OMB #: 0925-XXXX
Expiration Date: xx/xx/20xx

U.S. Radiologic Technologists Study
Fourth Survey

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

Instructions:

- Use blue or black ink
- Print legible numbers: 1 2 3
- Mark check boxes: Right ☒ Wrong ☑ ❑
- Do not make any stray marks on this form. If you have comments, please write them on a separate piece of paper.

(ADDRESS BLOCK FOR WINDOW ENVELOPE)

PARTICIPANT NAME
ADDRESS
CITY STATE ZIP

GENERAL QUESTIONNAIRE MODULE

Whether you are retired or still working, please complete this questionnaire to update us about your health, radiation exposure, and other factors. We realize that some questions from the past may be difficult to recall. Just do your best. Even if not exact, your best estimates are valuable to the study.

1. What is TODAY'S DATE? M M (MONTH) D D (DAY) 2 0 Y Y (YEAR)

2. What is your DATE OF BIRTH? M M (MONTH) D D (DAY) 1 9 Y Y (YEAR)

WORK HISTORY

In this questionnaire, "radiologic technologist" includes people working in radiology, nuclear medicine, radiation therapy or any other diagnostic imaging or therapeutic radiation jobs.

3. Are you currently working as a radiologic technologist? ❑ Yes ❑ No → Year last worked as a radiologic technologist? Y Y Y Y

Answer the following questions separately for each time period. Just do your best for each question.

	Before 1970	1970-1979	1980-1989	1990-1999	2000-2009
4. Did you work as a radiologic technologist during each time period?	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
5. How many HOURS PER WEEK did you usually work as a radiologic technologist?					

PRIVACY ACT NOTIFICATION STATEMENT
Collection of this information is authorized by The Public Health Service Act, Section 411 (42 USC 285a). Rights of study participants are protected by The Privacy Act of 1974. Please be assured that all information you provide will be kept private under the Privacy Act and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Any published results from this survey 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.

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN
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 (0925-0405). Do not return the completed form to this address.

6. About how many of each PROCEDURE type below did you perform or assist with in a typical WEEK?

	NEVER DID	NUMBER OF PROCEDURES PER WEEK				
		Before 1970	1970-1979	1980-1989	1990-1999	2000-2009
Diagnostic x-ray	❑					
Routine fluoroscopy						
Chest fluoroscopy	❑					
Upper GI series	❑					
Esophagram (barium swallow)	❑					
Oral cholescytogram (gallbladder)	❑					
Small bowel series	❑					
Lower GI series (barium enema)	❑					
Retrograde pyelogram/IVP/urethrogram	❑					
For orthopedic or other non-interventional surgical procedures in the operating room	❑					
Fluoroscopically-guided	❑					
Diagnostic radioisotope	❑					
Brachytherapy	❑					
Other therapeutic radioisotope	❑					

7. When performing diagnostic x-ray procedures, did you usually have to go into a control booth or shielded area to turn on the x-ray beam?

Before 1970	1970-1979	1980-1989	1990-1999	2000-2009
❑ No	❑ No	❑ No	❑ No	❑ No
❑ Yes	❑ Yes	❑ Yes	❑ Yes	❑ Yes

8. Did you ever work as a radiologic technologist in a military hospital or clinic?

❑ No ❑ Yes → **How many YEARS did you work in this type of facility?**

Before 1970	1970-1979	1980-1989	1990-1999	2000-2009

9. Were you ever removed from working as a radiologic technologist because your radiation exposure exceeded the allowable limit?

❑ No ❑ Yes → **How many TIMES did this happen?**

Before 1970	1970-1979	1980-1989	1990-1999	2000-2009

10. What is your approximate lifetime total radiation dose received while working as a radiologic technologist *(in mrem)*?

❑ Unknown

❑ Zero
❑ 1-999 mrem
❑ 1,000-4,999
❑ 5,000-9,999
❑ 10,000-24,999
❑ 25,000-49,999
❑ 50,000+

→ **Is your lifetime total radiation dose estimated or taken from your dosimetry reports?** →

❑ Estimated
❑ From dosimetry reports
❑ Combination of both

HEALTH HISTORY

Please answer the next questions to let us know if you have been diagnosed with cancer or any of the conditions listed.

