TERMINATION ……..
MISCARRIAGE	☐	DETAILS……
STILLBIRTH	☐	CAUSE OF STILLBIRTH ……..

IF A LIVE BIRTH	**PLEASE GO TO QUESTION f) BELOW**

IF NOT A LIVE BIRTH	**PLEASE GO TO PAGE 21 IF YOU HAVE HAD MORE PREGNANCIES** **PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES**

f) Has this child ever been diagnosed with an illness or condition which was life threatening or involved the child being admitted to hospital or involved the child taking drugs or other medication for a long period?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION g) BELOW**

YES ☐
↓
Illness or condition diagnosed .....……

Child's age at first diagnosis .....years

g) How is this child's health now?

ALIVE AND WELL	☐	
ALIVE WITH ILLNESS	☐	PLEASE DESCRIBE ILLNESS……
THIS CHILD HAS DIED	☐	DATE OF DEATH ……./……./……. DAY MONTH YEAR

PLEASE GO TO PAGE 21 IF YOU HAVE HAD MORE PREGNANCIES
PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES

SIXTH PREGNANCY

a) Was this a multiple pregnancy involving twins or triplets etc.?

NO ☐ **IF NO PLEASE COMPLETE THIS PAGE**

YES ☐ **IF YES PLEASE COMPLETE A PAGE FOR EACH CHILD**

b) Did you, or the father, have any medical assistance to help you become pregnant, for example drugs or some form of in-vitro fertilisation?

NO ☐
YES ☐ **Please describe** ……..

c) What was the date of the birth/ abortion/ termination/ miscarriage? ...../...../..... DAY MONTH YEAR

d) How many weeks did the pregnancy last? ..... weeks

e) What was the outcome of this pregnancy?

LIVE BIRTH	☐	BIRTHWEIGHT ……lbs/……..oz **OR** …….Kg
ABORTION/TERMINATION	☐	REASON FOR ABORTION/TERMINATION ……..
MISCARRIAGE	☐	DETAILS……
STILLBIRTH	☐	CAUSE OF STILLBIRTH ……..

IF A LIVE BIRTH	**PLEASE GO TO QUESTION f) BELOW**

IF NOT A LIVE BIRTH	**PLEASE GO TO PAGE 22 IF YOU HAVE HAD MORE PREGNANCIES** **PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES**

f) Has this child ever been diagnosed with an illness or condition which was life threatening or involved the child being admitted to hospital or involved the child taking drugs or other medication for a long period?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION g) BELOW**

YES ☐
↓
Illness or condition diagnosed .....……

Child's age at first diagnosis .....years

g) How is this child's health now?

ALIVE AND WELL	☐	
ALIVE WITH ILLNESS	☐	PLEASE DESCRIBE ILLNESS……
THIS CHILD HAS DIED	☐	DATE OF DEATH ...../...../..... DAY MONTH YEAR

PLEASE GO TO PAGE 22 IF YOU HAVE HAD MORE PREGNANCIES
PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES

SEVENTH PREGNANCY

a) Was this a multiple pregnancy involving twins or triplets etc.?

NO ☐ **IF NO PLEASE COMPLETE THIS PAGE**

YES ☐ **IF YES PLEASE TELEPHONE US**

b) Did you, or the father, have any medical assistance to help you become pregnant, for example drugs or some form of in-vitro fertilisation?

NO ☐
YES ☐ **Please describe** ……..

c) What was the date of the birth/ abortion/ termination/ miscarriage? ……./……./…….
DAY MONTH YEAR

d) How many weeks did the pregnancy last? ..... weeks

e) What was the outcome of this pregnancy?

LIVE BIRTH	☐	BIRTHWEIGHT ……lbs/……..oz **OR** …….Kg
ABORTION/TERMINATION	☐	REASON FOR ABORTION/TERMINATION ……..
MISCARRIAGE	☐	DETAILS……
STILLBIRTH	☐	CAUSE OF STILLBIRTH ……..

