ID# __ - __ - ____ ____ ____ ____ ____

LIVER CANCER STUDY

CASE AND HIGH RISK CASES QUESTIONNARE

National Cancer Institute
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Bethesda, Maryland 20892
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OMB# 0925-XXXX
Expiration Date: XX / XX / XXXX

Attachment # 8: Liver Case-Control Questionnaire

BURDEN STATEMENT:

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-XXXX). Do not return the completed form to this address.

PRIVACY STATEMENT:

Statement Of Privacy Act Applicability

You will be asked to participate in the research study "Resource Collection and Evaluation of Human Tissues from Donors with an Epidemiological Profile for NCI Contract # NO2-RC57700". The study will collect and use health information that can identify you. The authority to collect this information is under 42 USC 285 for the National Cancer Institute, National Institutes of Health. The Privacy Act from 1974 applies to the information collection.

Federal laws require researchers to protect the privacy of your health information. The collection of health information by this study "Resource Collection and Evaluation of Human Tissues from Donors with an Epidemiological Profile for NCI Contract # NO2-RC57700" is covered by the Privacy Act and is in compliance with the Privacy Act System of Records Notice (SORN) # 09-25-0200 http://oma.od.nih.gov/ms/privacy/pa-files /0200, which covers clinical, basic, and population-based research studies of the National Cancer Institute and the National Institutes of Health

ID# __ - __ - ____ ____ ____ ____ ____

TABLE OF CONTENTS

ID# __ - __ - ____ ____ ____ ____ ____

All the information & the data collected in this study are confidential & will not be used except for scientific research.

1. Date of interview: __ __ / __ __ / __ __ __ __
2. Interviewer's name: _____ Interviewer's ID __ __
3. Hospital: _____ ☐☐
4. Doctor's Name: _____ ☐☐☐
5. Patient's Medical Record #: _____
6. Patient's Ethnicity: ( )$_1$ Hispanic/Latino ( )$_2$ Not Hispanic/Latino
7. Patient's Race:
   ( )$_1$ White
   ( )$_2$ Black/African American
   ( )$_3$ Asian
   ( )$_4$ Native Hawaiian/Other Pacific Islander
   ( )$_5$ American Indian/Alaska Native ☐☐
8. Patient's Gender: ( )$_1$ Male
   ( )$_2$ Female
9. Time Started: __ __ : __ __ ( )$_1$ AM
   ( )$_2$ PM

OFFICE USE ONLY

Review

Reviewer's initials: __ __ __ Date Reviewed: __ __ / __ __ / __ __ __ __

Coding and Editing

Coder's initials: __ __ __ Date Coded: __ __ / __ __ / __ __ __ __

Data Entry

First Entry→ Initials: __ __ __ Date Entered: __ __ / __ __ / __ __ __ __

Second Entry→ Initials: __ __ __ Date Entered: __ __ / __ __ / __ __ __ __

Revisions

Revisor's initials: __ __ __ Date Revised: __ __ / __ __ / __ __ __ __

ID# __ - __ - ____ ____ ____ ____ ____

A. IDENTIFIER SHEET

Now I would like to ask you some general information about you.

1. What is your name? _____/_____/_____
   First Middle Last
2. What is your date of birth? __ __ / __ __ / __ __ __ __
3. What is your address:

   _____
   Street Apt. No.

   _____ ___ ___ __ __ __ __ __ - __ __ __ __
   City State Zip Code

4. What is your telephone number? Home: (__ __ __) __ __ __ - __ __ __ __

   Work: (__ __ __) __ __ __ - __ __ __ __

   Ext. __ __ __ __

5. Do you consider yourself Hispanic/Latino or Not Hispanic/Latino?
   ( )$_1$ Hispanic/Latino ( )$_2$ Not Hispanic/Latino

6. Do you consider yourself to be: ( )$_1$ White/Caucasian
   ( )$_2$ Black/African American
   ( )$_3$ Asian
   ( )$_4$ Native Hawaiian/Other Pacific Islander
   ( )$_5$ American Indian/Alaska Native ☐☐

7. What is your age?
   ( )$_0$ 18-24 years
   ( )$_1$ 25-29 years
   ( )$_2$ 30-34 years
   ( )$_3$ 35-39 years
   ( )$_4$ 40-44 years
   ( )$_5$ 45-49 years
   ( )$_6$ 50-54 years
   ( )$_7$ 55-59 years
   ( )$_8$ 60-64 years
   ( )$_9$ 65-69 years
   ( )$_{10}$ 70-74 years
   ( )$_{11}$ 75-79 years
   ( )$_{12}$ 80-84 years
   ( )$_{13}$ 85-90 years

ID# __ - __ - ____ ____ ____ ____ ____

8. What is the name, address and telephone number of a person who can help us contact you in the future, or your next-of-kin (or person who was interviewed if other than patient)?

