

FEMALE QUESTIONNAIRE

This questionnaire is part of an Australian and New Zealand study of families with breast cancer. The study is funded by the Kathleen Cuninghams Foundation and administered by the Peter MacCallum Cancer Institute, Melbourne.

INSTRUCTIONS:

- Use a blue/black biro or pencil, preferably 2B
- Do not use red pen or felt tip pen
- Do not fold or bend
- Erase mistakes fully
- Do not make any stray marks

Please **MARK LIKE THIS:**



NOT LIKE THIS:



Please write in boxes provided, then fill in the oval corresponding to each column.

EXAMPLE 1:

Postcode:

3 0 3 4



EXAMPLE 2:

A1. How old are you?

0 4 2 years

FAMILY ID

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

SUBJECT UPN

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

INTERVIEW DATE

		<input type="radio"/> JAN	<input type="radio"/> 1997
		<input type="radio"/> FEB	<input type="radio"/> 1998
		<input type="radio"/> MAR	<input type="radio"/> 1999
		<input type="radio"/> APR	<input type="radio"/> 2000
		<input type="radio"/> MAY	<input type="radio"/> 2001
		<input type="radio"/> JUN	<input type="radio"/> 2002
		<input type="radio"/> JUL	<input type="radio"/> 2003
		<input type="radio"/> AUG	<input type="radio"/> 2004
		<input type="radio"/> SEP	<input type="radio"/> 2005
		<input type="radio"/> OCT	<input type="radio"/> 2006
		<input type="radio"/> NOV	<input type="radio"/> 2007
		<input type="radio"/> DEC	<input type="radio"/> 2008

INTERVIEWER

0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

UPN of MOTHER

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

UPN of FATHER

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

UPN of SPOUSE

0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9

Please return questionnaire to:
Cancer Epidemiology Centre
Anti-Cancer Council of Victoria
1 Rathdowne St
Carlton South VIC 3052

A. Background Information

The first section asks some questions about your background.

A1. How old are you?

			years
0	0	0	
1	1	1	
2	2	2	
3	3	3	
4	4	4	
5	5	5	
6	6	6	
7	7	7	
8	8	8	
9	9	9	

Don't know

A2. What is your date of birth?

		<input type="radio"/> JAN			
		<input type="radio"/> FEB			
0	0	<input type="radio"/> MAR	<input type="radio"/>	0	0
1	1	<input type="radio"/> APR	<input type="radio"/>	1	1
2	2	<input type="radio"/> MAY	<input type="radio"/>	2	2
3	3	<input type="radio"/> JUN	<input type="radio"/>	3	3
4	4	<input type="radio"/> JUL	<input type="radio"/>	4	4
5	5	<input type="radio"/> AUG	<input type="radio"/>	5	5
6	6	<input type="radio"/> SEP	<input type="radio"/>	6	6
7	7	<input type="radio"/> OCT	<input type="radio"/>	7	7
8	8	<input type="radio"/> NOV	<input type="radio"/>	8	8
9	9	<input type="radio"/> DEC	<input type="radio"/>	9	9

- Don't know day
 Don't know month
 Don't know year

A3. What was the highest level of education that you completed?

- Primary school (some or all)
- Secondary school - year 7 or year 8
- Secondary school - year 9 or year 10
- Secondary school - year 11 or year 12
- Vocational training (e.g. technical college, business college, nursing)
- University - did not graduate
- University - graduated
- Don't know

A4. Are you currently . . . ?

- Married
- Widowed
- Never married
- Living as married
- Separated
- Divorced
- Don't know

A5. In which suburb or town do you usually live?

Postcode:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

A6. In which country were you, your parents and your grandparents born?

	You	Your mother	Your mother's mother	Your mother's father	Your father	Your father's mother	Your father's father
Australia	<input type="radio"/>						
New Zealand	<input type="radio"/>						
England	<input type="radio"/>						
Scotland	<input type="radio"/>						
Ireland	<input type="radio"/>						
Germany	<input type="radio"/>						
Netherlands	<input type="radio"/>						
Italy	<input type="radio"/>						
Poland	<input type="radio"/>						
Croatia	<input type="radio"/>						
Greece	<input type="radio"/>						
Malta	<input type="radio"/>						
South Africa	<input type="radio"/>						
India	<input type="radio"/>						
Sri Lanka	<input type="radio"/>						
Vietnam	<input type="radio"/>						
Philippines	<input type="radio"/>						
China	<input type="radio"/>						
Don't know	<input type="radio"/>						
Other, specify below	<input type="radio"/>						

--	--	--	--	--	--	--

If you were born in Australia go to question A8.

