

ID# _ _ - _ _ - _ _ _ _ _ _ _ _

LIVER CANCER STUDY
CASE AND HIGH RISK CASES
QUESTIONNAIRE

National Cancer Institute
Building 37, Third Floor
Bethesda, Maryland 20892
Phone (301) 496-2048 Fax (301) 496-0497

University of Maryland School of Medicine
Bressler Building, Third Floor, Suite 3-006-C
655 West Baltimore Street
Baltimore, Maryland 21201-1509
Phone (410) 706-5129 Fax (410) 706-5173

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-RC-2010-00117". 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-RC-2010-00117" 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

A. IDENTIFIER SHEET..... 4

B. MEDICAL HISTORY 5

C. FAMILY HISTORY..... 7

D. ALCOHOL HISTORY..... 9

E. TOBACCO HISTORY..... 11

E. REPRODUCTIVE HISTORY..... 13

G. GENERAL INFORMATION..... 15

H. ADMINISTRATIVE INFORMATION..... 23

I. INTERVIEWER REMARKS..... 23

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
patient/Hospital Control	() ₁ High Risk

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

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. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₂ 20-29 () ₃ 30-39 () ₄ 40-49	() ₅ 50-59 () ₆ 60-69 () ₇ >70 () ₈ Don't Know
b. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₂ 20-29 () ₃ 30-39 () ₄ 40-49	() ₅ 50-59 () ₆ 60-69 () ₇ >70 () ₈ Don't Know
c. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₂ 20-29 () ₃ 30-39 () ₄ 40-49	() ₅ 50-59 () ₆ 60-69 () ₇ >70 () ₈ Don't Know
d. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₂ 20-29 () ₃ 30-39 () ₄ 40-49	() ₅ 50-59 () ₆ 60-69 () ₇ >70 () ₈ Don't Know
e. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₂ 20-29 () ₃ 30-39 () ₄ 40-49	() ₅ 50-59 () ₆ 60-69 () ₇ >70 () ₈ Don't Know
f. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₂ 20-29 () ₃ 30-39 () ₄ 40-49	() ₅ 50-59 () ₆ 60-69 () ₇ >70 () ₈ Don't Know
g. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₁ <20 () ₂ 20-29 () ₃ 30-39 () ₄ 40-49	() ₅ 50-59 () ₆ 60-69 () ₇ >70 () ₈ Don't Know
h. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() 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 ()₃

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?	_____ () ₁ cigarettes () ₂ packs	_____ () ₁ cigarettes () ₂ packs	_____ () ₁ cigarettes () ₂ packs	_____ () ₁ cigarettes () ₂ packs	_____ () ₁ cigarettes () ₂ packs	_____ () ₁ cigarettes () 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

ID# ___ - ___ - _____

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

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) _____ <input type="checkbox"/>												
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

ID# ____ - ____ - _____

()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. Progesteron pills (Progestins, Provera, Megace)	() ₀ No () ₁ Yes	---	---
c. Estrogen and progesterone pills (Prempo)	() ₀ No () ₁ Yes	---	---
d. Estrogen and testosterone (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 _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() ₀ No () ₁ Yes	---	---

REPRODUCTIVE HISTORY ()₁ Very good ()₂

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. IFN α (Interferon)	() ₀ No () ₁ Yes () ₈ DK
d. Sorafenib (Nexavar)	() ₀ No () ₁ Yes () ₈ DK
e. Other (please specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() 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 Name	Treatment Session			
	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. IFN α (Interferon)	() ₀ No () ₁ Yes () ₈ DK
d. Sorafenib (Nexavar)	() ₀ No () ₁ Yes () ₈ DK
e. Other (please specify) _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() 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 Name	Treatment Session			
	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 _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	() 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. IFN α (Interferon)	() ₀ No () ₁ Yes () ₈ Don't Know
b. IFN α (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

ID# ____ - ____ - _____

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 Code (list treatment from question H.15 and write letter)	Treatment Session			
	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. IFN α (interferon)	() ₀ No
------------------------------	---------------------

ID# ____ - ____ - _____

	() ₁ Yes () ₈ Don't Know
b. IFN α (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 Code (list treatment from question H.18 and write letter)	Treatment Session			
	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?

ID# ____ - ____ - _____

- 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:
