70301

generations
The UK study of the causes of Breast Cancer

Questionnaire

Please complete this questionnaire in black or blue ink, using capital letters. Further instructions on how to complete this questionnaire can be found on the back of the covering letter. Several of the questions ask about events in your life since 1st January 2014, or since 10 years ago; this is to ensure that we cover the period since you last completed a questionnaire about these events.

Online Questionnaire

If you are able to complete this questionnaire online using our secure website at https://generations.icr.ac.uk we would appreciate it as this would save on resources. There is then no need to return the paper version.

1: General information about you

1.1 Is your **name and address** here correct?
***If no,** please write your correct name and address here or on the back page*

....

....

....

....

1.2 Please confirm your **date of birth** Day ☐☐ Month ☐☐ Year ☐☐☐☐

1.3 **Telephone number(s)** on which you may be contacted

Tel.1 ☐☐☐☐☐☐☐☐☐☐☐ Ext. ☐☐☐☐ Day ☐ Eve ☐ Either ☐

Tel.2 ☐☐☐☐☐☐☐☐☐☐☐ Ext. ☐☐☐☐ Day ☐ Eve ☐ Either ☐

1.4 Email address

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2: Illnesses

Cancer and breast diseases

2.1 Since 1st January 2014, have you been diagnosed with any type of cancer, including leukaemia or lymphoma? **Yes** ☐ **No** ☐

→**If yes,** what type was it?

☐ Left breast cancer ☐ Right breast cancer ☐ Cancer in both breasts ☐ Ovarian cancer

☐ Cervical cancer ☐ Uterus (womb) cancer ☐ Malignant melanoma ☐ Skin cancer, not melanoma. (Basal cell carcinoma; rodent ulcer; squamous cell carcinoma)

☐ Hodgkin's lymphoma ☐ Non-Hodgkin's lymphoma ☐ Leukaemia ☐ Colon or rectum (large bowel) cancer

List continued on next page

☐ Thyroid cancer ☐ Kidney cancer ☐ Bladder cancer

☐ Other cancer, please specify

2.2 Since 1st January 2014, have you been diagnosed with **any other breast disease**? **Yes** ☐ **No** ☐

→**If yes,** what type was it?

☐ Breast pre-cancer ("in situ" or DCIS) ☐ Benign breast cyst(s) ☐ Benign breast lump(s) ☐ Breast abscess

☐ Breast fibroadenoma ☐ Breast fibrocystic disease ☐ Mastitis

☐ Other breast abnormality, please specify

- Did you have a biopsy or surgery for this? Yes ☐ No ☐

2.3 **If you have reported cancer or breast disease** above, please enter the date and place here:

- **When it was diagnosed** Month ☐☐ Year ☐☐☐☐
- **Where it was diagnosed (hospital of first surgery, if you had surgery)** Hospital

Town

If you have had more than one cancer and/or breast disease since 1st January 2014, please cross here and describe the dates and places you were diagnosed on the back page. ☐

2.4 **If you have had cancer or breast disease,** would you be agreeable to the research team obtaining from your doctor or hospital a sample of the cancer or breast disease you had removed, as well as any corresponding pathology reports, to be used for the Generations Study research?

Yes, I do agree ☐ No, I do not agree ☐ Not applicable ☐

Your signature …… *Date* ……

3: Mammograms

3.1 Since 1st January 2014, have you had a mammogram (breast X-ray)? **Yes** ☐ **No** ☐

3.2 **If yes,** when was your most recent mammogram? Year ☐☐☐☐

- Where was it done?

Name of hospital or other location

Town

4: Menopause

4.1 Have you reached the menopause (i.e. your periods have now stopped completely and you believe permanently, and your last period was at least six months ago)?

Yes ☐ **No** ☐ Don't know because I am taking hormone replacement therapy, and therefore do not know whether I have reached natural menopause ☐

→**<u>If you reached menopause since 1st January 2014:</u>**

- How old were you when your periods stopped completely and permanently? Age ☐☐ years *or* Don't know ☐
- What was the reason for your periods stopping?

☐ Natural menopause ☐ Natural menopause while taking HRT or contraception

Surgical removal of :

☐ your ovaries (oophorectomy) ☐ your uterus (hysterectomy) ☐ your ovaries and uterus

☐ Chemotherapy or radiotherapy ☐ Don't know

☐ 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 ☐

5: Pregnancies

5.1 In the last 10 years **have you been pregnant** (including any miscarriages, terminations, stillbirths or ectopic pregnancies)? Yes ☐ No ☐ Don't know ☐

If no, go to Question 6.1

→ **If yes**, how many pregnancies have you had in the last 10 years, including any current pregnancy ☐☐

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

5.3 Please give information below on each pregnancy in the last 10 years, starting with the most recent one. Please include any ectopic pregnancies, and any pregnancies that resulted in miscarriage, induced abortion or stillbirth, but **<u>not</u>** any current pregnancy.