A7. For how many years have you lived in Australia?

			0	1	2	3	4	5	6	7	8	9
			0	1	2	3	4	5	6	7	8	9
			0	1	2	3	4	5	6	7	8	9

Don't know

A8. In which religion were you, your parents and your grandparents born?

	You	Your mother	Your mother's mother	Your mother's father	Your father	Your father's mother	Your father's father
Protestant - Anglican	<input type="radio"/>						
Eastern Orthodox	<input type="radio"/>						
Catholic	<input type="radio"/>						
Muslim	<input type="radio"/>						
Buddhist	<input type="radio"/>						
Hindu	<input type="radio"/>						
Latter Day Saints/Mormon	<input type="radio"/>						
Seventh day Adventist	<input type="radio"/>						
Sephardic Jewish	<input type="radio"/>						
Ashkenazi Jewish	<input type="radio"/>						
Other or uncertain Jewish	<input type="radio"/>						
None	<input type="radio"/>						
Don't know	<input type="radio"/>						
Other, specify below	<input type="radio"/>						
	<input type="text"/>						

A9. Which religion do you currently practice?

- | | |
|--|---|
| <input type="radio"/> Protestant/Anglican | <input type="radio"/> Seventh Day Adventist |
| <input type="radio"/> Eastern Orthodox | <input type="radio"/> Sephardic Jewish |
| <input type="radio"/> Catholic | <input type="radio"/> Ashkenazi Jewish |
| <input type="radio"/> Muslim | <input type="radio"/> Other or uncertain Jewish |
| <input type="radio"/> Buddhist | <input type="radio"/> None |
| <input type="radio"/> Hindu | <input type="radio"/> Don't know |
| <input type="radio"/> Latter Day Saints/Mormon | <input type="radio"/> Other, specify _____ |

A10. What is your ethnic background? (Fill in as many as apply)

- | | |
|---|--|
| <input type="radio"/> White/Caucasian | <input type="radio"/> Indian |
| <input type="radio"/> Aboriginal/Torres Strait Islander | <input type="radio"/> Pakistani |
| <input type="radio"/> Sri Lankan | <input type="radio"/> Korean |
| <input type="radio"/> Pacific Islander | <input type="radio"/> Maori |
| <input type="radio"/> Chinese | <input type="radio"/> Thai |
| <input type="radio"/> Japanese | <input type="radio"/> Indonesian |
| <input type="radio"/> Malaysian | <input type="radio"/> Cambodian |
| <input type="radio"/> Vietnamese | <input type="radio"/> Don't know |
| <input type="radio"/> Filipino | <input type="radio"/> Other, specify _____ |

C. Surgery and Mammograms

The next section asks questions about surgery and mammograms.

C1. Have you ever had a breast completely removed?

Yes, the right breast

Age when removed:

Don't know

Yes, the left breast

Age when removed:

Don't know

No

Don't know

C2. Have you ever had a BREAST BIOPSY or LUMPECTOMY that was diagnosed as cancer? By BREAST BIOPSY we mean breast tissue removed by surgery but excluding fine needle biopsy.

Yes (see below)

No

Don't know

Age when first removed:

Don't know

C3. Have you ever had a BREAST BIOPSY for BENIGN BREAST DISEASE, such as a NON-CANCEROUS CYST or a BREAST LUMP? By BREAST BIOPSY we mean breast tissue removed by surgery but excluding fine needle biopsy.

Yes (see below)

No

Don't know

Age when first removed:

Don't know

C4. Have you ever had one or both ovaries removed? If your ovaries were removed at different times, please give your age at the most recent operation.

Yes, one ovary

Age when removed:

Don't know

Yes, both ovaries

Age when removed:

Don't know

No

Don't know

C5. What is your usual bra size?

Don't know

C6. Have you ever had a mammogram (X-ray examination of the breasts)?

Yes

No (Go to question D1.)

Don't know (Go to question D1.)

C7. When and where did you have your last mammogram?

<input type="text"/>	<input type="text"/>	<input type="radio"/> JAN	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> FEB	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> MAR	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> APR	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> MAY	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> JUN	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> JUL	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> AUG	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> SEP	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> OCT	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> NOV	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> DEC	<input type="text"/>	<input type="text"/>	<input type="text"/>

Don't know day

Don't know month

Don't know year

Clinic: _____

Address: _____

C8. How many mammograms have you had?

Mammograms:

Don't know

F. Alcohol

The next section asks about alcoholic beverages that you may have consumed.

F1. Have you ever consumed any alcoholic beverages, such as beer, wine or spirits, at least once a week for six months or longer?