IF A LIVE BIRTH	**PLEASE GO TO QUESTION f) BELOW**

IF NOT A LIVE BIRTH	**PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES** **PLEASE TELEPHONE US IF YOU HAVE HAD MORE PREGNANCIES**

f) Has this child ever been diagnosed with an illness or condition which was life threatening or involved the child being admitted to hospital or involved the child taking drugs or other medication for a long period?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION g) BELOW**

YES ☐
↓
Illness or condition diagnosed .....……

Child's age at first diagnosis .....years

g) How is this child's health now?

ALIVE AND WELL	☐	
ALIVE WITH ILLNESS	☐	PLEASE DESCRIBE ILLNESS……
THIS CHILD HAS DIED	☐	DATE OF DEATH ……./……./……. DAY MONTH YEAR

PLEASE GO TO PAGE 23 IF YOU HAVE HAD NO MORE PREGNANCIES
PLEASE TELEPHONE US IF YOU HAVE HAD MORE PREGNANCIES

FAMILY HISTORY SECTION

Conditions or illnesses occurring in families may give important clues concerning our genetic make-up. This section of the form asks about cancers, leukaemias, tumours, birth defects and inherited conditions which are sometimes diagnosed in families.

THE LISTS BELOW SHOULD BE USED WHEN ANSWERING QUESTION 24

CANCER

CANCER INCLUDES THE FOLLOWING CONDITIONS:

Leukaemia
Retinoblastoma
Brain or spinal cord tumour
Hodgkin's disease
Carcinoma
Sarcoma
Germ cell tumour
Wilms' tumour
Lymphoma
Cancer
Teratoma
Seminoma
Neuroblastoma
Melanoma skin cancer
Non-melanoma skin cancer

BIRTH DEFECTS

BIRTH DEFECTS INCLUDE ANY CONDITION PRESENT FROM BIRTH SUCH AS:

Blindness or difficulty seeing
Crossed eyes
Eyes of different colours
Deafness or impaired hearing
Down's syndrome, trisomy 21
Water on the brain (hydrocephalus)
Hare lip (cleft lip)
Hole in the roof of mouth (cleft palate)
Small or no brain (anencephaly)
Enlarged head (macrocephaly)
Small head (microcephaly)
Diverted urinary stream (hypospadias)
Undescended testicle (cryptorchidism)
Large or multiple birth marks
Deformed chest
Hip dislocation
Shortened limbs
Enlargement of an arm or leg (hemihypertrophy)
Other skeletal abnormality
Hole in the heart
Other congenital heart disease
Absent, fused or extra fingers or toes
Club foot
Open spine (spina bifida)

INHERITED CONDITIONS: those conditions that pass down through families from one generation to the next

SOME OF THE MORE COMMON INHERITED CONDITIONS ARE:

Achondroplasia
Acrocephalosyndactyly
Aniridia
Aperts syndrome
Ataxia-telangiectasia
Beckwith-Wiedemann syndrome
Bilateral acoustic neurofibromatosis (type 2)
Bloom's syndrome
Congenital megacolon (Hirschsprung's disease)
Cystic fibrosis
Fanconi's anaemia
Klinefelter's syndrome
Marfan's syndrome
Multiple exostoses
Multiple polyposis
Myotonic dystrophy
Neurofibromatosis (type 1)
Naevoid basal cell carcinoma syndrome
Osteogenesis imperfecta
Polycystic kidney disease
Polyposis coli (Gardner's syndrome)
Tuberous sclerosis
Turner's syndrome
Von Hippel-Lindau syndrome
Von Recklinghausen's disease
Wiskott-Aldrich syndrome
Xeroderma pigmentosum

FOR QUESTION 24 WE WOULD LIKE YOU TO DO TWO THINGS:

1. **PLEASE FILL IN YOUR DETAILS AND THOSE OF ALL OF YOUR PARENTS, BROTHERS, SISTERS AND CHILDREN AND INDICATE WHETHER THEY ARE ALIVE. THIS INCLUDES BROTHERS, SISTERS, OR CHILDREN WHO WERE BORN DEAD (STILLBORN).**

2. **PLEASE TELL US IF THEY HAVE EVER HAD ANY OF THE CONDITIONS LISTED ABOVE, OR ANY OTHER CANCERS, LEUKAEMIAS, TUMOURS, BIRTH DEFECTS OR INHERITED CONDITIONS. FOR EACH FAMILY MEMBER WHO HAS HAD NO SUCH CONDITIONS PLEASE WRITE "NONE".**

TO HELP YOU FILL IN YOUR FAMILY HISTORY WE GIVE AN EXAMPLE BELOW.

