DFCI USE ONLY:
DFCI MRN #_____
Protocol ID # _____

Medical Questionnaire and Tissue Banking for Multiple Myeloma, Waldenström Macroglobulinemia, and Related Disorders

DFCI Protocol Number: 09-233 Principal Investigator: Irene M. Ghobrial, MD

Please complete and return in enclosed envelope to Irene Ghobrial at: Dana-Farber Cancer Institute,
450 Brookline Avenue, LG-LC, Boston, MA 02115.
OR fax to 617-582-7153 OR email to **DFCItissuebank@gmail.com**

Name: **Gender:** ☐ **Male** ☐ **Female**

D.O.B (*mm/dd/yyyy):* **Today's Date (*mm/dd/yyyy):***

We invite you to participate in a research project that is being organized by Dana-Farber/Harvard Cancer Center. We are studying the molecular characteristics of Multiple Myeloma (MM), Waldenström Macroglobulinemia (WM), Monoclonal Gammopathy of Undetermined Significance (MGUS), smoldering MM (sMM) and other lymphoplasmacytic lymphomas (LPL). Your participation in this study will help us understand the causes and help us move toward prevention and improved treatment. As part of the study, we will ask you to complete a medical questionnaire. Research participation is voluntary, and a decision not to participate will not affect your care. All information that contains personal identifiers will be held in strict confidence and will not be released without your signed consent.

Have you signed informed consent? ☐ No ☐ Yes
If no, please sign the informed consent document before completing this questionnaire.

Are you willing to complete this questionnaire? ☐ No ☐ Yes
If no, please mark your response and mail back, and we will not contact you again.

If yes, please provide the contact information identified below.

Mailing Address:_____

Telephone Number: _____

Email Address:_____

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CANCER HISTORY

1.) Were you ever diagnosed by a physician with any of the following types of cancer listed below? Select **all** that apply.

Cancer diagnosis	Approximate diagnosis date	How was your diagnosis established?
☐ Monoclonal gammopathy of unknown significance (MGUS)		☐ Lymph node biopsy ☐ Bone marrow biopsy ☐ Test on your blood ☐ Test on your urine ☐ Other (Please specify_____)
☐ Smoldering Myeloma (SM)		☐ Lymph node biopsy ☐ Bone marrow biopsy ☐ Test on your blood ☐ Test on your urine ☐ Other (Please specify_____)
☐ Multiple Myeloma (MM)		☐ Lymph node biopsy ☐ Bone marrow biopsy ☐ Test on your blood ☐ Test on your urine ☐ Other (Please specify_____)
☐ Lymphoplasmacytic lymphoma (LPL)		☐ Lymph node biopsy ☐ Bone marrow biopsy ☐ Test on your blood ☐ Test on your urine ☐ Other (Please specify_____)
☐ Waldenström's Macroglobulinemia (WM)		☐ Lymph node biopsy ☐ Bone marrow biopsy ☐ Test on your blood ☐ Test on your urine ☐ Other (Please specify_____)

If you are a patient diagnosed with any of the cancers listed above, please provide the following related to your care:

Primary Oncologist Name _____

Primary Oncologist Address: _____

Primary Oncologist Telephone: _____

☐ I am not a patient diagnosed with any of the cancers listed above. I am one of the following:

☐ Family member of:
☐ Non-family acquaintance of:
(i.e., neighbor or friend who has not ever shared a residence with the patient)

Patient Name: _____
Patient Date of Birth: _____

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PATIENT BACKGROUND INFORMATION

2.) How would you describe your racial background? Select **all** that apply.

Race and Ethnicity
☐ Ashkenazi Jewish
☐ Arab/West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan)
☐ Black
☐ Caucasian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Latin American
☐ Native/aboriginal people of North America
☐ South Asian (e.g. East Indian, Pakistani, Punjabi, Sri Lankan)
☐ South East Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese)
☐ Other (Please specify:)

3.) Were you born in the US? ☐ Yes ☐ No, I was born in _____ (country)

4.) In what religion were you raised?

☐ None
☐ Catholic
☐ Protestant
☐ Buddhism
☐ Hindu
☐ Jewish
☐ Muslim
☐ Eastern Orthodox (Greek or Russian)
☐ Mormon
☐ Seventh Day Adventist
☐ Other
(Please specify_____)

5.) What best describes your educational status? Select one.