Each column refers to a single pregnancy and needs to be filled in from top to bottom. The table is designed for up to 3 pregnancies. If you have had more than 3 in the last 10 years, please cross here and fill in the details of the 4th and later pregnancies on the back of the questionnaire. ☐

(There is no need to enter pregnancies that ended before 10 years ago, because you have already told us about these in your previous questionnaire).

Pregnancies in the last 10 years, starting with the most recent one in the left column

5.4 Date child was born/ pregnancy ended — Day Mth Year | Day Mth Year | Day Mth Year

5.5 Outcome of pregnancy

Single live born infant	☐	☐	☐
Twins, both live born	☐	☐	☐
Twins, one live born	☐	☐	☐
Twins, both stillborn	☐	☐	☐
Triplets or higher order birth *(enter details on back page)*	☐	☐	☐
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 back page)*

Boy	☐	☐	☐
Girl	☐	☐	☐
→**If twins** Boy-Boy	☐	☐	☐
Boy-Girl	☐	☐	☐
Girl-Girl	☐	☐	☐

5.10 Birthweight, if known *(if twins or triplets or more please enter details on back page)*

lbs, oz ☐☐ , ☐☐ | ☐☐ , ☐☐ | ☐☐ , ☐☐

or

grams ☐☐☐☐ | ☐☐☐☐ | ☐☐☐☐

5.11 Number of weeks breast fed (Enter 'CUR' if currently breastfeeding) ☐☐☐ | ☐☐☐ | ☐☐☐

5.12 Did you receive pills or hormone injections to dry up your milk secretion?

Yes	☐	☐	☐
No	☐	☐	☐

5.13 In the last 10 years, have you taken hormones to maintain a pregnancy (because you were at risk of miscarriage)? Yes ☐ No ☐

6: Contraceptive pill, hormone replacement therapy and other hormonal treatments

6.1 In the last 10 years, have you at any time taken:

- The oral contraceptive pill ("the pill") Yes ☐ No ☐
- Other hormonal contraception (e.g. contraception that was injected or implanted under your skin or applied as a patch on your skin, or a hormone-containing contraceptive coil such as mirena). Yes ☐ No ☐
- Hormone replacement therapy (HRT) (hormonal treatment at or after your menopause or for pre-menopausal symptoms) Yes ☐ No ☐
- Fertility drugs or hormones to help you conceive Yes ☐ No ☐
- Any other sex hormone treatment (e.g. to prevent osteoporosis (bone loss) or heart disease, or to retain a more youthful appearance) Yes ☐ No ☐

→If you replied **'yes**' to any of the above, please give details of each period of use below. *(If you stopped use and re-started again within 6 months, treat this as a single period of use; if you re-started 6 months or longer after stopping, enter this as a new episode.)*

To help you remember the names, these are some common ones:

Oral contraceptives			Other hormonal contraceptives		HRT	
cilest	eugynon	marvelon	depo-provera	elleste duet	kliofem	premique
cerazette	femodene	microgynon	mirena coil	estraderm	livial	prempak-C
dianette	logynon	ovranette	implanon	evorel	premarin	trisequens

1) **Type of hormone** ☐ The pill ☐ HRT ☐ Fertility drugs ☐ Injected hormonal contraception ☐ Other hormonal contraception ☐ Other sex hormone treatment

- Name of drug, if known
- Year started Year ended *or* ☐ Still using

2) **Type of hormone** ☐ The pill ☐ HRT ☐ Fertility drugs ☐ Injected hormonal contraception ☐ Other hormonal contraception ☐ Other sex hormone treatment

- Name of drug, if known
- Year started Year ended *or* ☐ Still using

If you have used hormonal contraceptives or treatments for more than 2 episodes in the last 10 years, please cross this box and describe the type and name of drug, and years of use, on the back page. ☐

7: Other illnesses

7.1 Diseases of ovary and uterus (womb)

Have you ever been diagnosed by a doctor with:		If yes, age when you were first diagnosed
Polycystic ovaries	Yes ☐ No ☐	☐☐ Years
Endometriosis	Yes ☐ No ☐	☐☐ Years

7.2 Diabetes

		If yes, age when you were first diagnosed
Have you ever been diagnosed with diabetes?	Yes ☐ No ☐	☐☐ Years

→If yes

		If yes, age when you were first treated with insulin
• Are you treated with insulin?	Yes ☐ No ☐	☐☐ Years

• Do you have type 1 or type 2 diabetes? Type 1 ☐ Type 2 ☐ Don't know ☐

8: Your body size and shape

8.1 Your weight. 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. *(If you are currently pregnant, tell us your pre-pregnancy weight.)*

