Introduction to the questionnaire

Thank you for agreeing to participate in this study. We are most grateful for your help.

About the contents of the questionnaire

Breast cancer is probably caused by a complex interplay of many different factors throughout life. The questions asked in this questionnaire cover a wide range of factors, some known to be associated with breast cancer, some suspected, and some that are included because they are frequently asked about by women, and give rise to anxiety without a scientific basis. Therefore you should not imply that the inclusion of a particular factor in the questionnaire means that it is causal or preventive for breast cancer – just that it is a factor that we are trying to find out about.

In testing the questionnaire with several hundred women, and in discussing it with groups, the views we heard, often from the same person, were: (1) that the questionnaire should include more questions, and ask in more detail, on particular issues the respondent was interested in, and (2) that it should be shorter. The two are of course contradictory, and to avoid trying women's patience beyond reason, we have had to strike a balance between the wish to include as many topics and as much detail as possible, and the need for the questionnaire to be of manageable length. We hope, therefore, that you will persevere with the questionnaire even if it seems to you longer, or less expansive (or both), than you would wish.

Confidentiality

We would like to stress again that your answers will be treated in the strictest confidence and will not be disclosed to any third party, including your doctors, unless you give us written permission to do so. The information you provide will only be used for statistical analysis. It will not be possible to identify individuals in any results.

How to answer

In order to include as many women as possible in this study, tens of thousands of questionnaires will need to be read by computer. To facilitate this it would be most helpful if you would write in black or blue ink and keep to the following instructions:

- For questions requiring you to indicate a choice, please cross, not tick, the box of your answer, like this: Yes [X] No [ ]
- If you have made a mistake, fill in the box with the wrong answer solidly and then cross the correct answer, like this: Yes [■] No [X]
- If you are asked to provide some details in words, please answer in block capital letters, writing one letter per space, like this: [B R E A S T]
- If a number is requested, write it in the box, like this: [1 9 6 4]
- If you do not know or cannot remember the answer to a question, or the question does not apply to you, please leave it blank: [ ]
- If the text box is not long enough for you, please continue neatly after or underneath the box, like this: [F O R M O R E] THAN 5 YEARS
- If your answer requires a fraction, round this down. For instance, round down 5ft 9¾ inches to 5ft 9 inches. [5] Feet [9] Inches
- If there is not enough space for any of your answers, please complete them on the sheet at the back of the questionnaire, or write them on separate sheets and return them with the questionnaire.
- Please do not staple or stick extra sheets to the questionnaire pages.

If you would like to talk to someone about the study, please call a member of the research team on the telephone number below. They will be able to help with any questions that you find unclear and answer any queries you may have.

The Breakthrough Generations Study Team
Institute of Cancer Research
15, Cotswold Road
Sutton
SM2 5NG
Telephone: 020 8722 4469

1: General information about you

Please complete the following general information about you.

1:1 Surname

First name(s)

Any other surnames (e.g. maiden name)

1:2 Has your home address changed from the one at which we mailed you? Yes ☐ No ☐

➔ **If yes,** please give new address below:

Home address

Postcode

1:3 Telephone number(s) on which you may be contacted:

Contact tel. 1 Ext. Day ☐ Evening ☐ Either ☐

Contact tel. 2 Ext. Day ☐ Evening ☐ Either ☐

1:4 E-mail address:

- Would you be happy to be contacted by e-mail at this address in the future? Yes ☐ No ☐ No e-mail ☐

1:5 Name of your GP Dr. Don't know ☐

Town of GP practice

1:6 What is your NHS number?
(This is the 10-digit number on your GP registration card)

The following is some general demographic information about you. This includes some information about your ethnic background, because risks of breast cancer seem to relate to ethnicity.

1:7 What is your current occupation?

☐ Paid or self-employed job ☐ Housewife ☐ Student

☐ Unemployed ☐ Retired ☐ Other

1:8 Please specify your current occupation, or if you are not currently working, your former usual occupation

1:9 How old were you when you left full time education (if you are not currently a student)? ☐☐ years old

1:10 What is your current marital status?

☐ Single, never married ☐ Married ☐ Separated/divorced

☐ Cohabiting ☐ Widowed ☐ Other

If other, please specify:

If married or cohabiting, what is your husband's/partner's current occupation, or if not currently working, their former usual occupation?

1:11 To which ethnic group do you consider you belong? *(Cross more than one box if applicable)*

☐ White ☐ Indian ☐ Jewish-Ashkenazi

☐ Black-Caribbean ☐ Pakistani ☐ Jewish-Sephardi

☐ Black-African ☐ Bangladeshi ☐ None of these *(please specify below)*

☐ Black-Other ☐ Chinese

If none of these, how would you describe yourself:

2: About your birth

2:1 What is your date of birth? Day ☐☐ Month ☐☐ Year ☐☐☐☐

2:2 In which country were you born? ☐ United Kingdom ☐ Other

If not UK, please specify:

2:3 In which town or region were you born?

2:4 Were you born in a hospital or at some other place? *(Cross one box)*

- ☐ In a hospital
- ☐ In a nursing home

} In which hospital or nursing home? ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

- ☐ At home
- ☐ Other — **If other**, please specify ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
- ☐ Don't know

2:5 Are you a twin or single born? Single born ☐ Twin ☐ Triplet or higher ☐ Don't know ☐

If 'triplet or higher', please give details on page 15:1

Twins only

2:6 Is your co-twin also female? **Yes** ☐ **No** ☐

If 'no', go to question 2:9

→ **If yes,** are you identical or non-identical twins? Identical ☐ Non-identical ☐ Don't know ☐

- How do you know? *(Please answer for each category)*

Parents told us	Yes ☐	No ☐	We look similar	Yes ☐	No ☐
Doctor said so	Yes ☐	No ☐	We look different	Yes ☐	No ☐
Blood test	Yes ☐	No ☐	Other reasons	Yes ☐	No ☐

2.7 As children, were you and your twin mistaken for each other by: *(Please answer for each category)*

Parents	Yes ☐	No ☐	Don't know ☐
Brothers and sisters	Yes ☐	No ☐	Don't know ☐
Close friends	Yes ☐	No ☐	Don't know ☐
Casual friends	Yes ☐	No ☐	Don't know ☐
Class-mates	Yes ☐	No ☐	Don't know ☐

2.8 When growing up, were you described as being:

- ☐ As alike as two peas in a pod
- ☐ Very alike but not completely identical
- ☐ Of ordinary family likeness
- ☐ Not alike
- ☐ Don't know

Your mother's pregnancy with you

2:9 How many weeks was your mother pregnant with you when you were born? ☐☐ Weeks *or* Don't know ☐

→ **If don't know**, do you know roughly whether you were born about the time expected or earlier or later?

Early ☐ About the time expected ☐

Late ☐ Don't know ☐

2:10 What was your birth weight? ☐☐ Lbs ☐☐ Oz *or* ☐☐☐☐ Grams

→ **If you do not know your birth weight,** have you been told that you were: Average ☐ Unusually light/small ☐ Unusually heavy/large ☐ Don't know ☐

2:11 How many pregnancies did your mother have before you were born?
(If none enter '00'. Count twins as 1 pregnancy, and include stillbirths but not miscarriages or terminations) ☐☐ Pregnancies Don't know ☐

2:12 Were you delivered by caesarean section? Yes ☐ No ☐ Don't know ☐

→ **If yes,** please specify the reason

2:13 Did your mother have pre-eclampsia or eclampsia while she was pregnant with you? Yes ☐ No ☐ Don't know ☐
This condition would have given her raised blood pressure, swelling, headaches and possibly convulsions

2:14 Did your mother have any other complications while she was pregnant with you? Yes ☐ No ☐ Don't know ☐

→ **If yes,** please specify

2:15 Were you nursed in an incubator or in a special care baby unit after you were born? Yes ☐ No ☐ Don't know ☐

2:16 Did you have any medical or physical abnormalities present when you were born? Yes ☐ No ☐ Don't know ☐

→ **If yes,** please specify

3: Your physical development and body size

The following questions are about your growth during childhood and your body size. If you cannot remember details, please give your best guess.

Your weight

3:1 At the age of 7 years, were you thinner, about the same or heavier than other girls of your age?

☐ Much thinner ☐ A little thinner ☐ About the same
☐ Much heavier ☐ A little heavier ☐ Don't remember

3:2 At the age of 11 years, were you thinner, about the same or heavier than other girls of your age?

☐ Much thinner ☐ A little thinner ☐ About the same

☐ Much heavier ☐ A little heavier ☐ Don't remember

3:3 What was your non-pregnant weight at the age of 20? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

3:4 **If you are aged 40 or more**
What was your non-pregnant weight at the age of 40? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

3:5 **If you are aged 60 or more**
What was your weight at the age of 60? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

3:6 What is the lowest weight you have had since age 18? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

- This was at age ☐☐ years

3:7 What is the greatest (non-pregnant) weight you have had since age 18? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

- This was at age ☐☐ years

If it is practical, we would be grateful if you would weigh yourself on scales today, and write down your weight in light clothes without shoes. If that is not practical, please tell us your current weight as best you know it.