Name: _____/_____/_____
First Middle Last

Relationship to Patient:
( )$_0$ Spouse
( )$_1$ Parent
( )$_2$ Child
( )$_3$ Brother or Sister
( )$_4$ Friend
( )$_5$ Other -Specify _____ ☐☐

Address:

_____
_
Street Apt. No.

_____ ___ ___ __ __ __ __ __ - __ __ __ __
City State Zip Code

Home telephone number: (__ __ __) __ __ __ - __ __ __ __

TYPE OF STUDY PARTICIPANT:
( )$_0$ Liver Cancer Case
( )$_1$ High Risk
patient/Hospital Control

B. MEDICAL HISTORY

Now I would like to ask some questions about your medical history and your health.

1. Have you ever had a blood transfusion?
( )$_0$ No (Skip to B.4)
( )$_1$ Yes
( )$_8$ Don't know

2. How many times have you had a blood transfusion in your life?
( )$_1$ One time
( )$_2$ 2-4 times
( )$_3$ 5 times or more
( )$_8$ Don't know

3. When was the last time you had a blood transfusion?

Year ___ ___ ___ ___
(calculate if he/she said how many years ago or age)
Fill 8's for Don't know

ID# __ - __ - ____ ____ ____ ____ ____

4. Have you ever donated blood?
   ( )$_0$ No (Skip to B.7)
   ( )$_1$ Yes
   ( )$_8$ Don't know

5. How many times have you donated your blood?
   ( )$_1$ One time
   ( )$_2$ 2-4 times
   ( )$_3$ 5 times or more
   ( )$_8$ Don't know

6. When was the last time you donated your blood?
   Year ___ ___ ___ ___
   (calculate if he/she said how many years ago or age)
   Fill 8's for Don't know

7. Did any doctor ever tell you that you have diabetes (too high or too low sugar level)?
   ( )$_0$ No (Skip to B.9)
   ( )$_1$ Yes
   ( )$_8$ Don't know

8. Do you need any insulin for diabetes?
   ( )$_0$ No (Skip to B.9)
   ( )$_1$ Yes
   ( )$_8$ Don't know

9. What is your height?
   ___ feet ___ ___ inches

10. What is your current weight?
    ___ ___ ____ pounds

11. Interviewer will ask: ***I would now like to measure your waist circumference.***

    Waist circumference (cm)

First	Second	Difference	Tolerance	Third
|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|	2.0	|__|__|__|.|__|

12. Interviewer will ask: ***I would now like to measure your hip circumference.***

    Hip circumference (cm)

First	Second	Difference	Tolerance	Third
|__|__|__|.|__|	|__|__|__|.|__|	|__|__|__|.|__|	2.0	|__|__|__|.|__|

ID# __ - __ - ____ ____ ____ ____ ____

MEDICAL HISTORY ( )1 Very good ( )2 Good

C. FAMILY HISTORY

Now, I would like to learn more about the members of your family. First, I need to get some background about the structure of your family?

1. How many children have you had? Please include only those children that are related to you by blood.

   ___ ___
   # of children

2. Were you adopted?

   ( )0 No
   ( )1 Yes (Skip to Section D)

   ( )8 Don't know

3. Counting only the brothers and sisters related to you by blood, how many brothers and sisters have you had? Please include half brothers and sisters.

   ___ ___ ___ ___
   # of brothers # of sisters

4. Counting only the aunts and uncles related to you by blood, how many aunts and uncles have you had? Please include half brothers and sisters.

   ___ ___ ___ ___
   # of uncles # of aunts

5. Has anyone in your family that is related to you by blood, ever been told they have cancer, include children, parents, grandparents, brothers, sisters, great grandparents, cousins or immediate aunts and uncles? (Include description of maternal or paternal relative)

   ( )0 No (Skip to Section D)
   ( )1 Yes
   ( )8 Don't know

ID# __ - __ - ____ ____ ____ ____ ____

6. Which relative?	First name	Where did the cancer start? DK=888	How old were they when they were diagnosed?	
a. ☐☐☐		☐☐☐	( )1 <20 ( )2 20-29 ( )3 30-39 ( )4 40-49	( )5 50-59 ( )6 60-69 ( )7 >70 ( )8 Don't Know
b. ☐☐☐		☐☐☐	( )1 <20 ( )2 20-29 ( )3 30-39 ( )4 40-49	( )5 50-59 ( )6 60-69 ( )7 >70 ( )8 Don't Know
c. ☐☐☐		☐☐☐	( )1 <20 ( )2 20-29 ( )3 30-39 ( )4 40-49	( )5 50-59 ( )6 60-69 ( )7 >70 ( )8 Don't Know
d. ☐☐☐		☐☐☐	( )1 <20 ( )2 20-29 ( )3 30-39 ( )4 40-49	( )5 50-59 ( )6 60-69 ( )7 >70 ( )8 Don't Know
e. ☐☐☐		☐☐☐	( )1 <20 ( )2 20-29 ( )3 30-39 ( )4 40-49	( )5 50-59 ( )6 60-69 ( )7 >70 ( )8 Don't Know
f. ☐☐☐		☐☐☐	( )1 <20 ( )2 20-29 ( )3 30-39 ( )4 40-49	( )5 50-59 ( )6 60-69 ( )7 >70 ( )8 Don't Know
g. ☐☐☐		☐☐☐	( )1 <20 ( )2 20-29 ( )3 30-39 ( )4 40-49	( )5 50-59 ( )6 60-69 ( )7 >70 ( )8 Don't Know
h. ☐☐☐		☐☐☐	( )1 <20 ( )2 20-29 ( )3 30-39 ( )4 40-49	( )5 50-59 ( )6 60-69 ( )7 >70 ( )8 Don't Know

FAMILY HISTORY ( )1 Very good ( )2 Good (

ID# __ - __ - ___ ___ ___ ___ ___

D. ALCOHOL HISTORY

Now, I would like to ask you some questions about any alcoholic beverages you may drink on a regular basis.

1. In your entire life, have you ever consumed more than 12 alcoholic beverages per year, such as beer, wine, wine coolers or liquor?
   - ( )$_0$ No (Skip to D.3)
   - ( )$_1$ Yes
   - ( )$_8$ Don't know

2. Tell me about the types of alcohol and when you were drinking them.

Period	1	2	3	4	5	6	7
a. At what age did you first start to drink/when you next began to drink?	— —	— —	— —	— —	— —	— —	— —
b. How many cans, bottles or 12 oz of beer did/do you drink?	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.
c. How many 4 oz glasses of wine did/do you drink?	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo. ( )$_4$ Per yr.
d. How many 1 ½ oz. shots of liquor, by itself or in a drink did/do you drink?	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo.	— — ( )$_1$ Per day ( )$_2$ Per wk. ( )$_3$ Per mo.

ID# __ - __ - ____ ____ ____ ____ ____

	( )4 Per yr.	( )4 Per yr.	( )4 Per yr.	( )4 Per yr.	( )4 Per yr.	( )4 Per yr.	( )4 Per yr.
Period	1	2	3	4	5	6	7
e. Have you ever stopped drinking or changed your patterns for more than 12 months?	( )0 No (D3) ( )1 Stopped ( )2 Changed pattern	( )0 No (D3) ( )1 Stopped ( )2 Changed pattern	( )0 No (D3) ( )1 Stopped ( )2 Changed pattern	( )0 No (D3) ( )1 Stopped ( )2 Changed pattern	( )0 No (D3) ( )1 Stopped ( )2 Changed pattern	( )0 No (D3) ( )1 Stopped ( )2 Changed pattern	( )0 No (D3) ( )1 Stopped ( )2 Changed pattern
f. What age did you stop drinking or change your patterns for more than 12 months?	__ __	__ __	__ __	__ __	__ __	__ __	__ __

3. Have you had any alcoholic beverages such as beer, wine or liquor in the last 7 days?
   ( )0 No (Skip to Section E)
   ( )1 Yes
   ( )8 Don't know

4.	In the last seven days, how much did you drink of the following?:	Number:
a.	Cans, bottles or 12 oz. glass of beer	__ __ __
b.	4 oz. glasses of wine	__ __ __
c.	1 ½ oz. shots of hard liquor or drinks containing a	__ __ __

ID# __ - __ - ____ ____ ____ ____ ____

shot of hard liquor	

ALCOHOL HISTORY ( )1 Very good ( )2 Good

E. TOBACCO HISTORY

Next, I would like to ask you some questions about any smoking history you may have.

1. Have you ever smoked more than 100 cigarettes, which is equivalent to five packs, in your life?
   - ( )0 No (Skip to Section F)
   - ( )1 Yes
   - ( )8 Don't know

2. Please tell me about your smoking history. I will be asking you about any times you may have stopped or changed your patterns.

Period	1	2	3	4	5	6
a. In what year did you start smoking cigarettes or change your patterns?	— — — —	— — — —	— — — —	— — — —	— — — —	— — — —
b. What was the average number of cigarettes or packs per day you smoked during this time?	— — — — ( )1cigarettes ( )2 packs	— — — — ( )1cigarettes ( )2 packs	— — — — ( )1cigarettes ( )2 packs	— — — — ( )1cigarettes ( )2 packs	— — — — ( )1cigarettes ( )2 packs	— — — — ( )1cigarettes ( )2 packs
c. After starting, did you change your patterns or stop smoking for more than 6 months?	( )0 No (E3) ( )1 Stopped smoking ( )2 Changed pattern	( )0 No (E3) ( )1 Stopped smoking ( )2 Changed pattern	( )0 No (E3) ( )1 Stopped smoking ( )2 Changed pattern	( )0 No (E3) ( )1 Stopped smoking ( )2 Changed pattern	( )0 No (E3) ( )1 Stopped smoking ( )2 Changed pattern	( )0 No (E3) ( )1 Stopped smoking ( )2 Changed pattern
d. In what year did you stop smoking or change your patterns for more than six	— — — — If this is a change of pattern, skip to	— — — — If this is a change of pattern, skip to	— — — — If this is a change of pattern, skip to	— — — — If this is a change of pattern, skip to	— — — — If this is a change of pattern, skip to	— — — — If this is a change of pattern, skip to

months?	E2a	E2a	E2a	E2a	E2a	E2a
e. Did you start smoking again?	( )$_0$ No (E3) ( )$_1$Yes (E2a)	( )$_0$ No (E3) ( )$_1$Yes (E2a)	( )$_0$ No (E3) ( )$_1$Yes (E2a)	( )$_0$ No (E3) ( )$_1$Yes (E2a)	( )$_0$ No (E3) ( )$_1$Yes (E2a)	( )$_0$ No (E3) ( )$_1$Yes (E2a)

If R stopped smoking more than 6 months ago, Skip to Section F

ID# __ - __ - ____ ____ ____ ____ ____

3. Have you increased or decreased your amount of cigarette smoking in the last 6 months?

( )$_0$ No (Skip to E6)
( )$_1$ Yes
( )$_8$ Don't know

	Period	1	2	3
4.	How long ago did you change your level of smoking?	__ __ ( )$_1$ weeks ( )$_2$ months	__ __ ( )$_1$ weeks ( )$_2$ months	__ __ ( )$_1$ weeks ( )$_2$ months
5a.	Since then, what is the average amount of cigarettes you smoked per day?	__ __ ( )$_1$ cigarettes ( )$_2$ packs	__ __ ( )$_1$ cigarettes ( )$_2$ packs	__ __ ( )$_1$ cigarettes ( )$_2$ packs
5b.	Did you change your level of smoking again?	( )$_0$ No (E6) ( )$_1$ Yes (E4)	( )$_0$ No (E6) ( )$_1$ Yes (E4)	( )$_0$ No (E6) ( )$_1$ Yes (E4)

6. How many cigarettes have you smoked in the last 48 hours?

__ __ __

7. Have you ever smoked at least one cigar a month for more than 6 months?

( )$_0$ No
( )$_1$ Yes
( )$_8$ Don't know

8. Have you ever smoked a pipe on a daily basis for more than 6 months?

( )$_0$ No
( )$_1$ Yes
( )$_8$ Don't know

TOBACCO HISTORY ( )$_1$ Very good ( )$_2$ Good

ID# __ - __ - ____ ____ ____ ____ ____

F. REPRODUCTIVE HISTORY (IF MALE SKIP TO SECTION G)

This next set of questions may seem personal, but remember that your answers are very important to us.

