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USRT

Study ID:

U.S. Radiologic Technologists Study

GENETIC STUDIES QUESTIONNAIRE

A collaborative effort between the University of Minnesota School of Public Health, National Cancer Institute, and American Registry of Radiologic Technologists.

CONFIDENTIALITY:
Please be assured that all information you provide will be kept confidential and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Any published results from this study will be reported in statistical summaries only and will never include a participant's name. Your participation in this study is completely voluntary and failure to answer any particular question or the information collection as a whole will not affect your future contacts with the University of Minnesota, the American Registry of Radiologic Technologists, or the National Institutes of Health.

Today's date: ☐☐ - ☐☐ - ☐☐☐☐
MONTH DAY YEAR

SECTION A: FAMILY HISTORY

In this section we are interested to learn more about the health history of some of your female family members. Please include only relatives who are related to you by blood, including half-siblings. Do not include adopted or step-relatives.

1. How many blood-related sisters (full and half) do you have, including any who have died? . . . . . ☐☐ NUMBER

2. How many biological daughters do you have, including any who have died? . . . . . ☐☐ NUMBER

3. Please complete the chart below for any of your first-degree female relatives (mother, sisters, or daughters) who have been diagnosed with breast or ovarian cancer. Use a separate row for each person.

0 None of my female relatives have been diagnosed with breast or ovarian cancer. [GO TO SECTION B, PAGE 2.]

	a. How is this person related to you? (Only include relatives who have been diagnosed with breast or ovarian cancer.)	b. What type of cancer did she have? How old was she when first diagnosed with this cancer?
1st relative	0 Mother 0 Sister → Is this a full or half sibling? 0 FULL 0 HALF 0 Daughter	0 Breast cancer → Age first diagnosed ☐☐ AGE 0 Ovarian cancer → Age first diagnosed ☐☐ AGE
2nd relative	0 Sister → Is this a full or half sibling? 0 FULL 0 HALF 0 Daughter	0 Breast cancer → Age first diagnosed ☐☐ AGE 0 Ovarian cancer → Age first diagnosed ☐☐ AGE
3rd relative	0 Sister → Is this a full or half sibling? 0 FULL 0 HALF 0 Daughter	0 Breast cancer → Age first diagnosed ☐☐ AGE 0 Ovarian cancer → Age first diagnosed ☐☐ AGE

Please list additional female relatives diagnosed with breast or ovarian cancer on a separate piece of paper and return with this form.

Barcode

SECTION B: REPRODUCTIVE HISTORY (WOMEN ONLY)

MEN - GO TO SECTION C, PAGE 3

PREGNANCY OUTCOMES

4. Please fill in the chart below for each pregnancy you have had. Please use more than one line if a pregnancy resulted in multiple births (twins, triplets, etc.)

0 I have never been pregnant. [GO TO QUESTION 5 BELOW.]

Pregnancy	When did this pregnancy end? MONTH / YEAR	Did this pregnancy result in a live birth? NO YES	Did you breast-feed this baby?	How many months?
First	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐
Second	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐
Third	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐
Fourth	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐
Fifth	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐
Sixth	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐
Seventh	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐
Eighth	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐
Ninth	☐☐/☐☐	0 NO 0 YES →	0 NO 0 YES →	☐☐

Please list additional pregnancies on a separate piece of paper and return with this form.

5. Have your menstrual periods stopped permanently?

0 Never menstruated
0 Still having menstrual periods
0 Not sure, periods are irregular or using hormone supplements
0 Menstrual periods have stopped permanently. → ☐☐ **Age menstrual periods stopped permanently**

6. Have you had surgery to remove your uterus or one or both of your ovaries? [Mark all that apply.]

0 No
0 Yes, removal of uterus → ☐☐ **Age when removed**
0 Yes, one ovary removed → ☐☐
0 Yes, both ovaries removed → ☐☐ **1st ovary** ☐☐ **2nd ovary**

SECTION C: PERSONAL MEDICAL RADIATION EXPOSURE

In this section we are interested in radiation exposure YOU RECEIVED AS A PATIENT, NOT procedures performed by you. Please indicate how frequently you had any of the following procedures during each time period listed since 1980. Please count the number of times you had the procedure, NOT the number of individual films taken. ***Please provide as much information as possible, including estimates if you cannot remember the exact number of procedures.***

7. Chest X-RAYS or Mammography performed on YOU	Between 1980 - 1989?					Between 1990 - 1999?					2000 to the present?				
	zero	1-3	4-7	8-10	11+	zero	1-3	4-7	8-10	11+	zero	1-3	4-7	8-10	11+
Chest X-ray	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mammography	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