3:8 What is your current weight? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

- When was your weight measured? ☐ Today ☐ In the last few months ☐ Not measured, it is an estimate

Your height

3:9 At the age of 7 years, were you relatively shorter, about the same height, or taller than other girls of your age?

☐ Much shorter ☐ A little shorter ☐ About the same

☐ Much taller ☐ A little taller ☐ Don't remember

3:10 At the age of 11 years, were you relatively shorter, about the same height, or taller than other girls of your age?

☐ Much shorter ☐ A little shorter ☐ About the same

☐ Much taller ☐ A little taller ☐ Don't remember

3:11 At what age did you stop growing taller? [ ] years *or* Don't remember [ ]

3:12 **If older than 20 years,**
what was your height at age 20? [ ] Feet [ ] Inches *or* [ ] Centimetres

3:13 What is your current height? [ ] Feet [ ] Inches *or* [ ] Centimetres

3:14 Do you have any records of your measured height at any point in your childhood?
(For instance some people have kept wall charts, or records their mother kept) Yes [ ] No [ ]

➔ **If yes,** please list below any recorded height you know under age 16:

Date, as exactly as you know it			or	Age		My height was			
Day	Month	Year		Years	Months	Feet	Inches		Centimetres
[ ]	[ ]	[ ]	or	[ ]	[ ]	[ ]	[ ]	or	[ ]
[ ]	[ ]	[ ]	or	[ ]	[ ]	[ ]	[ ]	or	[ ]
[ ]	[ ]	[ ]	or	[ ]	[ ]	[ ]	[ ]	or	[ ]

If you have further measurements please list on page 15:1

3:15 Are there any institutions that may have records of your height in childhood
for instance, a school or, if you were ill, a hospital? Yes [ ] No [ ]

➔ **If yes,** please state what the institutions were, and at what age or range of ages they measured you

1) Name of institution [ ]

Town [ ]

Age [ ] *or* age range [ ] to [ ]

2) Name of institution [ ]

Town [ ]

Age [ ] *or* age range [ ] to [ ]

If you have further measurements, please list on page 15:1

Development in puberty, and shape

3:16 How old were you when you first started to develop breasts? [ ] years *or* Don't remember [ ]

3:17 What is your current bra cup size? *(Cross only one option)*
If you are currently pregnant or breast feeding, please give your usual cup size before the pregnancy.
If you have had a mastectomy, please enter your cup size before the surgery.

☐ AA ☐ C ☐ E ☐ FF ☐ J
☐ A ☐ D ☐ EE ☐ G ☐ Other
☐ B ☐ DD ☐ F ☐ H **If other,** please specify ☐

3:18 **If over age 20,** what was your bra cup size at age 20? *(Cross only one option)*
If you were pregnant or breast feeding, please give your cup size before the pregnancy around age 20.

☐ AA ☐ C ☐ E ☐ FF ☐ J
☐ A ☐ D ☐ EE ☐ G ☐ Other
☐ B ☐ DD ☐ F ☐ H **If other,** please specify ☐

3:19 Is there a difference in size between your left and right breasts? Yes, left larger ☐ Yes, right larger ☐
Not applicable ☐ No ☐

➔ **If yes,** about how large is the difference between your left and right breasts? Less than 1 cup size ☐
About 1 cup size or more ☐

We would like to know your waist and hip circumferences. Again, if it is practical it would be best if you were able to tell us the actual measurement today, using a tape measure.

3:20 What is your waist circumference? ☐☐ Inches *or* ☐☐☐ Centimetres

If practical, please measure this as the number of inches or centimetres around your waist, holding the tape measure about 1 inch above your umbilicus (belly button). If not practical, please give an estimate.

- When was this measured? ☐ Today ☐ In the last few months ☐ Not measured, it is an estimate

3:21 What is your hip circumference? ☐☐ Inches *or* ☐☐☐ Centimetres

If practical, please measure this as the number of inches or centimetres around the widest part of your hips. If not practical, please give an estimate.

- When was this measured? ☐ Today ☐ In the last few months ☐ Not measured, it is an estimate

We would like to ask you to measure your arm span. In order to do this you would need the help of someone else. If this is not practical or if you do not have help, please cross the "not practical" box below. To measure your arm span, spread out your arms at shoulder level, and measure the distance from the tip of your longest finger of one hand to the tip of the longest finger of your other hand.

3:22 What is your arm span? ☐ Feet ☐☐ Inches *or* ☐☐☐ Centimetres Not practical ☐

4: Your menstrual cycle and menopause

This section includes questions about menstruation (your periods) and your menopause, if applicable to you.

Periods

4:1 Have you ever had any periods? **Yes** ☐ **No** ☐

If 'no', go to question 4.10 →

→ **If yes,** how old were you when you had your first period? ☐☐ years

4:2 How old were you when you began having regular cycles? (i.e. you had a period every month and could predict within 5 days when it would start)? ☐☐ years

Never had regular cycles ☐ Don't remember ☐

4:3 How did your periods become regular?

☐ Naturally ☐ Never did become regular

☐ Birth control pills ☐ After pregnancy ☐ Other

The following questions are about details of your menstrual cycle currently and when you were around 20 years of age and around 40 years of age. Think of a time around these ages when you were *not* pregnant, breastfeeding, or taking oral contraceptives (the pill). If you are aged under 40 or under 20, just leave out the columns that do not apply to you. If you have already passed the menopause, leave out the 'Now' column.

		Now	**Around age 20**	**Around age 40**
4:4	About how many days were there usually from the first day of one menstrual period to the first day of the next?	☐☐ Days ☐ Don't know	☐☐ Days ☐ Don't know	☐☐ Days ☐ Don't know
4:5	Did you usually have any breast discomfort before the start of your periods?	☐ No ☐ Yes ☐ Not applicable ☐ Don't know	☐ No ☐ Yes ☐ Not applicable ☐ Don't know	☐ No ☐ Yes ☐ Not applicable ☐ Don't know
4:6	Did you have **irregular** cycles around these ages? (Could not predict within 5 days in either direction when the next period would start)	☐ No ☐ Yes ☐ Not applicable ☐ Don't know	☐ No ☐ Yes ☐ Not applicable ☐ Don't know	☐ No ☐ Yes ☐ Not applicable ☐ Don't know
4:7	What was the number of days of flow, on average:	☐☐ Days	☐☐ Days	☐☐ Days

Cessation of periods and menopause

4:8 **Have your periods ever temporarily stopped** *(when not pregnant or breast feeding or on the contraceptive pill)* for more than three months – for instance, because of a medical condition, an eating disorder, athletic training, gymnastics, ballet or modelling? **Yes** ☐ **No** ☐

➔ **If yes,** how old were you when your periods stopped temporarily? ☐ years

- For how long did your periods stop? ☐ Years ☐ Months
- What was the reason for your periods stopping temporarily? ☐
- If there was another occasion when your periods stopped temporarily for more than 3 months, please cross this box and give details on page 15:1 ☐

4:9 **Have your periods now stopped completely?** *(That is, have you now gone at least 6 months without having a period and you are not pregnant or on the contraceptive pill)* Yes ☐ No ☐ Not applicable ☐ Don't know ☐

If 'no' go to question 4:10

If shortly before the age at which you expected your periods to cease, you started to take hormone replacement therapy that caused you to have periods, and therefore you do not know at what age you reached natural menopause, please cross this box and go to question 4:10. ☐

➔ **If your periods have stopped,** how old were you when your periods stopped completely? ☐ years

- What was the reason for your periods stopping?
  ☐ Natural menopause ☐ Surgery (e.g. hysterectomy/removal of ovaries)
  ☐ Chemotherapy, radiation, or other treatment ☐ Don't know ☐ Other
  If other, please specify ☐
- Before your last period how would you describe your cycle?
  ☐ Regular until my last period ☐ Irregular for ☐ years before my last period
  ☐ Always irregular
- Did you ever have hot flushes during your menopause? Yes ☐ No ☐

Operations on and diseases of your ovaries or uterus (womb)

4:10 Have you ever had an operation on your ovaries or uterus (womb)? **Yes** ☐ **No** ☐

If 'no', go to question 4:13 →

→ **If yes, First operation**

- What was the operation *(cross as many as apply)?*

☐ Both ovaries removed

☐ Only one ovary removed, on the Left ☐ Right ☐ Don't know side ☐

☐ Only part of an ovary removed, on the Left ☐ Right ☐ Don't know side ☐

☐ Total removal of your uterus (hysterectomy) or part of your uterus

☐ Other

If other, please specify type of operation and side

Left ☐ Right ☐ Don't know side ☐

- What was the operation for?
- How old were you at the time? ☐☐ years
- Where was the operation undertaken?