☐ Some grade school
☐ Some high school
☐ High school graduate
☐ Vocational or technical school beyond high school
☐ Some college or associate's degree
☐ College degree (bachelor's or equivalent)
☐ Graduate or professional school
☐ Other (Please specify_____)

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PATIENT BACKGROUND INFORMATION, continued

6.) What is your current employment status?

☐ Disabled
☐ Employed 32 hours or more per week
☐ Employed less than 32 hours per week
☐ Full time student
☐ Homemaker
☐ On medical leave
☐ Part time student
☐ Retired
☐ Unemployed and/or seeking work
☐ Other (Please specify_____)

7.) In which of the following locations have you lived the longest?

☐ On a farm
☐ Rural area, but not a farm
☐ City or town, population under 10,000
☐ City or town, population 10,000 to 100,000
☐ City or town, population over 100,000

8.) Have you ever lived in a residence situated within one kilometer (~6 blocks) of the following?

☐ Airport……....For approximately _____ years
☐ Railroad Station……....For approximately _____ years
☐ Railroad Track……For approximately _____ years
☐ Industrial Site……For approximately _____ years
☐ Multi-Lane Highway……..For approximately _____ years

9.) What is your current marital status?

☐ Married
☐ Widowed
☐ Separated
☐ Divorced
☐ Never married
☐ Living with someone in a marriage-like relationship

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PATIENT BACKGROUND INFORMATION, continued

10.) What is your current weight? ☐ Pounds ☐ Kilograms

11.) What was your weight 6 months ago? ☐ Pounds ☐ Kilograms

12.) Have you lost any weight in the past year? ☐ No ☐ Yes

a.) If yes, approximately how much weight have you lost? ☐ Pounds ☐ Kilograms

☐ 2-4
☐ 5-9
☐ 10-14
☐ 15-29
☐ 30-49
☐ 50+
☐ Not sure

13.) During the past two years, did you intentionally lose weight? ☐ No ☐ Yes

a.) If yes, approximately how much have you lost? ☐ Pounds ☐ Kilograms

☐ 2-4
☐ 5-9
☐ 10-14
☐ 15-29
☐ 30-49
☐ 50+
☐ Not sure

14.) What is your current height? ☐ Feet ☐ Meters

☐ Inches ☐ Centimeters

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PAST CANCER HISTORY, continued

15.) In the past, have you ever had any of the following types of cancer listed below? If yes, please specify the type of treatment you received for it. *Check all that apply (do not include basal cell skin cancer, MGUS, MM, Smoldering Myeloma, Lymphoplasmacytic lymphoma or WM).*

Cancer diagnosis	Approximate diagnosis date	Chemotherapy	Surgery	Hormone Therapy	Radiation Therapy
☐ Bladder		☐	☐	☐	☐
☐ Bone		☐	☐	☐	☐
☐ Brain		☐	☐	☐	☐
☐ Breast		☐	☐	☐	☐
☐ Colon		☐	☐	☐	☐
☐ Colorectal		☐	☐	☐	☐
☐ Hodgkin's lymphoma		☐	☐	☐	☐
☐ Invasive cervical		☐	☐	☐	☐
☐ Kidney		☐	☐	☐	☐
☐ Leukemia		☐	☐	☐	☐
☐ Liver		☐	☐	☐	☐
☐ Lung		☐	☐	☐	☐
☐ Melanoma		☐	☐	☐	☐
☐ Mouth/throat		☐	☐	☐	☐
☐ Muscle		☐	☐	☐	☐
☐ Non Hodgkin's Lymphoma		☐	☐	☐	☐
☐ Ovary		☐	☐	☐	☐
☐ Pancreas		☐	☐	☐	☐
☐ Prostate		☐	☐	☐	☐
☐ Rectal		☐	☐	☐	☐
☐ Sarcoma		☐	☐	☐	☐
☐ Skin		☐	☐	☐	☐
☐ Stomach		☐	☐	☐	☐
☐ Thyroid		☐	☐	☐	☐
☐ Unknown primary		☐	☐	☐	☐
☐ Uterus/Endometrium		☐	☐	☐	☐
☐ Other (Please specify:_____)		☐	☐	☐	☐

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MEDICAL HISTORY

16.) Has a doctor ever diagnosed you with any of the following conditions?