11. Did a doctor ever tell you that you had any type of skin cancer?

❑ No (Go to Q12) ❑ Yes

Please mark YES for each type of skin cancer you had and provide your age when first diagnosed.

For each type of skin cancer you had, how many skin cancers did you have at each body location?
(If lesion was located on a "side", choose nearest location)

TYPE OF SKIN CANCER (mark all that apply)	YES	AGE FIRST DIAGNOSED	FRONT OF HEAD OR NECK	BACK OF HEAD OR NECK	FRONT OF TORSO	BACK OF TORSO	FRONT OF LEGS	BACK OF LEGS	ARMS OR HANDS
Basal cell carcinoma	❑								
Squamous cell carcinoma	❑								
Melanoma	❑								
Other or type unknown	❑								

12. Did a doctor ever tell you that you had any other type of cancer?

❑ No (Go to Q13) ❑ Yes

Please mark YES for each type of cancer you had and provide your age when first diagnosed.

TYPE OF CANCER (mark all that apply)	YES	AGE FIRST DIAGNOSED
Bladder	❑	
Bone	❑	
Brain or nervous system	❑	
Breast:	❑	

If YES:

Which breast? Left	Which breast? Right	What type was it? Invasive Cancer	Ductal Carcinoma *In Situ*	Other Or Type Unknown	AGE FIRST DIAGNOSED
❑	❑	❑	❑	❑	
❑	❑	❑	❑	❑	

TYPE OF CANCER (mark all that apply)	YES	AGE FIRST DIAGNOSED
Cervix (excluding *in situ*)	❑	
Colon	❑	
Esophagus	❑	
Kidney	❑	
Leukemia		
Acute myelocytic (AML)	❑	
Acute lymphocytic (ALL)	❑	
Chronic myelocytic (CML)	❑	
Chronic lymphocytic (CLL)	❑	
Liver	❑	
Lung, trachea, or bronchus	❑	
Lymphoma:		
Hodgkin's disease	❑	
Non-Hodgkin's lymphoma (NHL)	❑	
Multiple myeloma	❑	
Ovary	❑	
Pancreas	❑	
Prostate	❑	
Rectum	❑	
Salivary gland	❑	
Stomach	❑	
Testis	❑	
Thyroid	❑	
Uterus (endometrium)	❑	
Other or unknown cancer (specify)	❑	

_____

13. Did a doctor ever tell you that you had any of the following medical conditions . . . ?

For each medical condition you mark YES, please provide your age when you were first diagnosed.

MEDICAL CONDITION (mark all that apply)	YES	AGE FIRST DIAGNOSED
Benign tumor of brain or nervous system:		
Meningioma	❑ →	
Schwannoma or neuroma	❑ →	
Other *(specify)* _____	❑ →	
Thyroid conditions:	YES	
Thyroid nodule	❑ →	
Goiter (enlarged thyroid)	❑ →	
Benign thyroid tumor (adenoma)	❑ →	
Thyroiditis (Hashimoto's Disease)	❑ →	
Hypothyroidism (underactive thyroid)	❑ →	
If YES, did you take medication *(e.g. synthroid, levothyroxine)* for hypothyroidism?	❑ No ❑ Yes	
Graves' Hyperthyroidism or Graves' Disease	❑ →	
Were you treated *(e.g. surgery,.I-131 drugs)* for hyperthyroidism?	❑ No ❑ Yes	
Eye conditions:		
Macular degeneration	❑ →	
Glaucoma	❑ →	

MEDICAL CONDITION (mark all that apply)	YES	AGE FIRST DIAGNOSED
Eye conditions, cont:		
Cataract	❑ →	
Did you have any cataracts removed?	❑ No ❑ Yes	
Age first removed	AGE	
Other conditions:	YES	
Sleep apnea	❑ →	
Osteoporosis	❑ →	
Hip fracture	❑ →	
Multiple sclerosis	❑ →	
Parkinson's Disease	❑ →	
Lupus	❑ →	
Osteoarthritis	❑ →	
Rheumatoid arthritis	❑ →	
Scleroderma	❑ →	
Chronic bronchitis	❑ →	
Emphysema	❑ →	
Asthma	❑ →	

14. Did a doctor ever tell you that you had any of the following CARDIOVASCULAR OR RELATED CONDITIONS?

For each medical condition you mark YES, please provide your age when you were first diagnosed.