Hospital

Town

4:11 Did you have any further surgery to your ovaries or uterus (womb)? **Yes** ☐ **No** ☐

If 'no', go to question 4:13 →

→ **If yes, Second operation**

- What was the operation *(cross as many as apply)?*

☐ Both ovaries removed

☐ Only one ovary removed, on the Left ☐ Right ☐ Don't know side ☐

☐ Only part of an ovary removed, on the Left ☐ Right ☐ Don't know side ☐

☐ Total removal of your uterus (hysterectomy) or part of your uterus

☐ Other

If other, please specify type of operation and side

Left ☐ Right ☐ Don't know side ☐

- What was the operation for?
- How old were you at the time? ☐☐ years

- Where was the operation undertaken?

Hospital

Town

4.12 Did you have any further surgery to your ovaries or uterus (womb)? **Yes** ☐ **No** ☐

➔ **If yes,** please give the same information for each operation in page 15:1 as you gave for questions 4.10 to 4.11

Other diseases of ovary and uterus (womb)

4.13 Have you been diagnosed by a doctor with:

Endometriosis? Yes ☐ No ☐

Fibroids of the uterus? Yes ☐ No ☐

Polycystic ovaries? Yes ☐ No ☐

Any other ovarian or uterine disease not requiring surgery? Yes ☐ No ☐

If other disease,
please describe what it was

5: Information about your fertility and pregnancies

Infertility

5.1 Was there ever a time as long as a year or more when you tried to get pregnant, but did not? Yes ☐ No ☐ Does not apply ☐

➔ **If yes,** how old were you when this first occurred? ☐☐ years

5:2 Have you ever been told by a doctor that you or your partner had an infertility problem? **Yes** ☐ **No** ☐

If 'no' go to question 5:3 →

→ **If yes,** what was the reason for the difficulty in conceiving?

☐ I did not ovulate regularly
☐ I had a hormone imbalance
☐ Blocked tubes
☐ Other
☐ Endometriosis
☐ Partner had low sperm count or other problem
☐ Don't know

If other, please specify

- Were you given fertility drugs or hormones to help you conceive? Yes ☐ No ☐ Don't know ☐

→ **If yes,** at what age were you first treated ☐☐ years

At what age were you last treated? ☐☐ years

Pregnancies

5:3 Have you ever been pregnant? Yes ☐ No ☐ Don't know ☐

If 'no', go to question 6:1 →

→ **If yes,** how many pregnancies have you had in total?
(not including the current one, if you are currently pregnant) ☐☐

- Are you currently pregnant? Yes ☐ No ☐ Not sure ☐

- Please fill in details on the next page(s) for each time you have been pregnant. This should include any ectopic pregnancies, and any pregnancies that resulted in miscarriage, induced abortion or stillbirth.

  Each column refers to a single pregnancy and needs to be filled in from top to bottom.

  If you are currently pregnant, there is no need to include this pregnancy in the table. The table is designed for up to 6 pregnancies. If you had more than 6 pregnancies please cross here and fill in the details of the 7th and later pregnancies on page 15:1 ☐

	Pregnancy	1st			2nd			3rd		
		Day	Mth	Year	Day	Mth	Year	Day	Mth	Year
5:4	Date pregnancy ended									

		1st	2nd	3rd
5:5	Outcome of pregnancy			
	Single live born infant	☐	☐	☐
	Twins, both live born	☐	☐	☐
	Twins, one live born	☐	☐	☐
	Twins, neither live born	☐	☐	☐
	Triplets or higher order birth *(please enter details on page 15:1)*	☐	☐	☐
	Miscarriage	☐	☐	☐
	Induced abortion	☐	☐	☐
	Stillborn child	☐	☐	☐
	Ectopic pregnancy	☐	☐	☐
5:6	Length of pregnancy (weeks)			
5:7	Did you have severe vomiting in the first 3 months of pregnancy? (i.e. every day for at least a week)			
	Yes	☐	☐	☐
	No	☐	☐	☐
	Don't know	☐	☐	☐
5:8	Did you suffer from eclampsia or pre-eclampsia (raised blood pressure during pregnancy)?			
	Yes	☐	☐	☐
	No	☐	☐	☐
	Don't know	☐	☐	☐
5:9	Sex of child, if known *(if triplets or more please enter details on page 15:1)*			
	Boy	☐	☐	☐
	Girl	☐	☐	☐
	If twins Boy-Boy	☐	☐	☐
	Boy-Girl	☐	☐	☐
	Girl-Girl	☐	☐	☐
5:10	Birthweight, if known *(if twins or triplets or more please enter details at page 15:1)*			
	grams			
	or			
	lbs, oz	,	,	,
5:11	Number of weeks breast fed			
5:12	Did you receive pills or hormone injections to dry up your milk secretion?			
	Yes	☐	☐	☐
	No	☐	☐	☐

Pregnancy

		4th			5th			6th		
		Day	Mth	Year	Day	Mth	Year	Day	Mth	Year
5:13	Date pregnancy ended									

5:14 Outcome of pregnancy

	4th	5th	6th
Single live born infant	☐	☐	☐
Twins, both live born	☐	☐	☐
Twins, one live born	☐	☐	☐
Twins, neither live born	☐	☐	☐
Triplets or higher order birth *(please enter details on page 15:1)*	☐	☐	☐
Miscarriage	☐	☐	☐
Induced abortion	☐	☐	☐
Stillborn child	☐	☐	☐
Ectopic pregnancy	☐	☐	☐

5:15 Length of pregnancy (weeks) ☐☐ ☐☐ ☐☐

5:16 Did you have severe vomiting in the first 3 months of pregnancy? (i.e. every day for at least a week)

	4th	5th	6th
Yes	☐	☐	☐
No	☐	☐	☐
Don't know	☐	☐	☐

5:17 Did you suffer from eclampsia or pre-eclampsia (raised blood pressure during pregnancy)?

	4th	5th	6th
Yes	☐	☐	☐
No	☐	☐	☐
Don't know	☐	☐	☐

5:18 Sex of child, if known *(if triplets or more please enter details on page 15:1)*

		4th	5th	6th
	Boy	☐	☐	☐
	Girl	☐	☐	☐
If twins	Boy-Boy	☐	☐	☐
	Boy-Girl	☐	☐	☐
	Girl-Girl	☐	☐	☐

5:19 Birthweight, if known *(if twins or triplets or more please enter details at page 15:1)*

		4th	5th	6th
	grams	☐☐☐☐	☐☐☐☐	☐☐☐☐
or	lbs, oz	☐☐, ☐☐	☐☐, ☐☐	☐☐, ☐☐

5:20 Number of weeks breast fed ☐☐ ☐☐ ☐☐

5:21 Did you receive pills or hormone injections to dry up your milk secretion?

	4th	5th	6th
Yes	☐	☐	☐
No	☐	☐	☐

5:22 Which breast did you use for breast feeding?

- ☐ Entirely left
- ☐ Entirely right
- ☐ Mainly left
- ☐ Mainly right
- ☐ Equally both sides
- ☐ Never breast fed

5:23 What was your weight at the beginning of your **first** pregnancy? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

5:24 What was your weight at the beginning of your **last** pregnancy? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

5:25 Have you ever taken hormones to maintain a pregnancy (because you were at risk of miscarriage)? Yes ☐ No ☐

→ **If yes,** at what age were you treated? ☐☐ years

6: Contraceptive pill and hormone replacement therapy

Oral contraceptives

We would like to know about any periods of time when you used the contraceptive pill ("the pill"). If you stopped and re-started the same pill within 6 months, treat this as a single episode. If you re-started after 6 months or longer enter this as a new episode.

6:1 Have you ever used "the pill"? **Yes** ☐ **No** ☐

If 'no' go to question 6:2

→ **If yes,** please give name of "pill". To help you remember the name we have given a list of the most common ones below.

Combined pill				**Biphasic and Triphasic pills**	**Progestogen only pills**
Anovlar 21	Gynovlar 21	Minulet	Ortho-Novin	BiNovum	Cerazette
Brevinor	Loestrin 20	Neocon 1/35	Ortho-Novin 1/50	C-Quens	Femulen
Cilest	Loestrin 30	Norimin	Ortho-Novin 1/80	Logynon	Micronor
Conova 30	Logynon	Norinyl-1	Ovanon	Ortho-Norvin SQ	Microval
Conovid	Logynon ED	Norinyl-1/28	Ovran	Sequens	Neogest
Conovid-E	Lyndiol	Norinyl-2	Ovran 30	Serial 28	Norgeston
Diannette	Lyndiol 2.5	Norlestrin	Ovranette	Synphase	Noriday
Demulen	Marvelon	Norlestrin 21	Ovulen	Triadene	Normenon
Demulen 50	Mercilon	Norolen	Ovulen 1	Tri-Minulet	Verton
Eugynon 30	Microgynon 30	Nuvacon	Ovulen 50	Trinordiol	
Feminor 21	Minilyn	Ortho-Norvin 2	Ovysmen	TriNovum	
Femodene	Minovlar	Orlest 21	Previson		
Femodene ED	Minovlar ED	Orlest 28	Volidan 21		
Femodette			Yasmin		

1) Name of pill ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐ Cannot remember

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

2) Name of pill ☐ Cannot remember

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

3) Name of pill ☐ Cannot remember

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

- If you have used the pill for more than three episodes, please cross this box and fill in the details on page 15:1 More than 3 episodes ☐

Other hormonal contraception

6:2 Have you ever used any other type of hormonal contraception, such as contraception that was injected or implanted under your skin or applied with a patch on your skin?