	No	Yes	Specify Treatment, if any:
Rheumatoid Arthritis	☐	☐	
Lupus erythematosus	☐	☐	
Celiac Sprue	☐	☐	
Sjögren's Syndrome	☐	☐	
HIV	☐	☐	
Lymph node Enlargement	☐	☐	
Hemolytic anemia	☐	☐	
Pernicious anemia	☐	☐	
Osteopenia or osteoporosis	☐	☐	
Renal Insufficiency (kidney problems)	☐	☐	
Venous Thrombosis (blood clots)?	☐	☐	
Stroke/TIA (transient ischemic attack)?	☐	☐	
Inflammatory bowel disease (ulcerative colitis/ Crohn's disease)	☐	☐	
Infectious mononucleosis (i.e. mono)	☐	☐	
Diabetes mellitus	☐	☐	
Thyroid disorder	☐	☐	
Other autoimmune disease (please specify_____)	☐	☐	

TOBACCO HISTORY

17.) Have you smoked more than five standard packs of cigarettes (i.e., more than 100 cigarettes) in your lifetime? ☐ No ☐ Yes

If Yes…

a.) How old were you when you started smoking cigarettes? ☐

b.) Throughout the time that you smoked cigarettes, what is the average number of cigarettes per day that you smoked? ☐

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TOBACCO HISTORY, continued

c.) Do you currently smoke cigarettes? ☐ No ☐ Yes

If No…

d.) What age were you when you stopped smoking cigarettes? ☐

18.) Have you ever been exposed to someone else's tobacco smoke? ☐ No ☐ Yes

a.) If yes, for how long were you exposed? ☐ ☐ Months ☐ Years

b.) If yes, on average how many hours per week were you exposed? ☐

19.) Please indicate where you typically experienced exposure to someone else's smoke.
Select **all** that apply.

☐ Home
☐ Work
☐ Other (please specify_____)

20.) Have you ever used any of the other tobacco or related products listed below? If yes, please indicate the number of times per day and number of years used.

Chewing tobacco	☐ No ☐ Yes	Number of times per day _____	Number of years_____
Snuff or dip	☐ No ☐ Yes	Number of times per day _____	Number of years_____
Pipes	☐ No ☐ Yes	Number of times per day _____	Number of years_____
Cigars	☐ No ☐ Yes	Number of times per day _____	Number of years_____
Nicotine gum/patch	☐ No ☐ Yes	Number of times per day _____	Number of years_____

SOCIAL HISTORY

21.) Have you ever or do you currently drink alcohol?

☐ No, never. ☐ Yes, but only in the past. ☐ Yes, currently.

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SOCIAL HISTORY, continued

a.) If yes, at what age did you FIRST start drinking alcohol at least once per week for a period of 6 months or longer? ☐

b.) For how many years total have you consumed alcohol at least once per week? ☐

c.) If you have stopped, at what age did you stop drinking alcohol at least once per week? ☐ Not Applicable – have not stopped ☐

22.) For each type of alcohol listed below, please list the average number of drinks per week.

a.) Beer (12 oz. can or bottle) Number of drinks per week ☐

b.) Wine or wine cooler (4 oz. glass) Number of drinks per week ☐
i.) Please circle one: Red or White

c.) Liquor (1 shot or jigger) Number of drinks per week ☐

23.) If your alcohol intake in the past was different from now, for each type of alcohol listed below, please list the average number of drinks per week.

a.) Beer (12 oz. can or bottle) Number of drinks per week ☐

b.) Wine or wine cooler (4 oz. glass) Number of drinks per week ☐
i.) Please circle one: Red or White

c.) Liquor (1 shot or jigger) Number of drinks per week ☐

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FAMILY HISTORY

24.) Please provide information about your immediate family: parents, grandparents, uncles, aunts, siblings and children as well as their history of cancer. These questions only apply to full biological or blood relatives. *Do not include relatives through marriage or adoption, and do not include step- or half-brothers or sisters*.

If you are unsure about or do not know the information for a relative, please put "DK" in the space provided.

Blood Relative	How many do you have?	Have any of them been diagnosed with cancer?
Brothers		☐ No ☐ Yes ☐ Don't Know
Sisters		☐ No ☐ Yes ☐ Don't Know
Daughters		☐ No ☐ Yes ☐ Don't Know
Sons		☐ No ☐ Yes ☐ Don't Know
Parents		☐ No ☐ Yes ☐ Don't Know
Grandparents		☐ No ☐ Yes ☐ Don't Know
Uncles		☐ No ☐ Yes ☐ Don't Know
Aunts		☐ No ☐ Yes ☐ Don't Know

****Cancer Types**		
Bladder	Leukemia	Pancreatic
Blood	Liver	Prostate
Brain	Lung	Rectum
Breast	Melanoma	Stomach
Colon	MGUS	Thyroid
Colorectal	Mouth/Throat	Unknown
Hodgkin's Lymphoma	Myeloma	Uterine/Endometrial
Invasive Cervical	Non-Hodgkin's Lymphoma	Waldenströms Macroglobulinemia
Kidney	Ovarian	Other (specify)

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FAMILY HISTORY, continued

Note: Please complete this section only for blood relatives diagnosed with cancer. If you have more than one relative of a particular type who has been diagnosed with cancer, please assign each a number in the relative column (e.g. Sister 1, Sister 2).

