Tissue Bank Questionnaire

Print

(1 of 15) Demographic Data

Informed Consent Number: HISPBB - - -

Are you currently being treated for cancer?

○ Yes ○ No

1. Sex / DOB	○ Male ○ Female
Date of Birth	-- -- --
2. Race **Which one of these groups would you say best represents your race? (Mark only one.)**	○ White ○ Black or African American ○ Asian ○ Native Hawaiian or other Pacific Islander ○ American Indian or Alaska Native ○ Don't know/Not sure ○ Prefer not to answer ○ Other, specify:
3. Do you consider yourself Hispanic or Latino?	○ Yes ○ No
4. Address	*Street 1: Street 2: *City: *State: *Zip Code:
5. Country	-Choose your country-
6. Marital Status	○ Married ○ Single ○ Divorced ○ Consensual Relationship ○ Widowed
7. Education	○ Up to 8 grade ○ 8-12 grade ○ Vocational School ○ Associate degree ○ Bachelor ○ Master ○ Doctor ○ Other
8 Current Occupation	Time: (years) (If < 1 yrs, enter '1')
9. Prior Job	Time: (years) (If < 1 yrs, enter '1')

10. Occupational Exposure

Chemicals	○ Yes ○ No Which:
Silica	○ Yes ○ No
Asbestos	○ Yes ○ No
Industrial wastes	○ Yes ○ No Which:
Construction	○ Yes ○ No
Others	

(2 of 15) Personal History of Cancer

11. How much do you weigh?	pounds
12. What is your height?	feet inches

13. Have you ever been told by a doctor or health care provider that you have any of the following infections?
Please make a check mark() in the table below.

Infection	**yes / no**	**Year of the first infection (Leave it blank if you do not remember)**
Hepatitis (Don't know the type)	☐ **(Don't know the type)**	--
Hepatitis A	○ **Yes** ○ **No**	--
Hepatitis B	○ **Yes** ○ **No**	--
Hepatitis C	○ **Yes** ○ **No**	--
Any type of Human Papillomavirus (HPV)	○ **Yes** ○ **No**	--
AIDS/HIV	○ **Yes** ○ **No**	--
***Helicobacter pylori* (causing ulcers)**	○ **Yes** ○ **No**	--

14. Have you ever told by a doctor or health care provider that you have cancer?

○ Yes ○ No

15. What type of cancer was diagnosed? Please complete the table below. If "No" in question 14, skip to question 18.

Type of Cancer	**Age at time of diagnosis (-1 for unknown age)**	**Treatment(s) you received for cancer**
1. Anal Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None

Type of Cancer	Age at time of diagnosis (-1 for unknown age)	Treatment(s) you received for cancer
2. Bladder Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
3. Brain Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
4. Breast Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
5. Carcinoid-/Neuroendocrine- Tumor		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
6. Cervical Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
7. Colon or Rectal Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
8. Endometrial/Uterine Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
9. Esophageal Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
10. Gall Bladder Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
11. GIST(Gastrointestinal Stromal Tumor)		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
12. Hodgkin's Lymphoma		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
13. Kidney (renal cell) Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
14. Leukemia Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
15. Liver Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
16. Lung Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
17. Melanoma (Skin) Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
18. Multiple Myeloma / Plasma Cell Tumor		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
19. Non-Hodgkin's Lymphoma		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
20. Oral Cavity or Throat Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
21. Ovarian Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
22. Pancreatic Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
23. Prostate Cancer		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None
24. Other		☐ Radiation ☐ Chemotherapy ☐ Surgery ☐ None

16. Have you ever been told by a doctor or a health professional that your cancer had spread or metastasized (spread) to other parts of your body?

○ Yes ○ No

17. To which organ/body part did your cancer metastatasize (spread)? (Mark all that apply.)

☐ Liver ☐ Brain ☐ Lung ☐ Bone ☐ Other Specify

(3 of 15) Family History of Cancer

18. Have any of your blood-related family members been told by a doctor or other health care professional that they have cancer?