Yes ☐ **No** ☐

If 'no', go to question 6:3

→ **If yes,** please give name of contraception. To help you remember the name of the contraception, we have given a list of the most common ones below:

Type	**Name**	**Type**	**Name**
Injection	Depo-Provera	Coil (intrauterine device)	Mirena
Injection	Noristerat	Implant under your skin	Implanon
Patches	Estraderm	Implant under your skin	Norplant

1) Name of contraception ☐

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

2) Name of contraception ☐

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

- If you have used these types of contraception for more than two episodes, please cross this box and fill in the details on page 15:1 More than 2 episodes ☐

Hormone replacement therapy

We would also like to know about any hormone replacement therapy (HRT) that you have had. By HRT we mean hormonal treatment at or after a natural menopause or a menopause caused by surgery or other medical treatments.

6:3 Have you ever had hormone replacement therapy? **Yes** ☐ **No** ☐

If 'no', go to question 6:5

→ **If yes,** please give the name of the HRT, and the ages at which you used it. To help you remember the name of any hormone preparation, we have given a list of the most common ones below

Tablets		**Patches**	**Tablets& patches**	**Pessary**
Adgyn Combi	Kliofem	Dermestril	Estrapak	Ortho-Gynest Pessary
Adgyn Estro	Kliovance	Dermestril Septem	Evorel-Pak	Tampovagan
Adgyn Medro	Livial	Elleste Solo MX	Femapak	
Climagest	Menophase	Estracombi		
Climaval	Micronor	Estraderm (MX)	**Creams/gels**	**Vaginal tabs**
Climesse	Harmogen	Evorel	Crinone	Vagifem
Cyclo-progynova	Novofem	Evorel conti	Menoring	
Duphaston	Nuvelle	Evorel Sequi	Oestrogel	**Spray**
Elleste Duet	Premique	Fematrix	Ortho-Gynest Cream	Aerodiol
Elleste Duet Conti	Premique Cycle	FemSeven	Ovestin	
Elleste Solo	Prempak	FemSeven Conti	Premarin	
Femoston	Prempak-C	FemSeven Sequi	Sandrena	
Femoston 2/10	Progynova	Menorest		
Femoston 2/20	Provera	Progynova TS		
Femoston conti	Tridesta			
Hormonin	Trisequens			
Indivina	Zumenon			

1) Name of hormone preparation

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

2) Name of hormone preparation

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

3) Name of hormone preparation

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

- If you have used these types of preparation for more than three episodes, please cross this box and fill in the details on page 15:1 More than 3 episodes ☐

6:4 When you were being considered for hormone replacement therapy, did a doctor measure your hormone levels? Yes ☐ No ☐ Don't know ☐

Other sex hormone treatment

6:5 Have you ever used any other type of sex hormone treatment or preparation, not mentioned above? For instance, to prevent osteoporosis (bone loss) or heart disease, to retain a more youthful appearance, or to treat pre-menopausal symptoms? **Yes** ☐ **No** ☐

→ **If yes,** please give the name of the treatment or preparation, and the ages at which you used it.

1) Name of treatment/preparation

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

2) Name of contraception

At what age did you start and stop using it? From age ☐☐ to age ☐☐ *or* ☐ Still using

- If you have used these types of preparation for more than two episodes, please cross this box and fill in the details on page 15:1 More than 2 episodes ☐

7: About mammograms, breast disease and breast surgery

Mammograms

7:1 Have you ever had an X-ray of your breast (mammogram)? **Yes** ☐ **No** ☐

If 'no', go to question 7:4 →

→ **If yes,** how many times have you been for a mammogram? ☐☐

- At what age was the first mammogram? ☐☐ years

7:2 Please give details of the mammogram you had most **recently**:

- Was this for screening? Yes ☐ No ☐
- Where was it done?
- In what year was it done? ☐☐☐☐

7:3 Have you had a mammogram where the result was abnormal? Yes ☐ No ☐

→ **If yes,** at what age? ☐☐ years

Please describe the abnormality:

Benign breast disease

7:4 Have you ever been told by a doctor that you have had benign breast disease or abnormality?
(e.g. mastalgia, breast cysts, lumps, fibroadenoma, fibrocystic disease) **Yes** ☐ **No** ☐

If 'no', go to question 7:5

→ **If yes,** what was the disease or abnormality?

- How old were you when it was first diagnosed? ☐☐ years
- In which breast was it? Left ☐ Right ☐ Both ☐
- Did you have surgery for it? Yes ☐ No ☐

→ **If 'yes' for surgery,** where was the surgery done?

- Hospital
- Town
- Did you have:
  - ☐ A cyst or fluid drained
  - ☐ A small sample removed (biopsy)
  - ☐ Part of the breast(s) or a lump removed
  - ☐ The whole breast removed
  - ☐ Both breasts removed
  - ☐ Other

If other, please specify

- If you have had further benign breast diseases, cross this box and fill in details on page 15:1 ☐

Breast cancer

7:5 Have you ever had breast cancer or pre-cancer ("in situ" or DCIS)? **Yes** ☐ **No** ☐

If 'no', go to question 7:9

→ **If yes,** what was it? ☐ Cancer ☐ Pre-cancer

- How old were you when it was diagnosed? ☐☐ years
- In which breast was it? Left ☐ Right ☐ Both ☐
- Did you have surgery for it? Yes ☐ No ☐

→ **If 'yes' for surgery,** did you have?

- ☐ A small sample removed (biopsy)
- ☐ Part of the breast(s) or a lump removed
- ☐ **Other,** specify
- ☐ A whole breast removed
- ☐ Both breasts removed

7:6 Did you receive **radiotherapy** (radiation treatment) for this cancer or pre-cancer? **Yes** ☐ **No** ☐

➔ **If 'yes' for radiotherapy** When did it start? ☐☐ Month ☐☐☐☐ Year When was it finished? ☐☐ Month ☐☐☐☐ Year

- At which hospital were you treated

Hospital

Town

7:7 Did you receive any **drug treatment** for this cancer or pre-cancer (e.g. Tamoxifen or chemotherapy)? **Yes** ☐ **No** ☐ ***If 'no', go to question 7:8***

➔ **If yes,** at which hospital were you treated?

Hospital

Town

- Please give the name(s) of the drugs and when you took them. To help you remember the names of the drugs, we have given a list of the most common types below:

Chemotherapy regimen	**Other drugs**			
AC	Arimidex	Megace	Provera	Taxotere
CAF	Aromasin	Modrenal	Raloxifene	Utovlan
CMF	Evista	Nolvadex-D	Soltamox	Virormone
CMFP	Fareston	Onkotrone	Taxol	Zoladex
CMVP	Farlutal	Orimeten	Tamofen	
FAC	Femara	Primoteston	Tamoxifen	
FEC				

1) Name of the drug or regimen

Date started ☐☐ Month ☐☐☐☐ Year Date stopped ☐☐ Month ☐☐☐☐ Year

2) Name of the drug or regimen

Date started ☐☐ Month ☐☐☐☐ Year Date stopped ☐☐ Month ☐☐☐☐ Year

- If you have had more than two episodes of drug treatment, please cross here and fill in the details (as in question 7:7) on page 15:1 More than 2 episodes ☐

7:8 Have you had a **second breast cancer** or pre-cancer diagnosed? **Yes** ☐ **No** ☐

➔ **If yes,** how old were you at that time? ☐☐ years

- In which breast was this cancer? Left ☐ Right ☐ Both ☐

Please fill in on page 15:1 information on your treatments for your second breast cancer or pre-cancer, as you did for your first breast cancer in questions 7:5 to 7:7

Other breast surgery

7:9 Have you had any surgery to your breasts for cosmetic reasons or other reasons not mentioned above?

Yes ☐ **No** ☐

If 'no', go to question 7:10

→ **If yes,** where was it done?

Hospital

Town

- How old were you when you had this surgery? ☐☐ years
- What was the operation?

☐ Breast reduction
☐ Breast enlargement
☐ Aspiration (needle) biopsy
☐ A small sample removed (biopsy)
☐ Part of breast(s) or a lump removed
☐ The whole breast removed
☐ Both breasts removed
☐ Other

If other, please specify

- In which breast was it? Left ☐ Right ☐ Both ☐
- If you have had any further breast operations not mentioned above, cross this box and fill in details on page 15:1 More breast operations ☐

Breast injury and other breast disease

7:10 Have you ever had a serious injury to your breast(s), or any breast disease not mentioned above?

Yes ☐ **No** ☐

If 'no', go to question 8:1

→ **If yes,** what was the injury or disease?