1. Have you ever been pregnant?
   ( )$_0$ No (Skip to question F.7)
   ( )$_1$ Yes
   ( )$_8$ Don't know

2. How many times have you been pregnant? __ __

	1	2	3	4	5	6	7	8	9	10	11	12
3. How old were you when you became pregnant? (Should be chronological)												
4. What was the outcome of this pregnancy? (Check one for each pregnancy)												
01 Single live birth												
02 Multiple live birth, any living												
03 Multiple birth, none living												
04 Stillbirth												
05 Miscarriage												
06 Induced Abortion												
07 Ectopic or tubal												
08 Currently pregnant												
09 Other (specify) _____ ☐												
If R had no live births, Skip to Section G												
	1	2	3	4	5	6	7	8	9	10	11	12
5. Did you breast feed any of these babies for at least two weeks or longer? ( )$_0$ No (Skip to Section G) ( )$_1$ Yes ( )$_8$ Don't know 6. For how many weeks did you breast feed these babies, until you stopped all together?												

7. Have you had a menstrual period in the last 6 weeks? ( )$_0$ No ( )$_1$ Yes( )$_8$ Don't know

8. Are you still menstruating? ( )$_0$ No ( )$_1$ Yes (Skip to H) ( )$_8$ Don't know

9. At what age was your last menstrual period? ____ ____

10. What was the reason that your menstrual periods stopped?
    ( )$_1$ Change of life or natural Menopause
    ( )$_2$ Hysterectomy, still has ovaries
    ( )$_3$ Hysterectomy, ovaries removed
    ( )$_4$ Hysterectomy, don't know whether ovaries removed
    ( )$_5$ Currently pregnant

( )$_6$ Other reason (specify why): _____ ☐

11. Has a doctor or other health professional ever told you that you had completed menopause or the change in life? ( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't know

12. Have you ever used hormonal medications just before, during or after menopause, such as pills, vaginal creams, shots, suppositories or skin patches?

( )$_0$ No (Skip to Section H)
( )$_1$ Yes
( )$_8$ Don't know

_____

		At what age did you start to use them?	Total number of years used? 77= still using
a. Estrogen pills (Premarin, Estrace, Estratab, Ogen)	( )$_0$ No ( )$_1$ Yes	__ __	__ __
b. Progresteron pills (Progestins, Provera, Megace)	( )$_0$ No ( )$_1$ Yes	__ __	__ __
c.Estrogen and progesterone pills (Prempo)	( )$_0$ No ( )$_1$ Yes	__ __	__ __
d. Estrogen and testerone (Estratest)	( )$_0$ No ( )$_1$ Yes	__ __	__ __
e. Estrogen vaginal cream	( )$_0$ No ( )$_1$ Yes	__ __	__ __
f. Estrogen shots	( )$_0$ No ( )$_1$ Yes	__ __	__ __
g. Estrogen skin patches (Estraderm)	( )$_0$ No ( )$_1$ Yes	__ __	__ __
h. Estrogen patch and progesterone pills	( )$_0$ No ( )$_1$ Yes	__ __	__ __
i. Suppository	( )$_0$ No ( )$_1$ Yes	__ __	__ __
j. Other _____ ☐☐☐	( )$_0$ No ( )$_1$ Yes	__ __	__ __

REPRODUCTIVE HISTORY ( )$_1$ Very good ( )$_2$

ID# __ - __ - ____ ____ ____ ____ ____

H. GENERAL HISTORY

1. Are you having surgery in the near future?
   - ( )$_0$ No (Skip to "Ask Liver Cases ONLY" or "Ask High Risk Hospital Control ONLY" dependent on patient type)
   - ( )$_1$ Yes
   - ( )$_8$ Don't know