○ Yes ○ No

Family	Type of Cancer / Age of Diagnosis (-1 for unknown age)
1. Mother	-Type of Cancer- /
2. Father	-Type of Cancer- /
3. Sister(s)	-Type of Cancer- /
4. Brother(s)	-Type of Cancer- /
5. Daugther(s)	-Type of Cancer- /
6. Son(s)	-Type of Cancer- /
7. Maternal grandmother	-Type of Cancer- /
8. Maternal grandfather	-Type of Cancer- /
9. Maternal aunt	-Type of Cancer- /
10. Maternal uncle	-Type of Cancer- /
11. Paternal grandmother	-Type of Cancer- /
12. Paternal grandfather	-Type of Cancer- /
13. Paternal aunt	-Type of Cancer- /
14. Paternal uncle	-Type of Cancer- /
15. Others	-Type of Cancer- /

(4 of 15) Alcohol Use and Tobacco Use

19. Please answer the next questions in regards to your average past or current intake of alcoholic beverages.
Please fill in only ONE box per beverage.

Do you now or have you previously drink / drank **beer or malt liquor (12 oz drinks)**?	○ Never ○ I used to but no longer/I quit ○ Currently drink	About how many drinks did you/do you drink per week?
Do you now or have you previously drink / drank **wine or**	○ Never ○ I used to but no longer/I quit ○ Currently drink	About how many drinks did you/do you drink per week?

wine cooler (6 oz drinks)?		
Do you now or have you previously drink / drank **hard liquor (e.g. Rum, Whiskey, Scotch; 6 oz drinks)**?	○ Never ○ I used to but no longer/I quit ○ Currently drink	About how many drinks did you/do you drink per week?

20. Have you currently or formerly ever used any of the following tobacco products?

Chewing Tobacco	○ Yes, currently ○ Yes, but quit ○ No	How many times a week? For how many years?
Snuff or Dip	○ Yes, currently ○ Yes, but quit ○ No	How many times a week? For how many years?
Pipe	○ Yes, currently ○ Yes, but quit ○ No	How many times a week? For how many years?
Cigars	○ Yes, currently ○ Yes, but quit ○ No	How many times a week? For how many years?

21. Have you smoked at least 100 cigarettes (that's about 5 packs of cigaretttes) in your entire life? (If no, skip to Question 27)	○ Yes ○ No
22. How old were you when you began to smoke cigarettes?	years old
23. About how many total years have you actually smoked cigarettes? (Do not include the times you may have quit smoking for a month or more)	Smoked for years
24. On average, how many cigarettes did/do you smoke per day?	Cigarettes per day
25. Do you still smoke cigarettes?	○ Yes ○ No
26. (If "no" above, how long ago did you stop?)	years months and/or -- -- --

(5 of 15) Physical Activity

27. Do you participate in any of the following physical activities? Complete the table below.

Activities	**Frequency**
Running	○ Daily ○ Weekly ○ Monthly ○ Never or rarely
Walking	○ Daily ○ Weekly ○ Monthly ○ Never or rarely
Swimming	○ Daily ○ Weekly ○ Monthly ○ Never or rarely
Aerobics	○ Daily ○ Weekly ○ Monthly ○ Never or rarely

Activities	Frequency
Weight lifting	○ Daily ○ Weekly ○ Monthly ○ Never or rarely
Bicycling	○ Daily ○ Weekly ○ Monthly ○ Never or rarely
Gymnastics	○ Daily ○ Weekly ○ Monthly ○ Never or rarely
Others	○ Daily ○ Weekly ○ Monthly ○ Never or rarely

28. How do you describe your level of activity? Please make a check mark () in the table below.

Level of Activity	()
1. Active, no restrictions	○
2. Restrictions, no exhaustive activities, but able to work	○
3. Ambulatory, not able to do any daily activities.	○
4. Confined to a wheelchair or bed partially	○
5. Complete handicapped, totally bedridden or wheelchair	○

(6 of 15) Quality of Life

29. How do you feel right now?	○ Calm ○ Much energy ○ Desolation ○ Sadness
30. How have you felt for the past 4 weeks?	
31. In the past 3 months have you had any health problem?	○ Yes ○ No If yes, explain:
32. Does your health affect your social activities?	○ Yes ○ No
33. How is your health?	○ Excellent ○ Very good ○ Good ○ Regular ○ Poor

34. Have you ever had any of the following Psychological or psychiatric problems?
Please make a check mark () in the table below.