- Yes
- No (Go to question F6.)
- Don't know (Go to question F6.)

F3. For how many years in total did you consume alcoholic beverages AT LEAST ONCE A WEEK?

Total years:
 Don't know

F2. At what age did you FIRST start drinking alcoholic beverages AT LEAST ONCE A WEEK?

Years:
 Don't know

F4. Are you consuming alcohol AT LEAST ONCE A WEEK?

- Yes
- No (see below)
- Don't know

Age stopped drinking:
 Don't know

F5. During the period when you drank AT LEAST ONCE PER WEEK, how often did you drink (type)?

STANDARD DRINKS	Never	Less than once a month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	≥6 per day	Don't know
Light beer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spirits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

F6. Over the previous 12 months, how often did you drink (type)?

STANDARD DRINKS	Never	Less than once a month	1-3 per month	1 per week	2-4 per week	5-6 per week	1 per day	2-3 per day	4-5 per day	≥6 per day	Don't know
Light beer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spirits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

F7. Between the ages of 18 and 21, how many alcoholic drinks did you usually have per day or per week?

Per day
 Per week
 Don't know

G. Reproductive History

This section deals with menstruation, pregnancies and the use of contraceptives.

G1. Have you ever had a menstrual period?

- Yes (See below)
- No
- Don't know

Age at first menstrual period:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

G2. Has a doctor ever told you that you had primary amenorrhea (failure of menstrual period to start naturally)?

- Yes (See below)
- No
- Don't know

Age when first diagnosed:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

G3. Have you ever used birth control pills or other hormonal contraceptives (implants or injections)?

- Yes (See below)
- No (Go to question G6.)
- Don't know (Go to question G6.)

Age when first used birth control pills:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

G4. Are you currently taking birth control pills or hormones?

- Yes (See below)
- No (See below)
- Don't know

Age when last took birth control pills:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

G5. In total, for how many weeks, months or years had you taken birth control pills or hormones?

- | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|------------------------------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|-----------------------------|
| <input style="width: 20px; height: 20px;" type="text"/> | <input style="width: 20px; height: 20px;" type="text"/> | <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr></table> | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | <input type="radio"/> Weeks |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | | | | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | | | | | | | | | | | | | |
| | | | <input type="radio"/> Months | | | | | | | | | | | | | | | | | | | | |
| | | | <input type="radio"/> Years | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> Don't know | | | | | | | | | | | | | | | | | | | | | | | |

G6. Have you ever been pregnant?

- Yes
- No (Go to question J1.)
- Don't know (Go to question J1.)

G7. Have you ever had a full term pregnancy?

- Yes
- No (Go to question H1.)
- Don't know (Go to question H1.)

If never taken birth control pills go to question H1.

G8. In total, for how many weeks, months or years did you take birth control pills before your first full-term pregnancy?

- | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--|------------------------------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|-----------------------------|
| <input style="width: 20px; height: 20px;" type="text"/> | <input style="width: 20px; height: 20px;" type="text"/> | <table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr><tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr></table> | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | <input type="radio"/> Weeks |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | | | | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | | | | | | | | | | | | | |
| | | | <input type="radio"/> Months | | | | | | | | | | | | | | | | | | | | |
| | | | <input type="radio"/> Years | | | | | | | | | | | | | | | | | | | | |
| <input type="radio"/> Don't know | | | | | | | | | | | | | | | | | | | | | | | |

G9. Was this during one continuous time span?

- Yes
- No
- Don't know

H1. On what date did your (first/next) pregnancy end?	H2. What was the outcome of this pregnancy?	H3. Taking 40 weeks as the usual length, how long was this pregnancy?	H4. IF LIVEBIRTH OR STILLBIRTH. What was the sex of the child(ren)?	H5. IF LIVEBIRTH. Did you breastfeed the child(ren)?	H6. IF BREASTFED. For how many weeks or months did you breastfeed the child(ren)?
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H7. How many PREGNANCIES have you had?

Pregnancies:

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<input type="text"/>									

 Don't know

H10. How old were you when your LAST (live) child was born?

Years of age:

<input type="text"/>									
<input type="text"/>									

 Don't know

H8. How many LIVE BIRTHS have you had?

Live births:

<input type="text"/>									
<input type="text"/>									

 Don't know

H11. Did you ever breastfeed a child for one month or more?

Yes
 No
 Don't know

H9. How old were you when your FIRST (live) child was born?

Years of age:

<input type="text"/>									
<input type="text"/>									

 Don't know

J. Menopause and Hormone Replacement Therapy

The next section asks questions about menopause and hormone replacement therapy.