8. Other FILM X-RAYS performed on YOU	Between 1980 - 1989?				Between 1990 - 1999?				2000 to the present?			
	zero	1	2-4	5+	zero	1	2-4	5+	zero	1	2-4	5+
Face or neck	0	0	0	0	0	0	0	0	0	0	0	0
Spine or back: Thoracic (upper) spine plain film	0	0	0	0	0	0	0	0	0	0	0	0
Full spine plain film	0	0	0	0	0	0	0	0	0	0	0	0
Lumbar (lower) spine plain film	0	0	0	0	0	0	0	0	0	0	0	0
Myelogram	0	0	0	0	0	0	0	0	0	0	0	0
Gastrointestinal (GI) tract or abdomen: Abdominal plain film	0	0	0	0	0	0	0	0	0	0	0	0
Upper gastrointestinal exam with contrast	0	0	0	0	0	0	0	0	0	0	0	0
Gallbladder exam with contrast	0	0	0	0	0	0	0	0	0	0	0	0
Barium swallow or meal with contrast	0	0	0	0	0	0	0	0	0	0	0	0
Barium enema with contrast	0	0	0	0	0	0	0	0	0	0	0	0
Urinary system (e.g. pyelogram, urethrogram, cystogram)	0	0	0	0	0	0	0	0	0	0	0	0
Bony pelvis or hip	0	0	0	0	0	0	0	0	0	0	0	0

9. SPECIAL PROCEDURES performed on YOU	Between 1980 - 1989?				Between 1990 - 1999?				2000 to the present?			
	zero	1	2-4	5+	zero	1	2-4	5+	zero	1	2-4	5+
Cerebral arteriogram	0	0	0	0	0	0	0	0	0	0	0	0
Coronary angiogram or cardiac catheterization (including angioplasty)	0	0	0	0	0	0	0	0	0	0	0	0
Carotid arteriogram	0	0	0	0	0	0	0	0	0	0	0	0
Pulmonary arteriogram	0	0	0	0	0	0	0	0	0	0	0	0
Renal arteriogram	0	0	0	0	0	0	0	0	0	0	0	0
Other fluoroscopy exam of the chest (specify_____)	0	0	0	0	0	0	0	0	0	0	0	0

Barcode

10. CT SCANS performed on YOU	Between 1980 - 1989? zero	1	2-4	5+	Between 1990 - 1999? zero	1	2-4	5+	2000 to the present? zero	1	2-4	5+
Head or neck	0	0	0	0	0	0	0	0	0	0	0	0
Chest	0	0	0	0	0	0	0	0	0	0	0	0
Abdomen	0	0	0	0	0	0	0	0	0	0	0	0
Pelvis	0	0	0	0	0	0	0	0	0	0	0	0
Upper back or spine	0	0	0	0	0	0	0	0	0	0	0	0
Lower back or spine	0	0	0	0	0	0	0	0	0	0	0	0

11. THERAPEUTIC X-RAY SERIES performed on YOU	Between 1980 - 1989? zero	1	2-4	5+	Between 1990 - 1999? zero	1	2-4	5+	2000 to the present? zero	1	2-4	5+
Note: If your treatment involved a course of multiple radiation treatments over time *(such as 1 treatment per day, 5 days per week for 4-6 weeks)*, this should be counted as "1" series. If you later received a course of radiation treatments for a new cancer, a recurrence, or a metastasis, please count that as a separate series. We are interested in the number of series, not the number of sessions.												
Treatment series to breast	0	0	0	0	0	0	0	0	0	0	0	0
Treatment series to chest other than breast	0	0	0	0	0	0	0	0	0	0	0	0
Treatment series to abdomen	0	0	0	0	0	0	0	0	0	0	0	0
Treatment series to pelvis	0	0	0	0	0	0	0	0	0	0	0	0
Treatment series to thyroid or other part of neck	0	0	0	0	0	0	0	0	0	0	0	0
Treatment series to head	0	0	0	0	0	0	0	0	0	0	0	0
Treatment series to extremities	0	0	0	0	0	0	0	0	0	0	0	0

SECTION D: CHEMOTHERAPY

12. Have you ever had CHEMOTHERAPY for cancer, leukemia, lymphoma, a brain tumor or malignancy, or other condition? If yes, please report each year you received chemotherapy and the reason for the treatment. Please include treatment you received for a recurrence or metastasis.

NO	YES	YEAR(S)	TYPE OF CANCER AND/OR REASON FOR TREATMENT
0	0 →		

This is the end of the questionnaire. Please return completed questionnaire in postage-paid envelope provided as soon as possible. If you have any questions, please call the USRT Study office toll-free at 1-800-447-6466.

Thank you for your participation