Diagnosis	yes / no
Depression	○ Yes ○ No
Dementia	○ Yes ○ No
Schizophrenia	○ Yes ○ No
Attention Deficit Disorder	○ Yes ○ No
Manic-Depressive Disorder	○ Yes ○ No

Diagnosis	yes / no
Obsessive-Compulsive Disorder	○ Yes ○ No
Other:	○ Yes ○ No

(7 of 15) History of Prostate Cancer (to be completed only by males) ♂

35. In the last 3 months, have you ever had any of the following problems?
Please make a check mark () in the table below.

Problems	yes / no
Painful urination	○ Yes ○ No
Difficulty starting urine stream	○ Yes ○ No
Blood in urine	○ Yes ○ No
Sensation of not emptying bladder completely after you finished urinating	○ Yes ○ No
Urinating more than once every two hours during the day	○ Yes ○ No
Getting up more than once a night to urinate	○ Yes ○ No

36. Has your doctor ever told you that you have any of the following problems with your prostate?
Please make a check mark () in the table below.

Prostate problems	yes / no
Prostatitis (any infection or inflammation of the prostate)	○ Yes ○ No
Enlarged prostate or Benign Prostatic Hypertrophy	○ Yes ○ No
Needed a prostate biopsy	○ Yes ○ No

37. Have you ever had a rectal exam?	○ Yes ○ No	When: -- --	Findings:
38. Have you ever had a Prostate Specific Antigen(PSA) test?	○ Yes ○ No	Most recent test: -- --	Results:
39. Have you ever had erectile dysfunction?	○ Yes ○ No		

(8 of 15) History of Colon Cancer

40. Have you ever had any digestive tract problems?

○ Yes ○ No

41. In the last 3 months, have you ever had any of the following symptoms?
Please make a check mark () in the table below.

Symptoms	yes / no
Change in bowel habits	○ Yes ○ No

Symptoms	yes / no
Change in stool color	○ Yes ○ No
Constipation	○ Yes ○ No
Fine stool	○ Yes ○ No
Blood in stool	○ Yes ○ No
Black or tarry stool	○ Yes ○ No

42. Have you ever had rectal bleeding? How would you describe it:	○ Yes ○ No ○ Don't Know ○ Bright red bleeding ○ Melena(Black stool)
43. If you ever had rectal bleeding, did you feel pain?	○ Yes ○ No
44. Have your doctor or health care provider recommended that you have a Fecal Occult Blood Test?	○ Yes ○ No
45. Results of the fecal occult blood test:	○ Negative ○ Positive
46. Have you ever had a digital rectal exam?	○ Yes ○ No ○ Five (5) or more years ago When: -- --
47. Have you ever had a Sigmoidoscopy or Colonoscopy?	○ Yes ○ No When: -- --

If yes in the question above. Please make a check mark () in the table below.

Findings	yes / no
Normal	○ Yes ○ No
Ulcers	○ Yes ○ No
Tumor	○ Yes ○ No
Diverticulitis	○ Yes ○ No
Colitis	○ Yes ○ No
Fistula	○ Yes ○ No
Hemorrhoids	○ Yes ○ No
Polyps	○ Yes ○ No

48. Was a biopsy performed during the Sigmoidoscopy or Colonoscopy?	○ Yes ○ No Results:

49. Have you ever had anemia?	○ Yes ○ No Hemoglobin levels:

(9 of 15) History of Ovarian Cancer (to be completed only by females) ♀

50. In the last 3 months, have you had any of the following gynecological problems?
Please make a check mark () in the table below.