- Current weight: ☐ Stones ☐☐ Lbs *or* ☐☐☐ Kilograms
- When was this measured? ☐ Today ☐ In the last few months ☐ Not measured, it is an estimate

Measurements ***(pre-pregnancy if you are currently pregnant)***

8.2 What is your **waist circumference**? *If practical, please measure this in inches or centimetres around your waist, holding the tape measure about 1 inch above your umbilicus (belly button). If you don't have a tape measure, please give an estimate.*

☐☐ Inches *or* ☐☐☐ Centimetres

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

8.3 What is your **hip circumference**? *If practical, please measure this in inches or centimetres around the widest part of your hips. If you don't have a tape measure, please give an estimate.*

☐☐ Inches *or* ☐☐☐ Centimetres

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

8.4 What is your current **bra size**? (e.g. 36C, or 38FF)
If you are currently pregnant or breast feeding, please give your usual bra size before the pregnancy.
If you have had a mastectomy or other breast surgery, please enter your bra size before the surgery.

- ☐☐ Inches
- Cup size *(Cross only one option)*

☐ AA ☐ B ☐ D ☐ E ☐ F ☐ G ☐ H ☐ Other, specify
☐ A ☐ C ☐ DD ☐ EE ☐ FF ☐ GG ☐ J ☐☐

9: Your life during adolescence and young adulthood

The following questions relate to your life when you were an adolescent and young adult. Many women's activities change greatly after the birth of their first child, so if you have had your first child during one of the age-intervals below, please answer the questions for that age-interval for your behaviour before the child was born.

	Age (years) 9-12	13-17	18-21	22-30
9.1 Smoking				
• Did you smoke most days of the week at this age?	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
→**If yes**, how many cigarettes per day did you usually smoke?	☐☐	☐☐	☐☐	☐☐
9.2 Alcohol				
• Did you drink alcoholic drinks at least once per week at this age?	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐
→**If yes**, how many drinks did you usually have per day: on weekdays	☐☐	☐☐	☐☐	☐☐
at weekends	☐☐	☐☐	☐☐	☐☐
9.3 Diet				
• Were you at this age a vegetarian or vegan?	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐	Yes ☐ / No ☐

→**If yes**, at what age did you start to be a vegetarian or vegan? ☐☐ Years

9.4 Weight and Size

	Age (years) 9-12	13-17	18-21	22-30
• How much did you weigh compared with other girls/women of the same age as you? (Cross one box per age)				
Much thinner	☐	☐	☐	☐
A little thinner	☐	☐	☐	☐
About the same	☐	☐	☐	☐
A little heavier	☐	☐	☐	☐
Much heavier	☐	☐	☐	☐
Don't remember	☐	☐	☐	☐

9.5 Strenuous Exercise

• How many days per week, on average, did you do strenuous exercise that got you out of breath and caused you to sweat, at this age?	Days per week	☐	☐	☐	☐
• How many hours per week did you take part in organised sports (e.g. school games periods, competitive swimming, team sports, athletics) that got you out of breath and caused you to sweat?	Hours per week	☐☐	☐☐	☐☐	☐☐
• How many hours per week did you take part in other leisure exercise (e.g. at home or with friends or family) that got you out of breath and caused you to sweat?	Hours per week	☐☐	☐☐	☐☐	☐☐
• How many hours per week did you participate in activities at work that got you out of breath and caused you to sweat?	Hours per week	☐☐	☐☐	☐☐	☐☐

10: Your lifestyle now

Smoking

10.1 In the last 10 years, have you at any time been a regular smoker (of tobacco)? (i.e. smoked most days for at least **6** months) Yes ☐ No ☐

→**If yes**

10.2 How many cigarettes per day did you usually smoke? ☐☐

10.3 Do you still smoke tobacco regularly? Yes ☐ No ☐ →If **'no',** at what age did you stop? ☐☐ Years

If yes, when did you start?

10.4 Do you smoke e cigarettes or vape? Yes ☐ No ☐ Age (years) ☐☐

If no, what age did you stop?

Do you still smoke e cigarettes or vape? Yes ☐ No ☐ Age (years) ☐☐

Alcohol

10.5 In the last 10 years, have you drunk any alcoholic drinks? Yes ☐ No ☐

→**If you have stopped drinking alcohol completely (not temporarily, e.g. because of pregnancy),** at what age did you stop? ☐☐ Years

10.6 In a usual week over the last 6 months, how many days in the week would you drink any alcohol? ☐ days

10.7 In a usual week in the last 6 months, how much of the following would you typically drink (*leave blank any types you did not drink, or that you drink less than once per week*):