FULL NAME Forenames Surname	SEX	DATE OF BIRTH day month year			STATUS	DATE OF DEATH day month year			CANCER, LEUKAEMIA, TUMOUR, BIRTH DEFECT OR INHERITED CONDITION DIAGNOSED (If none, write NONE)	AGE AT DIAGNOSIS (IN YEARS)
	male ☐ female ☐				alive ☐ dead ☐					
	male ☐ female ☐				alive ☐ dead ☐					

24a) YOU

PLEASE INDICATE WHETHER YOU HAVE EVER HAD ANY CANCERS, LEUKAEMIAS, TUMOURS, BIRTH DEFECTS OR INHERITED CONDITIONS

FULL NAME Forenames Surname	SEX	DATE OF BIRTH day month year			CANCER, LEUKAEMIA, TUMOUR, BIRTH DEFECT OR INHERITED CONDITION DIAGNOSED (If none, write NONE)	AGE AT DIAGNOSIS (IN YEARS)
	male ☐ female ☐					

24b) YOUR BIRTH OR NATURAL PARENTS

PLEASE LIST YOUR BIRTH OR NATURAL PARENTS AND WHETHER THEY ARE ALIVE.
PLEASE DO NOT GIVE DETAILS OF STEP OR FOSTER OR ADOPTIVE PARENTS.
PLEASE INDICATE WHETHER THEY HAVE EVER HAD ANY CANCERS, LEUKAEMIAS, TUMOURS, BIRTH DEFECTS OR INHERITED CONDITIONS.

FULL NAME Forenames Surname	SEX	DATE OF BIRTH day month year			STATUS	DATE OF DEATH day month year			CANCER, LEUKAEMIA, TUMOUR, BIRTH DEFECT OR INHERITED CONDITION DIAGNOSED (If none, write NONE)	AGE AT DIAGNOSIS (IN YEARS)
	male ☐ female ☐				alive ☐ dead ☐					
	male ☐ female ☐				alive ☐ dead ☐					

24c) YOUR <u>FULL</u> BROTHERS AND SISTERS

THOSE WITH THE <u>SAME MOTHER AND FATHER</u> AS YOU

IF YOU NEVER HAD A FULL BROTHER OR SISTER
PLEASE TICK THIS BOX ☐ AND GO TO QUESTION 24d) ON PAGE 25

PLEASE LIST ALL OF YOUR FULL BROTHERS AND SISTERS AND WHETHER THEY ARE ALIVE.
PLEASE INDICATE WHETHER THEY HAVE EVER HAD ANY CANCERS, LEUKAEMIAS, TUMOURS, BIRTH DEFECTS OR INHERITED CONDITIONS.

FULL NAME Forenames Surname	SEX	DATE OF BIRTH day month year			STATUS	DATE OF DEATH day month year			CANCER, LEUKAEMIA, TUMOUR, BIRTH DEFECT OR INHERITED CONDITION DIAGNOSED (If none, write NONE)	AGE AT DIAGNOSIS (IN YEARS)
	male ☐ female ☐				alive ☐ dead ☐					
	male ☐ female ☐				alive ☐ dead ☐					
	male ☐ female ☐				alive ☐ dead ☐					
	male ☐ female ☐				alive ☐ dead ☐					
	male ☐ female ☐				alive ☐ dead ☐					
	male ☐ female ☐				alive ☐ dead ☐					
	male ☐ female ☐				alive ☐ dead ☐					

24d) OTHER CHILDREN PRODUCED BY YOUR MOTHER BUT NOT BY YOUR FATHER (HALF BROTHERS OR SISTERS)

IF YOU NEVER HAD SUCH A HALF BROTHER OR SISTER PLEASE TICK THIS BOX ☐ AND GO TO QUESTION 24e) BELOW

PLEASE LIST ALL SUCH HALF BROTHERS AND SISTERS AND WHETHER THEY ARE ALIVE.

PLEASE INDICATE WHETHER THEY HAVE EVER HAD ANY CANCERS, LEUKAEMIAS, TUMOURS, BIRTH DEFECTS OR INHERITED CONDITIONS.

FULL NAME Forenames Surname	SEX	DATE OF BIRTH day month year	STATUS	DATE OF DEATH day month year	CANCER, LEUKAEMIA, TUMOUR, BIRTH DEFECT OR INHERITED CONDITION DIAGNOSED (If none, write NONE)	AGE AT DIAGNOSIS (IN YEARS)
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			

24e) OTHER CHILDREN PRODUCED BY YOUR FATHER BUT NOT BY YOUR MOTHER (HALF BROTHERS OR SISTERS)

IF YOU NEVER HAD SUCH A HALF BROTHER OR SISTER PLEASE TICK THIS BOX ☐ AND GO TO QUESTION 24f) ON PAGE 26

PLEASE LIST ALL SUCH HALF BROTHERS AND SISTERS AND WHETHER THEY ARE ALIVE.

PLEASE INDICATE WHETHER THEY HAVE EVER HAD ANY CANCERS, LEUKAEMIAS, TUMOURS, BIRTH DEFECTS OR INHERITED CONDITIONS.

FULL NAME Forenames Surname	SEX	DATE OF BIRTH day month year	STATUS	DATE OF DEATH day month year	CANCER, LEUKAEMIA, TUMOUR, BIRTH DEFECT OR INHERITED CONDITION DIAGNOSED (If none, write NONE)	AGE AT DIAGNOSIS (IN YEARS)
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			
	male ☐ female ☐		alive ☐ dead ☐			

24f) CHILDREN YOU HAVE PRODUCED

IF YOU HAVE NEVER PRODUCED A CHILD
PLEASE TICK THIS BOX ☐ AND GO TO QUESTION 25a) ON PAGE 27

PLEASE LIST ALL CHILDREN YOU HAVE PRODUCED AND WHETHER THEY ARE ALIVE.
PLEASE INDICATE WHETHER THEY HAVE EVER HAD ANY CANCERS, LEUKAEMIAS, TUMOURS, BIRTH DEFECTS OR INHERITED CONDITIONS.

FULL NAME OF CHILD Forenames Surname	SEX	DATE OF BIRTH d	 m	 y	STATUS	DATE OF DEATH d	 m	 y	CANCER, LEUKAEMIA, TUMOUR, BIRTH DEFECT OR INHERITED CONDITION DIAGNOSED (If none, write NONE)	AGE AT DIAGNOSIS (IN YEARS)	NAME OF FATHER OF THIS CHILD Forenames Surname
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						
	male ☐ female ☐				alive ☐ dead ☐						

FATHERS OF THE CHILDREN YOU HAVE PRODUCED

PLEASE LIST ALL FATHERS OF THE CHILDREN YOU HAVE PRODUCED AND WHETHER THEY ARE ALIVE.
PLEASE INDICATE WHETHER THEY HAVE EVER HAD ANY CANCERS, LEUKAEMIAS, TUMOURS, BIRTH DEFECTS OR INHERITED CONDITIONS.

FULL NAME OF FATHER OF CHILD Forenames Surname	DATE OF BIRTH day	 month	 year	STATUS	DATE OF DEATH day	 month	 year	CANCER, LEUKAEMIA, TUMOUR, BIRTH DEFECT OR INHERITED CONDITION DIAGNOSED (If none, write NONE)	AGE AT DIAGNOSIS (IN YEARS)
				alive ☐ dead ☐					
				alive ☐ dead ☐					
				alive ☐ dead ☐					
				alive ☐ dead ☐					

SMOKING

25a) Have you ever smoked a cigarette, a cigar or a pipe?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 28a) ON PAGE 29**

YES ☐

➔

IF YES **25b) Do you smoke cigarettes at all nowadays?**

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 26a) ON PAGE 28**

YES ☐

➔

IF YES **25c) About how many cigarettes a day do you usually smoke at weekends?**

.....per day at weekends

☐ less than 1 per day at weekends

About how many cigarettes a day do you usually smoke on weekdays?

.....per day on weekdays

☐ less than 1 per day on weekdays

How old were you when you started to smoke cigarettes regularly?

.....years old

☐ never smoked regularly

CURRENT SMOKERS

PLEASE GO TO QUESTION 27a) AT THE BOTTOM OF PAGE 28

26a) Have you ever smoked cigarettes regularly?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 28a) ON PAGE 29**

YES ☐

↓

IF YES **26b) About how many cigarettes did you smoke IN A DAY when you smoked them regularly?**

.....per day

☐ less than 1 per day

26c) How long ago did you stop smoking cigarettes regularly?

Less than 6 months ago	☐
6 months but less than a year ago	☐
1 year but less than 2 years ago	☐
2 years but less than 5 years ago	☐
5 years but less than 10 years ago	☐
10 years or more ago	☐

26d) How old were you when you started to smoke cigarettes regularly?

.....years old

27a) Has a medical person, for example, a doctor or nurse, ever advised you to stop smoking completely because of your health?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 28a) ON PAGE 29**

YES ☐

↓

IF YES **27b) How long ago was that ?**

within the last 12 months	☐
over 12 months ago	☐

ALCOHOL

28a) Do you ever drink alcohol nowadays including drinks you brew or make at home?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 29) ON PAGE 30**

YES ☐ ↓

IF YES **28b) During the last 12 months how much BEER, LAGER, STOUT, CIDER or SHANDY** (excluding cans and bottles of shandy) **have you drunk in an average week?**

THERE IS **ONE UNIT** OF ALCOHOL IN HALF A PINT OF 'NORMAL STRENGTH' BEER, LAGER, STOUT or CIDER and **TWO UNITS** OF ALCOHOL IN HALF A PINT OF 'STRONG' (AT LEAST 6% ALCOHOL BY VOLUME) BEER, LAGER, STOUT OR CIDER.

…….. Number of units of alcohol in an average week

28c) During the last 12 months how much SPIRITS or LIQUEURS (such as gin, whisky, brandy, rum, vodka, advocaat or cocktails) have you drunk in an average week?

THERE IS **ONE UNIT** OF ALCOHOL IN A SINGLE PUB MEASURE OF SPIRITS OR LIQUEURS

…….. Number of units of alcohol in an average week

28d) During the last 12 months how much SHERRY, MARTINI, PORT, CINZANO, DUBONNET, VERMOUTH or similar, have you drunk in an average week?

THERE IS **ONE UNIT** OF ALCOHOL IN ONE SMALL GLASS OF SHERRY OR MARTINI etc.

…….. Number of units of alcohol in an average week

28e) During the last 12 months how much WINE (including Babycham and Champagne) have you drunk in an average week?

THERE IS **ONE UNIT** OF ALCOHOL IN ONE GLASS OF WINE (1 STANDARD 75cl BOTTLE = 6 GLASSES)

…….. Number of units of alcohol in an average week

28f) During the last 12 months how much ALCOPOPS (such as alcoholic lemonade, alcoholic colas or other fruit-flavoured or herb-flavoured drinks including Hooch, Two Dogs and Alcola) have you drunk in an average week?

THERE ARE **TWO UNITS** OF ALCOHOL IN A BOTTLE OF ALCOHOLIC SOFT DRINK

…….. Number of units of alcohol in an average week

EDUCATIONAL QUALIFICATIONS

29) Please look at the different groups of qualifications listed below. Starting with group 1 and working towards group 8, tick the box of the first group which contains a qualification you have. PLEASE TICK ONE BOX ONLY

1 Degree (including first and higher degrees) → ☐

2 Teaching qualification
HNC or HND
BEC or TEC Higher
BTEC / SCOTVEC Higher
Nursing Qualifications (SRN, SCM, RGN, RM, RHV, Midwife)
NVQ / SVQ Level 4 or Level 5
RSA Higher Diploma → ☐

3 A levels or AS levels
SCE Higher
ONC or OND
BEC or TEC **not** Higher
City and Guilds Advanced/Final Level
BTEC / SCOTVEC National
GNVQ / GSVQ (Advanced Level)
NVQ / SVQ Level 3
RSA Advanced Diploma → ☐

4 GCE O level passes (Grade A – C if after 1974)
GCSE (Grades A – C)
CSE Grade 1
SCE Ordinary (Bands A – C) / Standard Grade (Level 1 – 3)
SLC Lower
SUPE Lower or Ordinary
School Certificate or Matric
City and Guilds Craft / Ordinary
BTEC / SCOTVEC First
GNVQ / GSVQ (Intermediate Level)
NVQ / SVQ Level 2
RSA Diploma → ☐

5 CSE Grades 2 - 5
GCE O level Grades D and E if after 1974
GCSE (Grades D, E, F, G)
SCE Ordinary (Bands D and E) / Standard Grade (Level 4, 5)
Clerical or Commercial qualifications
Apprenticeship
GNVQ / GSVQ (Foundation Level)
NVQ / SVQ Level 1 → ☐

6 CSE ungraded → ☐

7 Other qualifications → ☐

Please describe……

8 No qualifications → ☐

EMPLOYMENT

30) What is your current employment status? (PLEASE TICK ONE BOX ONLY)

working full-time (30 hours or more per week)	☐
working part-time (less than 30 hours per week)	☐
caring for home or family (not seeking paid work)	☐
unemployed and looking for work	☐
unable to work due to illness or disability	☐
retired	☐
student	☐

IF YOU ARE NOT CURRENTLY WORKING FULL OR PART-TIME
PLEASE GO TO QUESTION 32a) ON PAGE 32

31a) What is your present occupation?

PLEASE WRITE JOB TITLE AND BRIEF DETAILS OF WHAT YOU ACTUALLY DO.
(If you have more than one job, please give the title of **your main job**).

Job title? ……

What you actually do? ……

……..

What kind of business takes place where you work?
(FOR EXAMPLE: Making shoes, Repairing cars, Secondary education, Hospital)

……..

31b) Do you hold the position of supervisor or manager?

Yes, a supervisor ☐

Yes, a manager ☐

No, neither ☐

31c) At your place of work, how many people in total are employed by your employer, or by you if you are self-employed?

Less than 25 ☐

25 or more ☐

31d) Are you self-employed or an employee?

Self employed with employees ☐

Self employed without employees ☐

An employee ☐

PLEASE GO TO QUESTION 33) ON PAGE 32

32a) What was your most recent occupation?

PLEASE WRITE JOB TITLE AND BRIEF DETAILS OF WHAT YOU ACTUALLY DID.
(If you had more than one job, please give the title of **your main job**).

Job title? ……..

What you actually did? ……..

……

What kind of business took place where you worked?
(FOR EXAMPLE: Making shoes, Repairing cars, Secondary education, Hospital)

……

32b) Did you hold the position of supervisor or manager?

Yes, a supervisor ☐

Yes, a manager ☐

No, neither ☐

32c) At your place of work, how many people in total were employed by your employer, or by you if you were self-employed?

Less than 25 ☐

25 or more ☐

32d) Were you self-employed or an employee?

Self employed with employees ☐
Self employed without employees ☐
An employee ☐

---

33) Have you ever had problems getting or keeping full or part-time employment because of your health history?

YES ☐ **Please describe ……**

NEVER TRIED TO GET FULL
OR PART-TIME EMPLOYMENT ☐

NO ☐

LIFE INSURANCE

34a) Have you ever tried to obtain life insurance?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 36a) BELOW**
YES ☐
↓

IF YES 34b) Have you ever had difficulty in obtaining life insurance because of your health history?

NO ☐
YES ☐ **Please describe** ……

35a) Do you currently have life insurance?

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 36a) BELOW**
YES ☐
↓

IF YES 35b) Does this life insurance policy have any exclusions or restrictions because of your health history?

DON'T KNOW ☐
NO ☐
YES ☐ **Please describe** ……
……

35c) Is there any extra amount paid for your life insurance because of your health history?