Gynecological Problem	yes / no
1. Irregular menstrual cycles	○ Yes ○ No
2. Significant gain or loss of weight	○ Yes ○ No
3. Abdominal inflammation	○ Yes ○ No
4. Pelvic discomfort	○ Yes ○ No
5. Vaginal bleeding	○ Yes ○ No
6. Back pain that worsens with time	○ Yes ○ No
7. Increased abdominal size	○ Yes ○ No

51. Have you had any of the following gastrointestinal symptoms?
Please make a check mark () in the table below.

Gastrointestinal Symptom	yes / no
1. Increased gas production	○ Yes ○ No
2. Lack of appetite	○ Yes ○ No
3. Indigestion	○ Yes ○ No
4. Nausea, Vomiting	○ Yes ○ No
5. Abdominal distention	○ Yes ○ No
6. Increased urinating frequency	○ Yes ○ No
7. Other	

52. With how much frequency do you visit your gynecologist?	○ Every 6 months ○ Every year ○ Less frequent than every year ○ Never
53. When was the last time you visited your gynecologist?	-- --
54. Have you ever had a pelvic exam?	○ Yes ○ No Findings:
55. Have you ever had a digital rectal exam?	○ Yes ○ No Findings:

56. Did your doctor order any of the following diagnostic tests?

○ Yes ○ No

If yes, please make a check mark () in the table below.

Diagnostic Test	yes / no	Month / Year	Results (#: Number only)
1. CA 125	○ Yes ○ No	-- --	# U/mL
2. Alpha-fetoprotein	○ Yes ○ No	-- --	# ng/mL
3. Quantitative HCG	○ Yes ○ No	-- --	# mIU/mL
4. Sonogram	○ Yes ○ No	-- --	
5. Barium Enema	○ Yes ○ No	-- --	
6. Intravenous Pyelogram	○ Yes ○ No	-- --	

57. Have you ever had a Pap Smear?	○ Yes ○ No Most recently: -- -- Results:
58. Have you ever used medications for fertility?	○ Yes ○ No Which one : How long (months):

(10 of 15) History of Gynecological and Obstetrical Hormonal History (to be completed only by females) ♀

(*: Optional)

59. At what age was your first menstruation?	*
60. How often do you typically have your menstrual cycle?	* Every days
61. How many days does your bleeding last?	* days
62. Have you ever bled between menstrual periods?	* ○ Yes ○ No
63. Have you ever had pain during your menstrual periods?	* ○ Yes ○ No

64. Have your uterus (matrix) been removed?	○ Yes ○ No If your answer is yes, why? At what age?
65. Have you ever had endometriosis?	○ Yes ○ No
66. Was it diagnosed by surgery?	○ Yes ○ No At what age?
67. Have your ovaries been removed?	○ Yes ○ No

68. Were both ovaries removed?	○ Yes ○ No
69. Reason why your ovaries were removed?	
70. At what age were your ovaries removed?	
71. Were you in menopause?	○ Yes ○ No
72. Are you going through menopause?	○ Yes ○ No
73. At what age did your menopause symptoms start?	years old
74. Do you take any prescribed hormones?	○ Yes ○ No Which ones? For what? At what age you started?
75. Do you have a mammogram every year?	○ Yes ○ No
76. When was your last mammogram?	-- --

(11 of 15) Pregnancy History (to be completed only by females) ♀

77. Have you ever been pregnant?	○ Yes ○ No
78. How many times have you been pregnant?	Alive: Dead: Miscarriage:
79. At what age did you have your first pregancy?	years old
80. At what age did you have your first child?	years old
81. How many children have you had?	

82. Did you breastfeed your children?	○ Yes ○ No

83. For how long have you breastfed your children? Answer the table below.

Baby	Weeks / Months
1st	/
2nd	/
3rd	/
4th	/
5th	/
6th	/
7th	/

Baby	Weeks / Months
8th	/
9th	/
10th	/

84. Did you take estrogen during any of your pregnancies?	Yes No

85. Have you ever used any contraceptive methods?	Yes No Which ones? At what age? years old For how long? years (If 6 months, enter 0.5)
86. Which contraceptive method are you currently using?	, Other:

(11b of 15) Family History of Breast Cancer

87. Have any of your family members been diagnosed with any breast cancer? Fill the table below	Yes No

Family	Had Cancer? (y/n)	Type of Breast Cancer (DCIS, invasive or do-not-know)	At what age was the cancer diagnosed?	Alive/Dead
1. Mother	Yes No			
2. Father	Yes No			
3. Sister(s)	Yes No			
4. Brother(s)	Yes No			
5. Daughter(s)	Yes No			
6. Son(s)	Yes No			
7. Maternal grandmother	Yes No			
8. Maternal grandfather	Yes No			
9. Maternal aunt	Yes No			
10. Maternal uncle	Yes No			
11. Paternal grandmother	Yes No			
12. Paternal grandfather	Yes No			
13. Paternal aunt	Yes No			