Red wine (glasses per week)	☐☐	White wine (glasses per week)	☐☐
Rosé wine (glasses per week)	☐☐	Sherry, liqueurs, Martini and other similar drinks (glasses per week)	☐☐
Beer, lager, stout or cider (pints per week)	☐☐	Alcopops or spirits (e.g. vodka, gin, whisky, brandy) glasses (singles) per week)	☐☐
Other types of alcohol (glasses per week)	☐☐	**If other**, specify type	☐☐☐☐☐☐☐☐☐☐

10.8 On how many days in the last 7 days have you drunk alcohol? ☐ days

Late evening and night work

10.9 In the last 10 years, have you had any jobs that regularly involved work in the late evening or night (between 10 pm and 7 am) Yes ☐ No ☐

→**If 'yes',**

	Type of job	**Year started**	**Year ended** *(if continuing, enter CONT)*	**Number of days per week *working late evening or at night***	**Usual number of hours per day worked between 10pm and 7am *on these days***
1)	☐☐☐☐☐☐☐☐☐☐	☐☐☐☐	☐☐☐☐	☐	☐
2)	☐☐☐☐☐☐☐☐☐☐	☐☐☐☐	☐☐☐☐	☐	☐
3)	☐☐☐☐☐☐☐☐☐☐	☐☐☐☐	☐☐☐☐	☐	☐

- If you have had more jobs in the last 10 years involving work at night, please cross this box and fill in details as above on the back page. ☐

Sleeping pattern

(Please cross box)

10.10 Over the last year, at what time have you usually gone to sleep on weekdays? ☐☐ Hour ☐☐ Minutes

☐ am (after midnight)
☐ pm (before midnight)
☐ midnight

10.11 Over the last year how many hours per night have you usually slept? If you nap during the day, please add this to your total ☐☐ Hours ☐☐ Minutes

Exercise

10.12 Strenuous exercise. In a normal week during approximately April to September in the last year, how much time did you spend:

	No of days per week you usually did this	Total time per week you did this
1) Doing sports or training sufficient to get you out of breath and make you sweat considerably? (e.g. jogging, exercise machine, tennis, swimming)	☐ Days per week	☐☐ Hours ☐☐ Minutes
2) In activities at work 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 covered above that get you out of breath and make you sweat considerably?	☐ Days per week	☐☐ Hours ☐☐ Minutes

10.13 Running. If you go running or jogging, how far in total do you usually run per week?

☐☐☐ Miles *or* ☐☐☐ Kilometres

and how long on average does it take you per mile ☐☐ mins *or* per kilometre ☐☐ mins

How many times per week do you go running? ☐☐

10.14 Moderate & light exercise. In a normal week during approximately April to September in the last year, how much time did you spend doing the following. (Please do not duplicate here any activities you described above. For instance, if you are a competitive cyclist and entered this under the 'strenuous' section, do not also include it under the cycling question below):

	No of days per week you usually did this	Total time per week you did this
1) Walking, including to and from work, for your work, to the shops, and for pleasure?	☐ Days per week	☐☐ Hours ☐☐ Minutes
2) Cycling, including to and from work, for your work, and for pleasure?	☐ Days per week	☐☐ Hours ☐☐ Minutes

10.15 Steps per day

If you wear a fitness watch (e.g.Fitbit) or pedometer or use a fitness app on your mobile, how many steps per day do you usually walk?

on a weekday ☐☐☐☐☐ per day

and on a weekend day ☐☐☐☐☐ per day

Sitting

10.16 How much time per day do you spend on average sitting:

	Work days		Non-work days	
At work	☐☐ Hours	☐☐ Minutes		
In a car, bus, train or other vehicle	☐☐ Hours	☐☐ Minutes	☐☐ Hours	☐☐ Minutes
Other e.g. at home watching TV or on a computer or at meals or reading	☐☐ Hours	☐☐ Minutes	☐☐ Hours	☐☐ Minutes

10.17 On how many days per week do you work? ☐ days

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 difficulty with this, ask someone to do it 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. Alternatively, you may have an app on your mobile phone, smartwatch or fitness watch that can measure it for you.

10.18 Your pulse rate per minute (number of beats per 60 seconds): ☐☐

10.19 Method you used to measure your pulse (cross as applicable):

On myself by hand ☐ Someone else measured it on me by hand ☐

I used a phone or watch app or other device ☐

10.20 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 ☐

11: Space for extra details

If you had too little space for providing details, or you have any further information or comments you want to add, including any serious illnesses since 1st January 2014 you have not mentioned previously, please write here.

Question number	Additional details

Thank you: you have finished. Please enter today's date Day ☐☐ Month ☐☐ Year ☐☐☐☐

and return the questionnaire in the envelope enclosed to:-

The Generations Study Team, Sir Richard Doll Building
Institute of Cancer Research, 15 Cotswold Road, Sutton, SURREY SM2 5NG

Office use only A ☐ T ☐ ☐