MEDICAL CONDITION (mark all that apply)	YES	AGE FIRST DIAGNOSED	DIAGNOSIS AND TREATMENT	NO	YES
Angina pectoris	❑ →		→ Was the angina confirmed by angiogram?	❑	❑
Ischemic heart disease	❑ →		→ Was it confirmed by ECG, stress test, or angiogram?	❑	❑
Heart attack (myocardial infarct)	❑ →		→ Did you have a coronary bypass, angioplasty, or stent?	❑	❑
Stroke	❑ →		→ Was stroke confirmed by arteriography, CT scan or MRI?	❑	❑
High blood pressure	❑ →		→ Do you currently take blood pressure medication?	❑	❑
Diabetes	❑ →		→ Do you currently take insulin?	❑	❑

PERSONAL DIAGNOSTIC RADIATION EXAMS

15. Please provide your age(s) at first and last exam. Please indicate APPROXIMATELY how many times you had the following selected diagnostic radiation exams during each time period. Count the number of exams that you had, NOT the number of individual films taken. (If you never had a specific exam, mark the box "never had" and leave all other columns blank.)

X-RAY exams performed ON YOU	NEVER HAD	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS BY TIME PERIOD				
				<1970	1970-1979	1980-1989	1990-1999	2000-2009
Dental								
Bite-wing	❑							
Panoramic x-ray	❑							
Skull	❑							
Sinus	❑							
Neck and soft tissue	❑							
Spine								
Full	❑							
Cervical	❑							
Thoracic	❑							
Lumbar	❑							
Lumbosacral	❑							
Ribs	❑							
Abdomen	❑							
Pelvis	❑							
Sacrum	❑							
Mammogram	❑							

FLUOROSCOPY exams performed ON YOU with or without X-Rays	NEVER HAD	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS BY TIME PERIOD				
				<1970	1970-1979	1980-1989	1990-1999	2000-2009
Cerebral arteriogram	❑							
Carotid arteriogram	❑							
Cardiac angiogram or catheterization	❑							
Cardiac angioplasty or stent placement	❑							
Pulmonary arteriogram	❑							

FLUOROSCOPY exams performed ON YOU with or without X-Rays, continued	NEVER HAD	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS BY TIME PERIOD				
				<1970	1970-1979	1980-1989	1990-1999	2000-2009
Upper GI series	❑							
Esophagram (barium swallow)	❑							
Liver, gallbladder, or bile ducts	❑							
Small bowel series	❑							
Lower GI series (barium enema)	❑							

TOMOGRAPHY or CT scans performed ON YOU (Count exams taken with and without contrast separately.)	NEVER HAD	AGE 1ST SCAN	AGE LAST SCAN	NUMBER OF SCANS BY TIME PERIOD				
				<1970	1970-1979	1980-1989	1990-1999	2000-2009
Head	❑							
Neck	❑							
Chest	❑							
Spine	❑							
Abdomen with pelvis	❑							
Abdomen without pelvis	❑							
CT angiography	❑							

RADIONUCLIDE tests performed ON YOU	NEVER HAD	AGE 1ST TEST	AGE LAST TEST	NUMBER OF TESTS BY TIME PERIOD				
				<1970	1970-1979	1980-1989	1990-1999	2000-2009
Brain scan	❑							
Thyroid scan	❑							
Thyroid uptake or function	❑							
Cardiac scan	❑							
Lung scan	❑							
Liver scan	❑							
Renogram	❑							
Bone scan	❑							

PERSONAL THERAPEUTIC RADIATION PROCEDURES

16. Please indicate APPROXIMATELY how many times you had radionuclide therapy procedures performed on you for the selected medical conditions below. Also provide your age(s) at first and last treatment.