2. What kind of surgery are you having?

   _____ ☐☐☐.☐☐

3. When are you having this surgery?

   __ __ / __ __ / __ __ __ __

ASK LIVER CANCER CASES ONLY (High Risk Cases, Skip to H.13)

4. Are you currently receiving treatment?
   - ( )$_0$ No (Skip to H.7)
   - ( )$_1$ Yes
   - ( )$_8$ Don't know

5. What type(s) of treatment are you currently receiving?

a. TACE (chemotherapy through blood vessels)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
b. RFA (Tumor burning with radio waves)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
c. IFNα (Interferon)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
d. Sorafenib (Nexavar)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
e. Other (please specify) _____ ☐ ☐ ☐	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK

ID# __ - __ - ____ ____ ____ ____ ____

6. How many treatment sessions have you received in your current treatment cycle and how long did you receive this/these treatment(s)?

	Treatment Session			
Treatment Name	**First Treatment (Duration)**	**Second Treatment (Duration)**	**Third Treatment (Duration)**	**Keep repeating until last treatment documented (Duration)**
TACE (chemotherapy through blood vessels)	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
RFA (Tumor burning with radio waves)	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
IFNα (Interferon)	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
Sorafenib (Nexavar)	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
Other	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __

7. Did you have any prior surgeries related to this cancer?
   ( )$_0$ No (Skip to H.10)
   ( )$_1$ Yes
   ( )$_8$ Don't know

8. What kind of surgery did you have?

   _____ □□□.□□

9. When did you have this surgery?

   __ __ / __ __ / __ __ __ __

ID# __ - __ - ____ ____ ____ ____ ____

10. Have you had any treatment in the past (before this treatment or treatment cycle)?
    ( )$_0$ No (Skip to H.17)
    ( )$_1$ Yes
    ( )$_8$ Don't know

11. What type of treatment did you receive?

a. TACE (chemotherapy through blood vessels)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
b. RFA (Tumor burning with radio waves)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
c. IFNα (Interferon)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
d. Sorafenib (Nexavar)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
e. Other (please specify) _____ ☐ ☐ ☐	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK

12. How many treatment sessions did you receive in the past and how long did you receive this/these treatment(s)?

	Treatment Session			
Treatment Name	**First Treatment (Year) (Duration)**	**Second Treatment (Year) (Duration)**	**Third Treatment (Year) (Duration)**	**Keep repeating until last treatment documented (Duration)**
TACE (chemotherapy through blood vessels)	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
RFA (Tumor burning with radio waves)	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
IFNα (Interferon)	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
Sorafenib (Nexavar)	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
Other	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	)$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __

ID# __ - __ - ____ ____ ____ ____ ____

ASK HIGH RISK PATIENTS ONLY (Liver Cases Skip to question H.14)

13. What type of chronic liver disease have you been diagnosed with?

a. Hepatitis C Virus Infection	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
b. Hepatitis B Virus Infection	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
c. Alcoholic Liver Disease	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
d. Hemochromatosis (Iron Overload Disease)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
e. Primary Biliary Cirrhosis	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
f. Wilson's Disease (Copper Overload Disease)	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
g. Autoimmune Hepatitis	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
h. Nonalcoholic steatosis	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK
i. Other _____ ☐☐☐	( )$_0$ No ( )$_1$ Yes ( )$_8$ DK

14. Are you currently receiving treatment for chronic liver disease?

( )$_0$ No (Skip to H.20)
( )$_1$ Yes
( )$_8$ Don't know

15. What type of treatment are you currently receiving?

a. IFNα (Interferon)	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
b. IFNα (interferon)+ Ribavarin	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
c. Lamivudin	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
d. Adefovir	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
e. Entecavir	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
f. Telbivudine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know

g. Phlebotomy (Blood letting)	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
h. Chelation	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
i. Ursodeoxycholic acid	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
j. Mthotraxate	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
k. Colchicine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
l. Penicillamine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
m. Trientine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
n. Oral zinc	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
o. Amminium tetrathiomolybdate	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
p. Prednisone	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
q. Azathioprine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
r. Mercaptopurine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
s. Other	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know

16. How many treatment sessions have you received (of each treatment) in your current treatment cycle and how long did you receive this/these treatment(s)?