J1. How long ago was your last period?

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

- Weeks
 Months
 Years
 Never had a period (Go to question J5.)
 Don't know

J2. Have your menstrual periods stopped for ONE YEAR OR MORE? Please do not include times when your period stopped when you were pregnant, breast feeding or due to serious illness (eg. anorexia) or strenuous exercise.

- Yes (See below)
 No (Go to question J5.)
 Don't know

Age when period stopped:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

J3. Why did your menstrual periods stop?

- Natural menopause (that is, periods stopped by themselves) (Go to question J5.)
 Surgery or other medical treatment
 Don't know (Go to question J5.)

J4. What surgery or other medical treatment did you receive that made your periods stop? (Fill in as many as apply)

- Hysterectomy (uterus or womb removed)
 Both ovaries removed
 Radiation or chemotherapy
 Don't know
 Other (specify) _____

J5. Have you ever taken oestrogens, progesterone or other female hormones for menopause? The preparation may be pills, injections, skin patches, vaginal creams or vaginal suppositories. This question does not include oral contraceptive (birth control) pills.

- Yes (See below)
 No (Go to question J9.)
 Don't know (Go to question J9.)

Age when first took hormones:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

J6. Were you still having periods when you first took oestrogens, progesterone or other female hormones?

- Yes
 No
 Don't know

J7. Are you currently taking oestrogens, progesterone or other female hormones?

- Yes
 No (See below)
 Don't know

Age when last took hormones:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

J8. In total for how many weeks, months or years did you take oestrogens, progesterone or other female hormones?

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Weeks
 Months
 Years
 Don't know

J9. Have you ever taken a drug for infertility (that is, to try to become pregnant) or because your periods stopped?

- Yes (See below.)
 No (Go to question J13.)
 Don't know (Go to question J13.)

Age when first started this drug:

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Don't know

J10. Was the drug prescribed for infertility as part of GIFT (gamete intra-fallopian transfer) or IVF (in vitro fertilisation) treatment?

- Yes
 No
 Don't know

J11. In total for how many weeks, months or years did you take this type of drug?

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

Weeks
 Months
 Years
 Don't know

K2. Have you ever had any of the following types of X-ray examinations that included the lower abdomen or pelvis?

Barium examination of lower bowel

Number of x-ray examinations:

 Don't know

Age at first x-ray examination:

 Don't know

CT scan or X-rays of the lower spine or pelvis

Number of x-ray examinations:

 Don't know

Age at first x-ray examination:

 Don't know

Other intensive X-rays of the lower abdomen or pelvis (specify):

Number of x-ray examinations:

 Don't know

Age at first x-ray examination:

 Don't know

None
 Don't know

K3. Have you ever been TREATED with radiation that included the chest area for any of the following conditions?

Tuberculosis

Number of treatments:

 Don't know

Age at first treatment:

 Don't know

Cancer

Number of treatments:

 Don't know

Age at first treatment:

 Don't know

Acne

Number of treatments:

 Don't know

Age at first treatment:

 Don't know

Mastitis

Number of treatments:

 Don't know

Age at first treatment:

 Don't know

Enlarged thymus gland

Number of treatments:

 Don't know

Age at first treatment:

 Don't know

Hemangioma

Number of treatments:

 Don't know

Age at first treatment:

 Don't know

Other intensive X-rays of the chest areas (specify):

Number of treatments:

 Don't know

Age at first treatment:

 Don't know

None
 Don't know

K4. Have you ever been TREATED with radiation that included the lower abdomen or pelvis for any of the following conditions?

Cancer

Number of treatments:

 Don't know

Age at *first* treatment:

 Don't know

Bleeding from the uterus or womb

Number of treatments:

 Don't know

Age at *first* treatment:

 Don't know

Growth on the uterus or womb

Number of treatments:

 Don't know

Age at *first* treatment:

 Don't know

Other (specify):

Number of treatments:

 Don't know

Age at *first* treatment:

 Don't know

None
 Don't know

K5. Have you participated in other research studies of familial cancer, or attended a cancer family clinic?

No
 Yes (specify) _____

L. Twin and Other Questions

L1. Are you a twin?

Yes
 No (Go to question L4.)
 Don't know

L2. Non-identical twins are no more alike than ordinary brothers and sisters. Genetically identical twins, on the other hand, look so much alike (that is, they have such a strong resemblance to each other in stature, colouring, features of the face, etc.) that people often mistake one for the other, especially during their childhood. Do you think that you and your twin are genetically identical?

Yes
 No
 Don't know

L3. May we pass your name to the Australian NHMRC Twin Registry?

Yes
 No