Family	Had Cancer? (y/n)	Type of Breast Cancer (DCIS, invasive or do-not-know)	At what age was the cancer diagnosed?	Alive/Dead
14. Paternal uncle	○ Yes ○ No			
15. Others	○ Yes ○ No			

(12 of 15) Radiation History

88. Have you been exposed to a radiation treatment?

○ Yes ○ No

89. For what disease? Please make a check mark() on those that apply to you:

Disease/Type of Radiation	yes / no	When did you receive the radiation?	At what age?
1. Tuberculosis (TB)	○ Yes ○ No	-- -- --	
2. Vertebral Column	○ Yes ○ No	-- -- --	
3. Chest	○ Yes ○ No	-- -- --	
4. Abdomen	○ Yes ○ No	-- -- --	
5. Acne	○ Yes ○ No	-- -- --	
6. Thymus (gland situated superior part of the bone located between both breasts)	○ Yes ○ No	-- -- --	
7. Non- Hodgkin's Lymphoma (cancer cell in the lymphatic system)	○ Yes ○ No	-- -- --	
8. Neck	○ Yes ○ No	-- -- --	
9. Fluoroscopic (study of the organs in movements)	○ Yes ○ No	-- -- --	
10. Indicate another place(s) that has not been mentioned.	○ Yes ○ No	-- -- --	

(13 of 15) Nutritional History

90. Are you currently on any kind of diet?

○ Yes ○ No

Which ones?

Please make a check mark() on the table below of saturated fat foods or vegetable that you usually eat.

Saturated fats	Daily / Weekly / Monthly
Poultry (e.g. chicken)	○ Daily ○ Weekly ○ Monthly ○ None

Saturated fats	Daily / Weekly / Monthly
Fast foods	○ Daily ○ Weekly ○ Monthly ○ None
Pork	○ Daily ○ Weekly ○ Monthly ○ None
Butter	○ Daily ○ Weekly ○ Monthly ○ None
Fried Foods	○ Daily ○ Weekly ○ Monthly ○ None
Ice cream	○ Daily ○ Weekly ○ Monthly ○ None
Cheese	○ Daily ○ Weekly ○ Monthly ○ None
Lard	○ Daily ○ Weekly ○ Monthly ○ None
Vegetable oils	○ Daily ○ Weekly ○ Monthly ○ None
Dairy products	○ Daily ○ Weekly ○ Monthly ○ None
Bacon	○ Daily ○ Weekly ○ Monthly ○ None
French Fries	○ Daily ○ Weekly ○ Monthly ○ None
Red meat	○ Daily ○ Weekly ○ Monthly ○ None
Others	○ Daily ○ Weekly ○ Monthly ○ None

Vegetables	Daily / Weekly / Monthly
Broccoli	○ Daily ○ Weekly ○ Monthly ○ None
Carrots	○ Daily ○ Weekly ○ Monthly ○ None
Cauliflower	○ Daily ○ Weekly ○ Monthly ○ None
Spinach	○ Daily ○ Weekly ○ Monthly ○ None
Lettuce	○ Daily ○ Weekly ○ Monthly ○ None
Tomatoes	○ Daily ○ Weekly ○ Monthly ○ None
Asparagus	○ Daily ○ Weekly ○ Monthly ○ None
Beetroot	○ Daily ○ Weekly ○ Monthly ○ None
Green beans	○ Daily ○ Weekly ○ Monthly ○ None
Pumpkin	○ Daily ○ Weekly ○ Monthly ○ None
Gherkin	○ Daily ○ Weekly ○ Monthly ○ None
Plantains	○ Daily ○ Weekly ○ Monthly ○ None
Beans	○ Daily ○ Weekly ○ Monthly ○ None
Others	○ Daily ○ Weekly ○ Monthly ○ None

91. During last five (5) years, have you taken any vitamins or minerals?	○ Yes ○ No
92. Are you currently taking any vitamins or minerals?	○ Yes ○ No