ID# __ - __ - ___ ___ ___ ___ ___

	Treatment Session			
Treatment Code (list treatment from question H.15 and write letter)	**First Treatment (Duration)**	**Second Treatment (Duration)**	**Third Treatment (Duration)**	**Keep repeating until last treatment documented (Duration)**
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	)$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __

17. Have you had any treatment for chronic liver disease in the past?

( )$_0$ No (Skip to H.20)
( )$_1$ Yes
( )$_8$ Don't know

18. What type of treatment did you receive?

a. IFNα (interferon)	( )$_0$ No

	( )$_1$ Yes ( )$_8$ Don't Know
b. IFNα (interferon)+ Ribavarin	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
c. Lamivudin	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
d. Adefovir	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
e. Entecavir	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
f. Telbivudine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
g. Phlebotomy (Blood letting)	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
h. Chelation	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
i. Ursodeoxycholic acid	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
j. Mthotraxate	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
k. Colchicine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
l. Penicillamine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
m. Trientine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
n. Oral zinc	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
o. Amminium tetrathiomolybdate	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
p. Prednisone	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
q. Azathioprine	( )$_0$ No ( )$_1$ Yes

ID# __ - __ - ___ ___ ___ ___ ___

	( )$_8$ Don't Know
r. Mercaptopurine	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know
s. Other	( )$_0$ No ( )$_1$ Yes ( )$_8$ Don't Know

19. How many treatment sessions did you receive (of each treatment) and how long did you receive this/these treatment(s)?

	Treatment Session			
Treatment Code (list treatment from question H.18 and write letter)	**First Treatment (Duration)**	**Second Treatment (Duration)**	**Third Treatment (Duration)**	**Keep repeating until last treatment documented (Duration)**
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __
	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	)$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __	( )$_0$ Days __ __ __ ( )$_1$ Weeks __ __ __ ( )$_2$ Months __ __ __

ASK ALL PARTICIPANTS

20. May we contact you again later if we need to clarify any of the information you have provided?
( )$_0$ No
( )$_1$ Yes

ID# __ - __ - ____ ____ ____ ____ ____

18. Time ended: __ __ : __ __ ( )1 AM
( )2 PM

This completes our interview. I would like to now take the blood and urine sample. I want to thank you very much for the time you have spent in answering my questions today.

First get specimens and then provide reimbursement of $25.00.

☐ Blood Specimen Collected

☐ Urine Specimen Collected

H. ADMINISTRATIVE INFORMATION

1. Date form completed: __ __ / __ __ / __ __ __ __
2. Name of Interviewer: _____
3. Interviewer ID number: __ __
4. Interviewer's Signature:
_____

I. INTERVIEWER REMARKS

1. Interview was conducted:
( )1 Home ☐☐
( )2 Hospital – inpatient (specify) _____
( )3 Hospital – outpatient (specify) _____ ☐☐
( )4 Non-residential, non-hospital location
(specify) _____ ☐☐
( )5 One of the Study Offices
( )6 Other (specify)_____ ☐☐

2. Respondent's cooperation was: ( )1 Very good
( )2 Good
( )3 Fair
( )4 Poor

3. The overall quality of the interview was: ( )1 Very good
( )2 Good
( )3 Fair
( )4 Poor

4. Did any of the following occur during the interview?

a. R did not know enough information regarding the topics	( )$_0$ No	( )$_1$ Yes
b. R did not want to be more specific	( )$_0$ No	( )$_1$ Yes
c. R did not understand or speak English well	( )$_0$ No	( )$_1$ Yes
d. R was upset or depressed	( )$_0$ No	( )$_1$ Yes
e. R had poor hearing or speech	( )$_0$ No	( )$_1$ Yes
f. R was confused by frequent interruptions	( )$_0$ No	( )$_1$ Yes
g. R was emotionally unstable	( )$_0$ No	( )$_1$ Yes
h. Others helped with the answers	( )$_0$ No	( )$_1$ Yes
i. Patient was reserved	( )$_0$ No	( )$_1$ Yes
k. R was physically ill	( )$_0$ No	( )$_1$ Yes
l. Other, specify _____	( )$_0$ No	( )$_1$ Yes

5. Comments/Remarks:

_____
_____
_____
_____
_____
_____
_____