RADIONUCLIDE THERAPY procedures performed ON YOU for the following medical conditions:	NEVER HAD	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS BY TIME PERIOD <1970	1970-1979	1980-1989	1990-1999	2000-2009
Hyperthyroidism	❑							
Thyroid cancer or ablation	❑							
Leukemia	❑							
Non-Hodgkin's lymphoma	❑							
Polycythemia vera	❑							
Other *(please specify)* _____	❑							

17. Please indicate how many times you had radiation therapy (radiotherapy, cobalt therapy) to any of the following body areas during each time period, first for CANCERS and then for P conditions, and your age(s) at first and last treatment.

If you had a treatment series for a single cancer occurrence, count as one treatment.

RADIATION THERAPY procedures performed ON YOU to the following body areas for <u>CANCER</u> conditions:	NEVER HAD	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS BY TIME PERIOD CANCER (series) <1970	1970-1979	1980-1989	1990-1999	2000-2009
Head	❑							
Neck	❑							
Chest (including breast)	❑							
Spine	❑							
Abdomen	❑							

For non-cancer conditions, count the number of individual treatment sessions that you had.

RADIATION THERAPY procedures performed ON YOU to the following body areas for <u>NON-CANCER</u> conditions:	NEVER HAD	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS BY TIME PERIOD NON-CANCER (sessions) <1970	1970-1979	1980-1989	1990-1999	2000-2009
Head	❑							
Neck	❑							
Chest (including breast)	❑							
Spine	❑							
Abdomen	❑							

WOMEN ONLY - Men go to Page 9, Question 24

18. Have you ever given birth? ❑ No ❑ Yes

For each birth please complete the following questions (Include still births. Exclude step- or adopted children).

Birth Order	Year of birth	Did you breast feed this baby?	How many months?
First		❑ No ❑ Yes →	
Second		❑ No ❑ Yes →	
Third		❑ No ❑ Yes →	
Fourth		❑ No ❑ Yes →	
Fifth		❑ No ❑ Yes →	

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

19. Did a doctor ever tell you that you had postpartum mastitis?

❑ No ❑ Yes

Age when first diagnosed? AGE

Age when last diagnosed? AGE

Number of times? NO. TIMES

20. Have your menstrual periods stopped permanently *(i.e., no period for at least six months)***?**

❑ Yes → AGE STOPPED

❑ No, still having periods

❑ No, menstrual periods are irregular or using hormones

❑ Never menstruated

21. Did you have surgery to remove your uterus or ovaries? (Mark all that apply)

❑ No

❑ Yes, uterus removed → **Ages when removed?**

❑ Yes, one or both ovaries removed → FIRST SECOND

22. Did you ever take prescription hormone replacement therapy for symptoms of menopause?

❑ No ❑ Yes

Age started taking? AGE STARTED

Total number of years taken? YEARS

Currently taking? ❑ No ❑ Yes

23. Did you ever have a breast biopsy (or aspiration)?

❑ No ❑ Yes

Age at time of first biopsy/aspiration? AGE

Number of biopsies/aspirations? NUMBER

Did any biopsy or aspiration lead to a diagnosis of. . .	AGE FIRST DIAGNOSED?	Reason for biopsy or aspiration? (Mark all that apply) Abnormal Self-exam (e.g. lump, pain, discharge)	Abnormal physician exam	Abnormal screening mammogram	Abnormal diagnostic mammogram
Breast cancer or ductal carcinoma *in situ* ..... ❑ Yes →	→	❑	❑	❑	❑
Atypia or atypical hyperplasia .. ❑ Yes →	→	❑	❑	❑	❑
Hyperplasia without atypia ..... ❑ Yes →	→	❑	❑	❑	❑
Fibroadenoma ..... ❑ Yes →	→	❑	❑	❑	❑

WOMEN and MEN complete remainder of Questionnaire.

The following questions will help us understand whether these factors may be related to health for people working in the field of medical radiation. Please answer to the best of your knowledge.

24. How tall are you without shoes? ☐ FEET ☐☐ INCHES

25. How much do you weigh without shoes and clothes? ☐☐☐ POUNDS

26. Do you currently smoke cigarettes?

❑ No ❑ Yes →

How many cigarettes do you usually smoke per day? ..... ☐☐ NUMBER PER DAY

How soon after you wake up do you usually smoke your first cigarette of the day? .....
❑ Within 5 minutes ❑ 6-30 minutes
❑ 31-60 minutes ❑ More than 60 minutes

How many days per week do you usually smoke cigarettes? ..... ☐ DAYS PER WEEK

Are you an ex-smoker?