93. How often do you take vitamins or minerals?	○ Daily ○ Weekly ○ Sometimes

94. Which of the following vitamins or minerals are you taking?

Vitamins	**yes / no**
1. Multi-vitamins	○ Yes ○ No
2. Vitamin A	○ Yes ○ No
3. Vitamin B	○ Yes ○ No
4. Vitamin C	○ Yes ○ No
5. Vitamin E	○ Yes ○ No
6. Calcium	○ Yes ○ No
7. Beta-carotene	○ Yes ○ No
8. Other	

(14 of 15) Lung Cancer Risk Assessment

95. Has a doctor ever told you that you have had any of the following medical conditions?
If 'yes', at what age or which year were you diagnosed?

1. Asthma	○ Yes ○ No	Age	Year --
2. Chronic bronchitis	○ Yes ○ No	Age	Year --
3. Emphysema	○ Yes ○ No	Age	Year --
4. Pneumonia	○ Yes ○ No	Age	Year --
5. Hay fever	○ Yes ○ No	Age	Year --
6. Eczema/dermatitis	○ Yes ○ No	Age	Year --

96. Now, I'd like to ask you a few questions about your exposure to second-hand-smoke at home, work, and leisure.
Second-hand-smoke is other people's cigarette smoke.

Have you ever been exposed to someone else's cigarette smoke...	
1. ...at Home	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
2. ...at Work	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
3. ...at Leisure*	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?

* Leisure places: you could regularly be exposed to cigarette smoke include restaurants, bars, casinos, car, etc.

97. Indicate which specific materials or substances you may have handled, used, or been in contact with for at least 8 hours a week for a year or more.
It can either be on a job or working on a hobby.

1. Asbestos	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
2. Sand, Silica, Concrete Dust, Dust Storms	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
3. Solvents, Paint, Thinners, Toluene/Xylene	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
4. Arsenic	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
5. Chromium or Nickel	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
6. Cadmium	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
7. Berylium	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
8. Radon, Uranium	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?
9. Benzene	○ Never/Infrequent ○ Yes, in the past ○ Yes, currently How many years?

98a. Have you ever used or are you currently using nicotine replacement products?

○ Yes ○ No

98b. If 'yes', which product(s), for how long, and are you still using them?

1. Pills	○ Never ○ Yes, in the past ○ Yes, currently Months of use
2. Nicotine gum	○ Never ○ Yes, in the past ○ Yes, currently Months of use
3. Nicotine patch	○ Never ○ Yes, in the past ○ Yes, currently Months of use
4. Nicotine lozenge	○ Never ○ Yes, in the past ○ Yes, currently Months of use
5. Nicotine nasal spray/ oral inhaler(per spray)	○ Never ○ Yes, in the past ○ Yes, currently Months of use

99. Current and former medication use:

Have you ever taken any of the following drugs/medications on a regular basis, that is at least once per week for six months or more?

Name of Medicine	Age Started Use	Number of pills per week	Still using or quit using	Age Stopped Use
1. NSAIDS (Non-Steroidal Anti-Inflammatory Drugs)			○ Still using ○ No longer using	

Have you ever taken any of the following drugs/medications on a regular basis, that is at least once per week for six months or more?				
Name of Medicine	**Age Started Use**	**Number of pills per week**	**Still using or quit using**	**Age Stopped Use**
Examples: Aleve, Motrin, Bayer,Aspirin, Ibuprofen, Tylenol, Celebrex				
2. STATINS (Lipid-Lowering Drugs) **Examples: Baycol, Crestor, Lipitor, Zocor**			○ Still using ○ No longer using	
3. Asthma Medicine **Examples: Albuterol, Prednisone, Advair, Combivent, Symbicort**			○ Still using ○ No longer using	
4. Diabetes Medicine **Examples: Metformin, Glucotrol, Prandin, Humalog, Novalog**			○ Still using ○ No longer using	
5. Other medication use 1			○ Still using ○ No longer using	
6. Other medication use 2			○ Still using ○ No longer using	

(15 of 15) Contact Info (Doctor)

100. Name, address and telephone number of your doctor.

Name of your doctor	
Telephone Number of your doctor	
Other info (email, fax, etc.)	
Address of your doctor	Street 1: Street 2: City: State: Zip Code: Country