DON'T KNOW ☐
NO ☐
YES ☐ **Please describe** ……
……

MEDICAL INSURANCE

36a) Have you ever tried to obtain medical insurance to cover the cost of private medical treatment should you need it? (EXCLUDE INSURANCE FOR HOLIDAYS ABROAD)

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 38) ON PAGE 34**
YES ☐
↓

IF YES 36b) Have you ever had difficulty in obtaining medical insurance because of your health history?

NO ☐
YES ☐ **Please describe** ……

37a) Do you currently have medical insurance? (EXCLUDE INSURANCE FOR HOLIDAYS ABROAD)

NO ☐ ➔ **IF NO PLEASE GO TO QUESTION 38) BELOW**

YES ☐

↓

IF YES 37b) Does this medical insurance policy have any exclusions or restrictions because of your health history?

DON'T KNOW ☐

NO ☐

YES ☐ **Please describe** ……

……

37c) Is there any extra amount paid for your medical insurance because of your health history?

DON'T KNOW ☐

NO ☐

YES ☐ **Please describe** ……

……

YOUR CONCERNS

38) Please indicate how concerned you are about the following issues?

	NOT AT ALL CONCERNED	SLIGHTLY CONCERNED	MODERATELY CONCERNED	VERY CONCERNED
Your future health	☐	☐	☐	☐
Your ability to have children	☐	☐	☐	☐
Developing a cancer	☐	☐	☐	☐
Your ability to get medical insurance	☐	☐	☐	☐
Your ability to get life insurance	☐	☐	☐	☐
Other issues	☐	☐	☐	☐

Please describe ……

STUDY NEWSLETTERS

We shall prepare newsletters to inform those who take part in the study about the main study findings. Would you like to receive copies of such newsletters?

YES ☐

NO ☐

35

DETAILS OF THE PERSON WHO FILLED IN THE FORM

Date filled in ……/……/……
DAY MONTH YEAR

Your full name PLEASE PRINT……

We may need to contact you about the form, can you please supply a telephone number and address at which we may contact you?

Telephone number (Including STD code if known).....……

Address ……..… Postcode …….

Are you the person named on the front of the form?

YES ☐
NO ☐
↓

IF NO **What is your relationship to the person named on the front of the form?**

PARENT of the person named on the form	☐
HUSBAND/PARTNER of the person named on the form	☐
BROTHER OR SISTER of the person named on the form	☐
OTHER RELATIVE of the person named on the form	☐
PLEASE DESCRIBE……	
OTHER	☐
PLEASE DESCRIBE……	

PERMISSION TO OBTAIN CONFIDENTIAL INFORMATION

In several questions we have asked about illnesses or problems which you may have had. To enable us to draw valid conclusions which may inform decisions concerning the medical care of existing and future patients it may be important to confirm details of your diagnosis or treatment. If we need to obtain further details relating to your illnesses or problems may we contact your GP or the relevant hospital?

☐ I **give** my consent for a representative of the study to contact the relevant GP or hospital to obtain further details relating to my illness.

☐ I **do not give** my consent for a representative of the study to contact the relevant GP or hospital to obtain further details relating to my illness.

FULL NAME OF PERSON NAMED ON FRONT OF FORM……..
PLEASE PRINT

SIGNATURE OF PERSON NAMED ON FRONT OF FORM …….

PERMISSION TO KEEP CONFIDENTIAL INFORMATION

The information obtained by this study will form part of an important national resource and would be of considerable value in the future for comparison with survivors of cancer, leukaemia, tumour or similar illness diagnosed in the future. We should therefore like to keep, under conditions of strict confidentiality, the information obtained by this study for as long as it is possible to secure funding for these national studies. May we keep the information obtained by this study for as long as it is possible to carry out these national studies?

☐ I **give** my consent for information collected on me to be kept for as long as it is possible to carry out these national studies.

☐ I **do not give** my consent for information collected on me to be kept for as long as it is possible to carry out these national studies.

FULL NAME OF PERSON NAMED ON FRONT OF FORM ……..
PLEASE PRINT

SIGNATURE OF PERSON NAMED ON FRONT OF FORM …….

THANK YOU FOR FILLING IN THE FORM, PLEASE RETURN IT TO US IN THE POSTAGE PAID ENVELOPE PROVIDED.