Blood Relative	**Maternal (M)/ Paternal (P)/ Both (B)**	**Cancer Type****	**Age at diagnosis** *Enter DK if unknown*	**Is Age estimated to decade?**	**Alive?**	**If deceased, at what age?**
Sample Sister 1	M	Myeloma	63	☐ Yes	☐ No ☒ Yes ☐ DK	N/A
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	
				☐ Yes	☐ No ☐ Yes ☐ DK	

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OB/GYN HISTORY (If Male, please skip to Question 30)

25.) At what age did you have your first menstrual period?

- ☐ Younger than 11
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ Older than 16

26.) Have you ever been pregnant? ☐ No ☐ Yes

If yes:

a.) How many times have you been pregnant? ☐

b.) How many miscarriages have you had? ☐

c.) How many abortions have you had? ☐

d.) How many live births have you had? ☐

e.) If you have children, what was your age at your first live birth? ☐

i.)If you had/ have children, did / do you breastfeed? ☐ No ☐ Yes

If yes:

ii.) How many of your children did you breastfeed? ☐

iii.) What was the total number of months you spent breastfeeding? ☐

iv.) Did you ever experience mastitis (an infection of the breast)? ☐ No ☐ Yes

---

27.) Have you had a menstrual period within the last six months?

- ☐ No
- ☐ Yes; have menstrual periods on hormone replacement therapy
- ☐ Yes; natural menstrual periods or menstrual periods on birth control pills
- ☐ Not sure

OB/GYN HISTORY, continued

If no,

a.)Why did your periods stop?

- ☐ Anorexia
- ☐ Athlete
- ☐ Both ovaries removed; no hysterectomy
- ☐ Chemotherapy or radiation therapy
- ☐ Hysterectomy with both ovaries removed
- ☐ Hysterectomy with ovaries left in
- ☐ Hysterectomy; not sure about ovaries
- ☐ Lupron
- ☐ Natural menopause
- ☐ Pregnancy and/or breastfeeding
- ☐ Other medication that suppresses your period
- ☐ Other (Please specify _____)

28.) Have you ever used estrogen or estrogen replacement therapy? ☐ No ☐ Yes

a.) If yes, what form of estrogen do/did you use? Select **all** that apply

- ☐ Estring
- ☐ Patch
- ☐ Pill
- ☐ Vaginal Cream
- ☐ Other (Please specify_____)

OTHER MEDICATIONS and/or TREATMENTS

29.) Outside of a multivitamin do you REGULARLY use other complementary/nontraditional/ alternative therapies?

☐ No ☐ Yes

a.) If yes, which therapies? Select **all** that apply

- ☐ Acupressure
- ☐ Acupuncture
- ☐ Biofeedback
- ☐ Body Work
- ☐ Herbal and botanical remedies
- ☐ Hypnosis
- ☐ Macrobiotics
- ☐ Massage
- ☐ Meditation
- ☐ Megavitamins
- ☐ Reiki
- ☐ Spiritual healing
- ☐ Tai Chi or Chi Gong
- ☐ Other (Please specify_____)

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OTHER MEDICATIONS and/or TREATMENTS, continued

30.) Please complete the table below by indicating average use for the following:

Aspirin (including regular Anacin, Bufferin, etc. but NOT aspirin-free products or Tylenol or Acetaminophen)

Non-Steroidal Anti-Inflammatory Drugs (including Ibuprofen, Advil, Motrin, Aleve, Nuprin, Naprosyn, Anaprox, Relafen, Clinoril, Indocin, Feldene, Keptoprofen, Celebrex, Vioxx but NOT aspirin-free products or Tylenol or Acetaminophen).