- Which breast(s) was affected? Left ☐ Right ☐ Both ☐

At what age did the injury happen or was the disease diagnosed? ☐☐ years

- If you have had any further breast injuries or disease not mentioned above, please cross this box and enter details on page 15:1 Further breast injury or disease ☐

8: About your medical history: illnesses

Cancer and benign tumours

8:1 Have you ever been diagnosed with any other type of cancer or a benign tumour (other than in the breasts), including leukaemia, Hodgkin's disease or other lymphoma? **Yes** ☐ **No** ☐

If 'no', go to question 8:2

→ **If 'yes',** when was this diagnosed? Year ☐☐☐☐ *or* Age ☐☐ years

- What type of cancer or benign tumour was it?

  Part of body

  Type of cancer or tumour

- Where was it treated?

  Hospital

  Town

- If you have been diagnosed with non-breast cancer more than once, please cross here and give details, as in question 8:1, on page 15:1 More than once ☐

Diabetes

8:2 Have you ever been diagnosed with diabetes? **Yes** ☐ **No** ☐

→ **If 'yes',** at what age was this diagnosed? ☐☐ years

- Are you treated with insulin? Yes ☐ No ☐

Thyroid disease

8:3 Have you ever been diagnosed with any thyroid disease or thyroid problems? **Yes** ☐ **No** ☐

If 'no', go to question 8:4

→ **If 'yes',** what was the disease or problem?

☐ Hyperthyroidism (overactive thyroid) ☐ Hypothyroidism (underactive thyroid)

☐ Thyroid cyst(s) ☐ Other

If other, please specify

- Please give dates and names of drug treatments. To help you remember the name of the drug, we have given a list of the common types below:

Brand names		**Generic names**	
Armour Thyroid	Synthroid	Carbimazole	Propylthiourcil/PTU
Cytomel	Tapazole	Levothyroxine/L-Thyroxine	Natural Thyroid
Eltroxin	Tertroxin	Liothyronine	Thyrotropin Alfa
Levothoid	Thyrogen	Liotrix	Thyroxine Sodium
Levoxyl	Thyrolar	Methimazole	
Naturethriod	Unithroid		
Neo-mercazole	Westhroid		

1) Name of drug treatment

Age at first treatment ☐☐ years

Duration of treatment Years ☐☐ Months ☐☐ *or* Still using ☐

2) Name of drug treatment

Age at first treatment ☐☐ years

Duration of treatment Years ☐☐ Months ☐☐ *or* Still using ☐

- If you have used more than two thyroid drugs, or used them in more than two episodes, please cross the box and fill in the details, as in question 8:3, on page 15:1 More than 2 ☐

Visual impairment

8:4 Are you registered as blind or as partially sighted? **Yes** ☐ **No** ☐

Gallstones and gallbladder removal

8:5 Have you ever been diagnosed with gallstones? **Yes** ☐ **No** ☐

➔ **If yes,** at what age? ☐☐ years

8:6 Have you ever had your gallbladder removed (cholestectomy)? **Yes** ☐ **No** ☐

➔ **If yes,** at what age? ☐☐ years

Broken (fractured) hips

8:7 Have you ever been told by a doctor that you had broken your hip? **Yes** ☐ **No** ☐

→ **If 'yes',** when did you break your hip for the first time? Year ☐☐☐☐ *or* Age ☐☐ years

Eating disorders

8:8 Have you ever had an eating disorder for which you saw a doctor or because of which you temporarily lost your periods?

☐ No ***(go to question 8:11)*** ☐ Yes, consulted a doctor

☐ Yes, temporarily lost my periods ☐ Yes, both

→ **If yes,** what was the disorder? ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

- If you saw a doctor, at what age did this first happen? ☐☐ years Not applicable ☐
- **If you lost your periods** because of your eating disorder, at what age did you first lose your periods? ☐☐ years Not applicable ☐
- For how long did you lose your periods? ☐☐ Years ☐☐ Months

8:9 What was your **weight** before the onset of this eating disorder? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

8:10 Did you gain or lose weight during this eating disorder, or did your weight stay the same on average?

☐ Gained weight ☐ Lost weight ☐ Stayed the same

→ **If you lost weight,** what was your lowest weight during the period that you had this eating disorder? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

→ **If you gained weight,** what was your greatest weight during the period that you had this eating disorder? ☐☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms

If you had further separate episodes of eating disorder, please cross the box and give details on page 15:1 ☐

8: About your medical history: drugs and supplements

Tamoxifen and raloxifene

8:11 Other than for treatment of breast cancer, have you ever used, or are you currently using, the drugs tamoxifen (Soltamox, Nolvadex-D, or Tamofen) or raloxifene (Evista)? **Yes** ☐ **No** ☐

→ **If yes,** what was the drug? ☐ Tamoxifen ☐ Raloxifene

At what age did you first use it? ☐☐ years

For how long in total did you use it? ☐☐ Years ☐☐ Months *or* Still using ☐

- If you have used these drugs for more than 1 episode, please cross this box and give details on page 15:1 More than 1 episode ☐

Growth hormone

8:12 Have you ever been treated with growth hormone? **Yes** ☐ **No** ☐

Acne treatment

8:13 Have you ever been prescribed tablets or pills by a doctor for acne? **Yes** ☐ **No** ☐

→ **If yes,** at what age did you start treatment? ☐☐ years

Antibiotics

8:14 In the last 12 months have you taken antibiotics by mouth or injection (not, for instance, mouthwash or on the skin)? **Yes** ☐ **No** ☐

→ **If yes,** on how many days in the last 12 months? ☐☐☐ days

Aspirin

Current use

8:15 Have you taken aspirin or any products containing aspirin in the last 7 days? **Yes** ☐ **No** ☐

→ **If yes,** on how many days did you take it in the last 7 days? ☐ days

The following are some of the common names of aspirin-containing medicines:

Alka-Seltzer	Aspro/Aspro Clear	Boots-Seltzer	Novasen
Anadin	Asasantin Retard	Caprin	Nu-seals Aspirin
Angettes 75	Bayer	Codis 500	Phensic
Apo-ASA	Beechams Aspirin	Disprin	Toptabs
ASA	Beachams Lemon Tablets	Entrophen	
Askit	Beechams Powders	Fynnon Calcium Aspirin	
Asaphen	Boots Back pain relief	Imazin XL	

Regular use

8:16 Have you ever taken aspirin or products containing aspirin regularly?
By 'regularly' we mean every day or almost every day for 6 months or longer. **Yes** ☐ **No** ☐

→ **If yes,** please fill in details of any periods in your life you were taking aspirin every day or almost every day for at least 6 months.

1) Age at start ☐☐ years Age at end ☐☐ years *or* Still using ☐

2) Age at start ☐☐ years Age at end ☐☐ years *or* Still using ☐

- If there were other periods in your life where you took aspirin regularly, please cross this box and give details on page 15:1 ☐

Ibuprofen

Current use

8:17 Have you taken any products containing ibuprofen in the last 7 days? **Yes** ☐ **No** ☐

→ **If yes,** on how many days did you take it in the last 7 days? ☐ days

The following are some of the common names of ibuprofen-containing medicines:

Advil	Anadin Ultra	Anadin Ibuprofen	Arthofen
Brufen	Calprofen	Cuprofen	Galprofen
Hedex Ibuprofen	Ibufen	Ibrufhalal	Inoven
Librofem	Limsip Power+	Migrafen	Novaprin
Nurofen	Obifen	Pacifene	PhorPain
Relcoten	Solpaflex		

Regular use

8:18 Have you ever taken ibuprofen or medication containing ibuprofen regularly?
By 'regularly' we mean every day or almost every day for 6 months or longer. **Yes** ☐ **No** ☐

→ **If yes,** please fill in details of any periods in your life you were taking ibuprofen every day or almost every day for 6 months or longer.

1) Age at start ☐☐ years Age at end ☐☐ years *or* Still using ☐

2) Age at start ☐☐ years Age at end ☐☐ years *or* Still using ☐

- If there were other periods in your life where you took ibuprofen regularly, please cross this box and give details on page 15:1 ☐

Other painkillers

Current use

8:19 Have you taken any other painkillers in the last 7 days? **Yes** ☐ **No** ☐

If yes, on how many days did you take them in the last 7 days? ☐ days

- Name of painkiller

Regular use

8:20 Have you ever taken other painkillers regularly?
By 'regularly' we mean every day or almost every day for 6 months or longer. **Yes** ☐ **No** ☐

➔ **If yes,** please fill in details of the periods in your life you were taking other painkillers every day or almost every day for 6 months or longer.

1) Age at start ☐☐ years Age at end ☐☐ years *or* Still using ☐

- Name of painkiller

2) Age at start ☐☐ years Age at end ☐☐ years *or* Still using ☐

- Name of painkiller

- If there were other periods in your life where you took other painkillers regularly, please cross this box and give details on page 15:1 ☐

Vitamins and other supplements

8:21 Have you ever taken?