❑ No ❑ Yes **What year did you last smoke cigarettes?** ☐☐☐☐ YEAR LAST SMOKED

27. How much did you weigh when you were born? ☐☐ POUNDS ☐☐ OUNCES

28. Were you breastfed as a baby? ❑ No ❑ Yes ❑ Don't know

29. Were you born premature? ❑ No ❑ Yes ❑ Don't know

30. Have any of your blood-related parents, siblings, or children had any of the following primary cancers? (Mark all that apply)

		YOUNGEST age any of these relatives were first diagnosed					
		Under age 40	40-49	50-59	60-69	Age 70 or older	Age Unknown
Brain cancer	❑ Yes →	❑	❑	❑	❑	❑	❑
Breast cancer	❑ Yes →	❑	❑	❑	❑	❑	❑
Thyroid cancer	❑ Yes →	❑	❑	❑	❑	❑	❑
Leukemia, lymphoma, or multiple myeloma	❑ Yes →	❑	❑	❑	❑	❑	❑
Lung cancer	❑ Yes →	❑	❑	❑	❑	❑	❑

31. How many TIMES did you visit a medical facility or clinic for a ROUTINE PHYSICAL (exam)?

	TOTAL NUMBER OF EXAMS				
	Age 30-39	Age 40-49	Age 50-59	Age 60-69	Age 70 or older
Pap smear (women only)	☐☐	☐☐	☐☐	☐☐	☐☐
Breast exam (women only)	☐☐	☐☐	☐☐	☐☐	☐☐
Prostate exam (men only)	☐☐	☐☐	☐☐	☐☐	☐☐
Sigmoidoscopy or colonoscopy	☐☐	☐☐	☐☐	☐☐	☐☐
General physical exam	☐☐	☐☐	☐☐	☐☐	☐☐

IN THE PAST YEAR

The following questions will allow us to evaluate physical activity and health in the USRT Study.

32. During the PAST YEAR, how many HOURS per week did you. . .

	NUMBER OF HOURS PER WEEK							
	NONE	½ hr	1 hr	1-½	2-3	4-6	7-10	11 hours or more
Walk for exercise	❑	❑	❑	❑	❑	❑	❑	❑
Walk for daily activities other than for exercise *(e.g.at work, shopping)*	❑	❑	❑	❑	❑	❑	❑	❑
Strenuous aerobic exercise such as jogging, running, bicycling *(including stationary)*, swimming, playing tennis, treadmill, stairmaster, dance	❑	❑	❑	❑	❑	❑	❑	❑
Yoga or Pilates	❑	❑	❑	❑	❑	❑	❑	❑
Weight training or resistance exercises *(e.g. weight machines, free weights)*	❑	❑	❑	❑	❑	❑	❑	❑

33. During the PAST YEAR, how many HOURS per day did you spend . . . (mark only one response per activity)

	NUMBER OF HOURS PER DAY							
	NONE	1-2	3-4	5-6	7-8	9-10	11-12	13 hours or more
Sitting watching TV, video or DVD	❑	❑	❑	❑	❑	❑	❑	❑
Sitting or driving in a car, bus or train	❑	❑	❑	❑	❑	❑	❑	❑
Other sitting *(reading, knitting, using a computer)*	❑	❑	❑	❑	❑	❑	❑	❑

The following questions will allow us to evaluate sleep patterns and health in the USRT Study.

34. During the PAST YEAR, how many HOURS per day did you sleep in a typical 24-hour period on:

	HOURS OF SLEEP PER DAY						
TIME	1-4	5	6	7	8	9	10 hours or more
WEEKDAYS	❑	❑	❑	❑	❑	❑	❑
WEEKENDS	❑	❑	❑	❑	❑	❑	❑

35. During the PAST YEAR, how many TIMES in a typical week were your daily activities adversely affected because you got too little sleep?