Medication Name	Average frequency of use	Average number taken per week	If you use ½ tablet or more per week, for how many years have you been taking it?
Aspirin	☐ 0 days ☐ 1-3 days per month ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Daily	☐ 0 tablets ☐ ½ - 2 tablets ☐ 3-5 tablets ☐ 6-14 tablets ☐ 15 or more tablets *(4 baby aspirin = 1 tablet)*	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more
Non-Steroidal Anti-Inflammatory Drugs	☐ 0 days ☐ 1-3 days per month ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Daily	☐ 0 tablets ☐ ½ - 2 tablets ☐ 3-5 tablets ☐ 6-14 tablets ☐ 15 or more tablets	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more
Acetaminophen/ Tylenol	☐ 0 days ☐ 1-3 days per month ☐ 1-2 days per week ☐ 3-4 days per week ☐ 5-6 days per week ☐ Daily	☐ 0 tablets ☐ ½ - 2 tablets ☐ 3-5 tablets ☐ 6-14 tablets ☐ 15 or more tablets	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more

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OTHER MEDICATIONS and/or TREATMENTS, continued

31.) Please complete the table below by indicating average use for the medications listed.

Medication Name	Medication use	Average number taken per week	If you use ½ tablet or more per week, for how many years have you been taking it?
Multivitamin	☐ Take ☐ Do not take	☐ 2 or less ☐ 3-5 ☐ 6-9 ☐ 10 or more	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more
Folate Supplement (not including a multivitamin)	☐ Take ☐ Do not take	☐ 0 tablets ☐ ½ - 2 tablets ☐ 3-5 tablets ☐ 6-14 tablets ☐ 15 or more tablets	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more
Antacids (Maalox, Rolaids, Tums, etc.)	☐ Take currently ☐ Took only in the past ☐ Do not take	N/A	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more
Statins (cholesterol-lowering drugs such as Lipitor, Crestor, Pravachol, etc.)	☐ Take currently ☐ Took only in the past ☐ Do not take	N/A	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more
Metformin (for diabetes)	☐ Take currently ☐ Took only in the past ☐ Do not take	N/A	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more
Insulin (for diabetes)	☐ Take currently ☐ Took only in the past ☐ Do not take	N/A	☐ 1 or less ☐ 2-4 ☐ 5-9 ☐ 10 or more

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OTHER MEDICATIONS and/or TREATMENTS, continued

32.) Not counting multivitamins, do you take any of the following individual vitamin supplements?

- ☐ Vitamin A
- ☐ Vitamin B6
- ☐ Vitamin B12
- ☐ Vitamin C
- ☐ Vitamin D
- ☐ Vitamin E

33.) Are there any other supplements that you take on a regular basis?

- ☐ Metamucil/Citrucel
- ☐ Cod Liver Oil
- ☐ Fish Oil
- ☐ Flax seed oil
- ☐ Magnesium
- ☐ Calcium
- ☐ Coenzyme Q
- ☐ Niacin
- ☐ B-complex
- ☐ Ginkgo Biloba
- ☐ Lycopene
- ☐ Beta-carotene
- ☐ Melatonin
- ☐ Selenium
- ☐ Glucosamine/Chondroitin
- ☐ Iron
- ☐ Potassium
- ☐ Chromium
- ☐ Curcumin/turmeric
- ☐ Vitamin water
- ☐ Zinc
- ☐ Resveratrol
- ☐ Other (please specify _____)

ACTIVITY HISTORY

34.) What is your normal walking pace outdoors? Select **one**

- ☐ Slow (less than 2 miles per hour)
- ☐ Normal, average (2 to 2.9 miles per hour)
- ☐ Brisk (3 to 3.9 miles per hour)
- ☐ Very brisk / Striding (4 mph or faster)
- ☐ Unable to walk

35.) How many flights or sets of stairs (NOT steps) do you climb daily? Select **one**

- ☐ < 1 flight
- ☐ 1-2 flights
- ☐ 3-4 flights
- ☐ 5-9 flights
- ☐ 10-14 flights
- ☐ 15 or more flights

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ACTIVITY HISTORY, continued

36.) During the PAST 2 MONTHS, what was your average time PER WEEK spent doing each of the following recreational activities?

	0 min	1-4 min	5-19 mins	20-59 mins	1-1½ hrs	2-3 hrs	4-6 hrs	7-10 hrs	11+ hrs
Bicycling (including stationary machine)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Jogging (slower than 10 minutes/mile)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lap swimming	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower intensity exercise (yoga, stretching, toning)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other aerobic exercise (calisthenics, ski or stair machine, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other vigorous activities (e.g. lawn mowing)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Outdoor work	☐	☐	☐	☐	☐	☐	☐	☐	☐
Running (10 minutes/mile or faster)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tennis, squash, racquetball	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking for exercise or walking to work (including golf without a cart)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Weight training	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify_____)	☐	☐	☐	☐	☐	☐	☐	☐	☐

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EMPLOYMENT HISTORY

37.) Have you ever worked for more than 6 months in any of the following jobs? If your work in any of these industries is *primarily* office or administrative related, please indicate this by checking the appropriate box below.