Folic acid or Folate	Yes ☐	No ☐	**If yes,** total number of years	☐☐ Years
Vitamin D	Yes ☐	No ☐	**If yes,** total number of years	☐☐ Years
Calcium	Yes ☐	No ☐	**If yes,** total number of years	☐☐ Years

8:22 In the last 7 days, have you taken any vitamin supplements or other supplements? Yes ☐ No ☐

➔ **If yes,** what was it? ☐ Multivitamin ☐ Cod liver oil

☐ **Other,** specify:-

Melatonin

8:23 Have you ever taken a drug called melatonin? **Yes** ☐ **No** ☐
This drug is not available over the counter in the UK, but it can be bought in the US.
It is frequently used to overcome jet lag or to help sleeping.

Statins

8:24 Have you ever taken cholesterol lowering drugs called "statins"? **Yes** ☐ **No** ☐

These include:

Simvastatin	Pravastatin	Atorvastatin	Fluvastatin	Rosuvastatin
Zocar	Lipostat	Lipitor	Lescol	Crestor

9: About X-ray examinations

We would like to ask you about X-rays and other radiological examinations for diagnosis or treatment that have included your chest and breasts. We do not need to know about X-rays of other parts of the body – for instance x-rays for suspected broken arms or legs. We also do not need to know about mammograms, because we asked about these earlier, nor, if you have had breast cancer, do we need to know about X-rays you have had for diagnosis of the breast cancer.

Plain (simple) Chest X-rays

9:1 Have you ever had an X-ray to your chest or lungs *(such as for asthma, or tuberculosis, or for a hospital admission or routine examination)?* **Yes** ☐ **No** ☐

→ **If yes,** please state below the number of chest X-rays you have had. *(If you have not reached a particular age range, please leave the answers for that age blank. If you are not sure about the exact number of X-rays you had, please give your best estimate).*

Age range	**Total number of X-rays**
Under age 20	☐☐
Between ages 20-39 years	☐☐
Between ages 40-59 years	☐☐
Ages 60 and older	☐☐

Special X-ray examinations

9:2 Have you ever had any of the following X-ray examinations?
If you answer 'yes' to any of these, please fill in the details in question 9:4

X-ray to your spine, collar bone or neck?
This may or may not involve the injection of a dye to make the X-ray clearer. Yes ☐ No ☐

Barium swallow?
This involves X-rays to the stomach after drinking a thick chalky liquid. Yes ☐ No ☐

X-ray to your oesophagus or stomach, for which you were not given a barium swallow? Yes ☐ No ☐

Coronary angiogram or angioplasty?
A coronary angiogram is an X-ray of the blood vessels of the heart and angioplasty is a procedure used to stretch open narrowings in arteries. Yes ☐ No ☐

Arteriogram of the lung or stomach?
This is an X-ray of the blood vessels of your lung or stomach and involves a dye being injected or inserted through a catheter. Yes ☐ No ☐

CT or CAT (computerised tomography) scan of the chest or neck? Yes ☐ No ☐
For this you lie down on a table and are placed in a 'donut' shaped machine, which makes a soft humming sound. We do *not* mean an MRI scan, for which you are placed inside a tunnel that feels a little claustrophobic and makes a loud dinging noise.

X-ray of your gall bladder (cholecystogram)? Yes ☐ No ☐

Intravenous pyelogram X-ray of your kidneys? Yes ☐ No ☐

A full-mouth (panoramic) dental X-ray? Yes ☐ No ☐
This is a special dental X-ray where a machine moves around your head.
We do not mean a regular dental X-ray of one or only a few teeth.

A large dental x-ray to all the teeth on one side of your head? Yes ☐ No ☐
(when having orthodontic treatment or being considered for braces).

Fluoroscopic chest x-ray examination after tuberculosis? Yes ☐ No ☐

X-radiation treatments

9:3 Have you ever had any of the following treatments?
(If you answer 'yes' to any of these treatments, please fill in the details in question 9:4)

Chest or neck radiotherapy for Hodgkin's disease or for other cancer or tumour (including breast cancer)? Yes ☐ No ☐

Radiation treatment to the chest or neck for any other condition? Yes ☐ No ☐
(e.g. for ankylosing spondylitis, benign breast disease (including mastitis), an enlarged thymus or a thyroid condition, skin warts, scars, birthmarks, or scalp diseases or infections)

Further details of x-rays

9:4 If you answered 'yes' to any of the questions in 9:2 or 9:3, please fill in details here of these x-ray examinations or treatments

1) Type of x-ray examination or treatment

- When was it done? Year
- Hospital
- Town
- Reason

2) Type of x-ray examination or treatment

- When was it done? Year
- Hospital
- Town
- Reason

3) Type of x-ray examination or treatment

- When was it done? Year
- Hospital
- Town
- Reason

If you have had more X-ray examinations or radiation treatments, please cross this box and fill in the details on page 15:1 More X-rays or radiation treatments ☐

10: About your jobs

This section asks about some particular exposures at work that you might have had.

Ionising radiation

10:1 Have you ever had any jobs that involved working with ionising radiation (e.g x-rays, nuclear sources)? **Yes** ☐ **No** ☐

If 'no', go to question 10:2

→ **If yes,** please give details of your jobs involving ionising radiation.
If you have done the same work in more than one job, for instance, if you have worked as a radiographer in several hospitals, summarise these jobs under one job heading.

1st job When did you do this job? From Year to Year

- Did you wear a dosimeter (dosage badge) for this job? Yes ☐ No ☐
- What was the average time per week you worked around ionising radiation? Hours Minutes per week

- What were your radiation-related duties for this job?

- If you have had more jobs involving work with ionising radiation please cross the box and fill in the details on page 15:1 More jobs ☐

Late evening and night work

10:2 Over the last ten years, have you had any jobs that regularly involved work in the late evening or night (between 10pm and 7am) (e.g. nursing, bar or waitress work, night shifts, office cleaning)? **Yes** ☐ **No** ☐

→ **If yes,** please fill in details for each job. If you have done the same work in more than one job, it is sufficient to summarise these jobs under one heading

	Type of job	**Year started**	**Year ended**	**Average number of days per week** *working at night or late evening*	**Average number of hours worked between 10pm and 7am** *on these days*
1)					
2)					

- If you have had more jobs involving work at night please cross the box and fill in details on page 15:1 More jobs ☐

11: About alcohol, smoking and your diet

Alcohol

11:1 Have you ever been a regular drinker of alcohol in the sense of regularly drinking at least one glass of alcohol per week on average? **Yes** ☐ **No** ☐

→ **If yes,** at what age did you start drinking at least once a week? ☐☐ years

- Do you still drink at least once a week? Yes ☐ No ☐

→ **If you have stopped,** at what age did you stop? ☐☐ years

11:2 Please tell us on average the amount you drank at different periods of your life.
(If you are aged under 25 or under 50, just leave blank the columns that do not apply.)

Category of drink	At ages 18-24	At ages 25-49	At ages 50 and older
Beer, lager, stout or cider (pints per week)			
White wine (glasses per week)			
Red wine (glasses per week)			
Sherry, liqueurs, Martini and other similar drinks (glasses per week)			
Alcopops or spirits (e.g. vodka, gin or Pimms) (glasses (singles) per week)			
Other types of alcohol (glasses per week)			

If other, please specify type of alcohol

11:3 On how many days in the last 7 days have you drunk alcohol? ☐ days

Smoking

11:4 Have you ever smoked regularly (i.e. most days for at least 6 months)? **Yes** ☐ **No** ☐

If 'no', go to question 11:11

→ **If yes,** at what age did you start to smoke regularly? ☐ years

11:5 If you have ever been pregnant, did you smoke during your first pregnancy? Yes ☐ No ☐ Not applicable ☐

11:6 Do you still smoke regularly? Yes ☐ No ☐

→ **If no,** at what age did you stop? ☐ years

11:7 Have you ever stopped temporarily for a year or more and then re-started? Yes ☐ No ☐

11:8 How many cigarettes per day did you smoke on average, when you were a smoker, at different periods of your life. (Leave blank any ages that do not apply to you.)

	At ages 16-24	At ages 25-49	At ages 50 and older
Cigarettes per day			

11:9 Did you inhale? ☐ Yes, deeply ☐ Yes, moderately ☐ Yes, a little ☐ No, not at all

11.10 Have you regularly smoked any other form of tobacco (e.g. cigars, pipes)? Yes ☐ No ☐

Diet

We would like to ask you some general questions about your diet as it is nowadays.

11:11 Do you eat any **meat**, including poultry, and meat processed in sausages, meat pies etc.?

☐ Yes **If yes,** on how many days in the last 7 days? ☐ days

☐ No **If no,** how old were you when you last ate meat? ☐☐ years old *or* Never eaten ☐

11:12 Do you eat any **fish**?

☐ Yes **If yes,** on how many days in the last 7 days? ☐ days

☐ No **If no,** how old were you when you last ate fish? ☐☐ years old *or* Never eaten ☐

11:13 Do you eat any **eggs** (including in cakes and other baked foods)?

☐ Yes **If yes,** on how many days in the last 7 days? ☐ days

☐ No **If no,** how old were you when you last ate eggs? ☐☐ years old *or* Never eaten ☐

11:14 Do you eat any **dairy products** (e.g. milk, cheese, yoghurt, butter)?

☐ Yes **If yes,** on how many days in the last 7 days? ☐ days

☐ No **If no,** how old were you when you last ate or drank dairy products? ☐☐ years old *or* Never eaten ☐

11:15 Do you eat any **soya products**?

☐ Yes **If yes,** on how many days in the last 7 days? ☐ days

☐ No **If no,** how old were you when you last ate or drank soya products? ☐☐ years old *or* Never eaten ☐

11:16 How many servings of **green vegetables** do you eat daily on average? ☐☐ Servings per day
(Count two tablespoons of vegetables as one serving.)

11:17 How many servings of **fruit** do you eat daily on average? ☐☐ Servings per day
(Count a single piece of fruit such as an apple or orange or a handful of grapes as one serving.)

11:18 What kind of **fat** do you most often use for frying, roasting, grilling etc.?

☐ Butter
☐ Lard/dripping
☐ Olive oil
☐ Sunflower oil
☐ Other vegetable oil (e.g. rape seed, corn, soya, Frylight)
☐ Solid white vegetable fat
☐ Margarine/spreads (including Benecol)
☐ Other
☐ None

If other, please specify ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

12: About your physical activity

The questions in this section ask about your exercise. Because some people's exercise varies considerably by the time of the year (e.g. most people only play tennis in summer) please answer these questions for the warmer periods of the year only, approximately for *April to September*.

Exercise in childhood

12:1 During your childhood, did you ever participate regularly in any sporting activities outside school hours sufficiently strenuous to get you out of breath? **Yes** ☐ **No** ☐

→ **If yes,** on average how many days per week did you participate in sporting activities outside school hours, and for how much time in total per week. ☐ Days per week **Total time per week** ☐☐ Hours ☐☐ Minutes

Exercise as an adult

12:2 As an adult on how many days per week on average have you done **strenuous exercise** that gets you out of breath and causes substantial sweating, and how long in total over the week did you spend doing these activities?

		Total time per week
At ages 18 - 29	☐ Days per week	☐☐ Hours ☐☐ Minutes
At ages 30 - 49	☐ Days per week	☐☐ Hours ☐☐ Minutes
At ages over 50	☐ Days per week	☐☐ Hours ☐☐ Minutes

12:3 As an adult, on how many days per week on average have you done **light exercise** that would increase your heart rate slightly and cause light perspiration but not get you out of breath, and how long in total per week did you spend doing this?

		Total time per week
At ages 18 - 29	☐ Days per week	☐☐ Hours ☐☐ Minutes
At ages 30 - 49	☐ Days per week	☐☐ Hours ☐☐ Minutes
At ages over 50	☐ Days per week	☐☐ Hours ☐☐ Minutes

Exercise in the last year

The next questions ask about exercise you take in a typical week during approximately April to September in the last year. We ask first about strenuous exercise, sufficient to get you out of breath and make you sweat considerably, and then ask about less strenuous exercise. If you include a particular activity in the 'strenuous' section, please do not duplicate it in the less-strenuous section. For instance, if you engage in strenuous cycling (e.g. competitive) and have entered it as such, do not include it when asked about cycling in the less-strenuous cycling question.

Strenuous exercise

12:4 In a usual week during approximately the period April to September in the last year, how much time did you spend:

		Total time per week
1) Participating in a sport or training sufficient to get you out of breath and make you sweat considerably? (e.g. netball, jogging, exercise class, tennis, football, swimming)	☐ Days per week	☐☐ Hours ☐☐ Minutes
2) At work participating in activities that get you out of breath and make you sweat considerably? (e.g. lifting, climbing ladders, building work)	☐ Days per week	☐☐ Hours ☐☐ Minutes
3) In any other activities not already covered above that get you out of breath and make you sweat considerably?	☐ Days per week	☐☐ Hours ☐☐ Minutes

12:5 Compared with the answers in 12:4 above, do you exercise more, the same, or less during the winter months? More ☐ About the same ☐ Less ☐

Moderate and light exercise

12:6 In a usual week during approximately the period April to September in the last year, how much time did you spend:

		Total time per week
1) Doing active housework? e.g. hoovering, scrubbing floors, bed making, hanging out washing, etc	☐ Days per week	☐☐ Hours ☐☐ Minutes
2) In non-paid manual labour? e.g. gardening, decorating, washing car, etc.	☐ Days per week	☐☐ Hours ☐☐ Minutes
3) Walking, including walking to and from work, walking to the shops, walking for pleasure, etc?	☐ Days per week	☐☐ Hours ☐☐ Minutes
4) Cycling, including to and from work and for pleasure?	☐ Days per week	☐☐ Hours ☐☐ Minutes
5) Dancing?	☐ Days per week	☐☐ Hours ☐☐ Minutes
6) Engaged in moderate or light exercise at work, not covered above?	☐ Days per week	☐☐ Hours ☐☐ Minutes

12:7 Compared with the answers you have given in question 12:6, do you exercise more, the same, or less during the winter months?

More ☐ About the same ☐ Less ☐

Pulse

What is your resting pulse rate? Please make sure that you have been sitting quietly for at least 15 minutes before measuring your pulse. To measure it, place your index and middle fingers on the inside of your wrist down from the base of your thumb. Press a little but not hard, and count the beats for 60 seconds. If you have difficulties with this, ask someone to do this for you, but it is important that they do it with their index and middle fingers – we do not want them to feel their own pulse.

12:8 Your pulse rate per minute:

Number of beats per 60 seconds ☐☐☐

12:9 Are you currently taking any medication that may affect your pulse rate (e.g. for heart disease, irregular heartbeat (arrhythmia) or high blood pressure, including β-blockers)

Yes ☐ No ☐ Don't know ☐

13: About other lifestyle factors

The following questions are about your sleep. By 'night' in these questions we mean the time you usually sleep. This could be during the day if you work nights.

Sleeping pattern

13:1 Over the last year, what time have you usually gone to sleep on weekdays?

☐☐ Hours ☐☐ Minutes

(Please cross box)
☐ AM (after midnight)
☐ PM (before midnight)
☐ Midnight

13:2 What time do you usually wake up?

☐☐ Hours ☐☐ Minutes

(Please cross box)
☐ AM (before noon)
☐ PM (after noon)
☐ Noon

13:3 How many hours do you usually sleep per night? Please give an average over the last year. If you nap during the day, please add this to your total.

☐☐ Hours ☐☐ Minutes

13:4 On average over the last year, between closing your eyes to go to sleep and waking up, how dark has been the room you sleep in? *(cross only one box)*

☐ Light enough to read

☐ Light enough to see across the room, but not read

☐ Light enough to see your hand in front of you, but not to see across the room

☐ Too dark to see your hand, or you wear a mask

13:5 When you were 20 years old, between closing your eyes to go to sleep and waking up, on average how dark was the room you slept in? *(cross only one box)*

- ☐ Not yet 20 years old
- ☐ Light enough to read
- ☐ Light enough to see across the room, but not read
- ☐ Light enough to see your hand in front of you, but not to see across the room
- ☐ Too dark to see your hand, or you wore a mask

13:6 On average in recent months, how many times per night did you wake and put the lights on or go into a bright room? ☐☐ Times per night

13:7 When you were about 20 years old, how many times per night did you wake and put the lights on or go into a bright room? ☐☐ Times per night

Stress

13:8 Do you feel that you have been experiencing stress over the last 5 years?

☐ Never ☐ Occasionally ☐ Frequently ☐ Continuously

13:9 In the last 5 years have you experienced: *(cross any that apply)*

- ☐ Death of a husband or long-term partner
- ☐ Death of a child, parent or other close relative
- ☐ Divorce or separation
- ☐ Death of a close friend
- ☐ Serious personal illness or injury
- ☐ Loss of a job
- ☐ Other life event that you found very stressful

Air travel

13:10 Have you ever worked as an airline pilot or aircrew, or had a period of a year or more when you travelled as a passenger on an aircraft regularly for more than 20 hours per month?

Yes ☐ **No** ☐

If 'no' go to question 13:15

→ **If yes,** between what years did you work in aircraft/travel this much (if you had a second separate spell as aircrew or frequent travelling, please enter details on page 15:1)

From Year ☐☐☐☐ to Year ☐☐☐☐

or Still doing this ☐

13:11 On average, how many hours per week or month were you airborne during this period?

Number of hours per week ☐☐ *or* Number of hours per month ☐☐

13:12 During this period, on average how many flights per month did you make that lasted:-
(please count the number of flights, not the number of trips. For instance, a two-way trip would be two flights and a one-way trip with 1 stopover would also count as two flights)

	Number of flights
Between 5 and 9 hours?	☐☐ Per month
10 or more hours?	☐☐ Per month

13:13 During this period, on average how many flights per month did you make that were:

	Number of flights
Crossing the equator?	☐☐ Per month
Trans–Atlantic, but not crossing the equator?	☐☐ Per month
Trans–Pacific, but not crossing the equator?	☐☐ Per month

13:14 During this period, on average how many journeys did you make per month with a time difference between the place of departure and the final destination of:

	Number of journeys
Between 5 and 9 hours?	☐☐ Per month
10 or more hours?	☐☐ Per month

Anti-perspirant use

13:15 Have you ever regularly used any of the following products under your arms (cross all that apply)?
(By 'regular' we mean at least once a week for 1 year or more)

☐ Anti-perspirant deodorant
☐ Anti-perspirant only
☐ Deodorant only
☐ Talc products

14: About cancer in your family

We would now like to ask some details of your parents, and any brothers, sisters or children you may have. We ask for this information because we are trying to understand how cancers can sometimes run in families. We would like to know about your biological (blood) relatives, not relatives to whom you are not blood related, e.g. not step-parents, step-siblings or parents who adopted you.

Your parents

14:1 If you do not know about your biological parents, please cross the box and go to question 14:6.

Don't know ☐

14:2 Your father

- What is your father's name? First name
  Surname
- What is your father's date of birth? Day Mth Year *or* Don't know
- How tall is/was your father?
  (Please give your best guess if you are not sure) Feet Inches
- In what country was your father born? UK Other Don't know
  If other, please specify:
- As far as you know, has your father ever had any type of cancer, leukaemia or lymphoma?
  (If he had a cancer on both sides, e.g. cancers of the left and right testes, count this as two cancers)
  No Yes, one cancer Yes, more than one cancer
  → **If yes,** what type was it? **First cancer**
  Second cancer
  In what year was it diagnosed? **First cancer** Year *or* Don't know
  Second cancer Year *or* Don't know
- Is your father still alive? Alive Dead Don't know
  If he is dead, what was his date of death? Day Mth Year *or* Don't know
  What was his cause of death?

14:3 Your mother

- What is your mother's name? First name
  Surname
  Maiden name
- What is your mother's date of birth? Day Mth Year *or* Don't know
- In what country was your mother born? UK Other Don't know
  If other, please specify:
- How tall is/was your mother?
  (Please give your best guess if you are not sure) Feet Inches

- As far as you know, has your mother ever had any type of cancer, leukaemia or lymphoma?
  (If she had a cancer on both sides, e.g. cancers of the left and right ovaries, count this as two cancers)

  No ☐ Yes, one cancer ☐ Yes, more than one cancer ☐

  ➔ **If yes,** what type was it? **First cancer** [ ]

  Second cancer [ ]

  In what year was it diagnosed? **First cancer** Year [ ] *or* Don't know ☐

  Second cancer Year [ ] *or* Don't know ☐

- Is your mother still alive? Alive ☐ Dead ☐ Don't know ☐

  If she is dead, what was her date of death? Day [ ] Mth [ ] Year [ ] *or* Don't know ☐

  What was her cause of death? [ ]

Your grandparents

14:4 In what country were your grandparents born?

Mother's mother:
UK ☐ *or* Other country (specify) [ ] *or* Don't know ☐

Mother's father:
UK ☐ *or* Other country (specify) [ ] *or* Don't know ☐

Father's mother:
UK ☐ *or* Other country (specify) [ ] *or* Don't know ☐

Father's father:
UK ☐ *or* Other country (specify) [ ] *or* Don't know ☐

14:5 Have any of your grandparents had breast cancer? Yes ☐ No ☐

➔ **If yes,** who was it?
☐ Mother's mother ☐ Father's mother
☐ Mother's father ☐ Father's father

Your brothers and sisters

Please answer the following questions for any biological brothers, sisters, half-brothers and half-sisters you have. Please include any who have died. Start with the oldest sibling.

14:6 If you do not know about your biological siblings please cross this box and go to question 14:14 — Don't know ☐

14:7 How many brothers, sisters, half brothers and half sisters do you have in total? ☐☐

If 'none' go to question 14:14

Please now fill in a section below for each brother or sister you have.

14:8 **1st brother or sister.** Relationship to you: ☐ Brother ☐ Half-brother ☐ Sister ☐ Half-sister

- **If half brother or half sister,** which parent do you share? ☐ Mother ☐ Father
- What is your sibling's date of birth? Day ☐☐ Mth ☐☐ Year ☐☐☐☐ *or* Don't know ☐
- As far as you know, has your sibling ever had any type of cancer, leukaemia or lymphoma? No ☐ Yes, one cancer ☐ Yes, more than one cancer ☐

→ **If yes,** what type was it: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

In what year was it diagnosed? Year ☐☐☐☐ *or* Don't know ☐

14:9 **2nd brother or sister.** Relationship to you: ☐ Brother ☐ Half-brother ☐ Sister ☐ Half-sister

- **If half brother or half sister,** which parent do you share? ☐ Mother ☐ Father
- What is your sibling's date of birth? Day ☐☐ Mth ☐☐ Year ☐☐☐☐ *or* Don't know ☐
- As far as you know, has your sibling ever had any type of cancer, leukaemia or lymphoma? No ☐ Yes, one cancer ☐ Yes, more than one cancer ☐

→ **If yes,** what type was it: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

In what year was it diagnosed? Year ☐☐☐☐ *or* Don't know ☐

14:10 3rd brother or sister. Relationship to you: ☐ Brother ☐ Half-brother ☐ Sister ☐ Half-sister

- **If half brother or half sister,** which parent do you share? ☐ Mother ☐ Father
- What is your sibling's date of birth? Day ☐ Mth ☐ Year ☐ *or* Don't know ☐
- As far as you know, has your sibling ever had any type of cancer, leukaemia or lymphoma?
  No ☐ Yes, one cancer ☐ Yes, more than one cancer ☐

→ **If yes,** what type was it: ☐

In what year was it diagnosed? Year ☐ *or* Don't know ☐

14:11 4th brother or sister. Relationship to you: ☐ Brother ☐ Half-brother ☐ Sister ☐ Half-sister

- **If half brother or half sister,** which parent do you share? ☐ Mother ☐ Father
- What is your sibling's date of birth? Day ☐ Mth ☐ Year ☐ *or* Don't know ☐
- As far as you know, has your sibling ever had any type of cancer, leukaemia or lymphoma?
  No ☐ Yes, one cancer ☐ Yes, more than one cancer ☐

→ **If yes,** what type was it: ☐

In what year was it diagnosed? Year ☐ *or* Don't know ☐

14:12 5th brother or sister. Relationship to you: ☐ Brother ☐ Half-brother ☐ Sister ☐ Half-sister

- **If half brother or half sister,** which parent do you share? ☐ Mother ☐ Father
- What is your sibling's date of birth? Day ☐ Mth ☐ Year ☐ *or* Don't know ☐
- As far as you know, has your sibling ever had any type of cancer, leukaemia or lymphoma?
  No ☐ Yes, one cancer ☐ Yes, more than one cancer ☐

→ **If yes,** what type was it: ☐

In what year was it diagnosed? Year ☐ *or* Don't know ☐

14:13 If you have more than 5 siblings, please cross the box and fill in the details of other siblings on page 15:1 More than 5 ☐

Your children

14:14 We asked about your children earlier in the questionnaire. We would now like to ask if any of your children ever had any type of cancer, including Hodgkin's disease, leukaemia or lymphoma? No ☐ Yes ☐ Not applicable ☐

➔ **If yes,** who was it?

- What is his/her date of birth? Day ☐☐ Mth ☐☐ Year ☐☐☐☐ *or* Don't know ☐
- What type of cancer was it?
- In what year was it diagnosed? Year ☐☐☐☐ *or* Don't know ☐

14:15 If any more of your children have had cancer, please cross the box and fill in the details of other children on page 15:1 More children ☐

Breast cancer in other blood relatives

14:16 As far as you know, have any of your other, more distant, relatives had breast cancer? No ☐ Yes ☐ Don't know ☐

➔ **If yes,** which relative(s)? *(Please cross all that apply)*

Mother's side

- ☐ Mother's sister(s)
- ☐ 1st cousin(s) (i.e. aunt's or uncle's children)
- ☐ Niece(s)
- ☐ Great grandmother(s)
- ☐ Other blood relative(s) *(please specify below)*

Father's side

- ☐ Father's sister(s)
- ☐ 1st cousin(s) (i.e. aunt's or uncle's children)
- ☐ Niece(s)
- ☐ Great grandmother(s)
- ☐ Other blood relative(s) *(please specify below)*

Please specify:

15: Space for extra details

If you had too little space for providing details above, or if you have any further information you want to add, or have any other comments about the questionnaire or study, please write here.

Question number **Additional details**

Finally

Thank you for completing this questionnaire; we appreciate that it may have taken you considerable time and effort, and we are very grateful for your contribution.

Would you now please date this questionnaire.

Date of completion Day ☐☐ Month ☐☐ Year ☐☐☐☐

Please return the questionnaire in the envelope provided to:-

The Breakthrough Generations Study Team
Brookes Lawley Building
Institute of Cancer Research
15 Cotswold Road
Sutton
SURREY
SM2 5NG