Industry	Primarily Office/Administrative Work
☐ Aircraft maintenance	☐
☐ Building construction	☐
☐ Hair dressing	☐
☐ Fire-fighting	☐
☐ Maritime	☐
☐ Food services	☐
☐ Landscaping	☐
☐ Agriculture	☐
☐ Gas distribution as station attendant	☐
☐ Postal service as mail carrier	☐
☐ Mining	☐
☐ Oil refining	☐
☐ Police detachment	☐
☐ Plumbing	☐
☐ Road construction and maintenance	☐
☐ Roofing	☐
☐ Waterproofing	☐
☐ Rubber	☐
☐ Metal working	☐
☐ Traffic / Warehousing / Shipping	☐
☐ Manufacturing of electrodes	☐
☐ Gas works	☐
☐ Tar distillery	☐
☐ Aluminum production	☐

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EMPLOYMENT HISTORY, continued

38.) Have you ever performed any of the following tasks in the context of your work? If so, please specify the approximate number of months.

Tasks	Approximate number of months?
☐ Hair dying	
☐ Operating a boat engine	
☐ Metal working (grinding, cutting, extruding, machining)	
☐ Furnace work	
☐ Fire-fighting	
☐ Cooking	
☐ Baking bread products or pastries	
☐ Operating cook oven	
☐ Chimney sweeping	
☐ Brick-laying	
☐ Masonry	
☐ Carpentry	
☐ Repairing electrical equipment	
☐ Driving a forklift	
☐ Bartending	
☐ Waiter / Waitress	
☐ Gardening	
☐ Waste Incineration	

ENVIRONMENTAL HISTORY

39.) Have you ever used permanent hair dye for more than one year? ☐ No ☐ Yes

a.) If yes, approximately what year did you begin using it? ☐

b.) If yes, approximately how many years total have you used it? ☐

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ENVIRONMENTAL HISTORY, continued

40.) Have you ever been exposed to any of the substances listed below <u>for at least 8 hours per week</u> for 1 year or more, either on a job or while working on a hobby?

	At work	At home	Recreationally	Approximate number of years
☐ Asbestos	☐	☐	☐	
☐ Cutting oils or motor vehicle oils	☐	☐	☐	
☐ Asphalt, tar, or pitch	☐	☐	☐	
☐ Benzene or other solvents	☐	☐	☐	
☐ Pesticides	☐	☐	☐	
☐ Herbicides	☐	☐	☐	
☐ Fertilizers	☐	☐	☐	
☐ Gasoline or other solvents	☐	☐	☐	
☐ Petroleum products other than benzene	☐	☐	☐	
☐ Grain dust	☐	☐	☐	
☐ Engine exhaust	☐	☐	☐	
☐ Mercury	☐	☐	☐	
☐ Lead solder	☐	☐	☐	
☐ Cadmium	☐	☐	☐	
☐ Cotton dust	☐	☐	☐	
☐ Silica / sand dust	☐	☐	☐	
☐ Lead	☐	☐	☐	
☐ Arsenic	☐	☐	☐	
☐ Mineral oils	☐	☐	☐	
☐ Soot	☐	☐	☐	
☐ Creosote	☐	☐	☐	
☐ Inks, dyes, or tanning solutions	☐	☐	☐	
☐ Dry cleaning agents	☐	☐	☐	
☐ Vinyl chloride, or plastics	☐	☐	☐	
☐ Acrylic and oil-based paints	☐	☐	☐	
☐ Varnish, lacquer, or glue	☐	☐	☐	
☐ Paraffin wax	☐	☐	☐	
☐ Coal dust	☐	☐	☐	
☐ Metals (lead, nickel, zinc)	☐	☐	☐	
☐ Radioactive materials	☐	☐	☐	
☐ X-ray radiation	☐	☐	☐	
☐ Wood dust	☐	☐	☐	
☐ Agent Orange	☐	☐	☐	
☐ Agent White	☐	☐	☐	
☐ Welding fumes	☐	☐	☐	
☐ Pneumatic drills (vibrations)	☐	☐	☐	
☐ Other (Please specify:_____)	☐	☐	☐	

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Thank you for completing this questionnaire. We appreciate your participation.

We would like to invite you to complete the optional dietary questionnaire which will be provided to you.