TIMES PER WEEK					
None	1	2-3	4-5	6-7	8 or more
❑	❑	❑	❑	❑	❑

36. During the PAST YEAR, how much light was visible in your bedroom while you slept?

AMOUNT OF LIGHT		
Bright light (e.g. to read)	**Some light** (night light)	**Completely dark**
❑	❑	❑

37. During the PAST YEAR, did you go to bed after midnight at least once a week for at least three months?

❑ No ❑ Yes ⟶

What was your USUAL BEDTIME after midnight?				About how many TIMES PER MONTH did you go to bed after midnight?			
12:00 to 1:00 am	1:00 to 2:00 am	2:00 to 3:00 am	After 3:00 am	1-4	5-8	9-15	16+
❑	❑	❑	❑	❑	❑	❑	❑

38. What type of person do you generally consider yourself?

- ❑ Morning person
- ❑ Evening person
- ❑ Neither
- ❑ Both

39. During the PAST YEAR, did you take any of the following supplements?

	NO	YES	How many DAYS PER WEEK did you take?
Multivitamins	❑	❑	→ ☐☐

Other supplements taken separately from a multi-vitamin:

Calcium (including Tums)... ❑ NO ❑ YES → ☐☐ → **What was the total dosage (mg) of calcium per day?**

❑ Less than 500 mg ❑ 900-1299 ❑ 1600 or more
❑ 500-899 ❑ 1300-1599

Vitamin D (alone or in a calcium supplement)..... ❑ NO ❑ YES → ☐☐ → **What was the total dosage (IU) of Vitamin D per day?**

❑ All year
❑ Winter only

❑ Less than 400 IU ❑ 800-1399 ❑ 2000-3999
❑ 400-799 ❑ 1400-1999 ❑ 4000 or more

IN YOUR LIFETIME

40. Have you EVER used a SUNLAMP for tanning or to treat a skin condition?

❑ No ❑ Yes →

How old were you the FIRST time you used a sunlamp?	How old were you the LAST time you used a sunlamp?	How many times did you use a sunlamp in your life?
❑ Under 13 years old	❑ Under 13 years old	❑ 1-2 times
❑ 13-19	❑ 13-19	❑ 3-4
❑ 20-39	❑ 20-39	❑ 5-9
❑ 40-64	❑ 40-64	❑ 10-19
❑ Age 65 or older	❑ Age 65 or older	❑ 20 times or more

41. Have you EVER used a TANNING BOOTH or TANNING BED?

❑ No ❑ Yes →

How old were you the FIRST time you used a tanning booth or tanning bed?	How old were you the LAST time you used a tanning booth or tanning bed?	How many times did you use a tanning booth or tanning bed in your life?
❑ Under 13 years old	❑ Under 13 years old	❑ 1-2 times
❑ 13-19	❑ 13-19	❑ 3-4
❑ 20-39	❑ 20-39	❑ 5-9
❑ 40-64	❑ 40-64	❑ 10-19
❑ Age 65 or older	❑ Age 65 or older	❑ 20 times or more

42. How many MONTHS PER YEAR did you usually have a TAN FROM SUN EXPOSURE at each age listed below?

Under 13 years old	13-19	20-39	40-64	Age 65 or older
❑ Never had a tan	❑ Never had a tan	❑ Never had a tan	❑ Never had a tan	❑ Never had a tan
❑ 1-3 months	❑ 1-3 months	❑ 1-3 months	❑ 1-3 months	❑ 1-3 months
❑ 4-6	❑ 4-6	❑ 4-6	❑ 4-6	❑ 4-6
❑ 7-9	❑ 7-9	❑ 7-9	❑ 7-9	❑ 7-9
❑ 10-12 months	❑ 10-12 months	❑ 10-12 months	❑ 10-12 months	❑ 10-12 months

43. HOW OFTEN did you protect yourself from the sun by wearing a long-sleeve shirt or long pants, when you were in the sun on a typical day in the summer at each age listed below?

Under 13 years old	13-19	20-39	40-64	Age 65 or older
❑ Never	❑ Never	❑ Never	❑ Never	❑ Never
❑ Rarely	❑ Rarely	❑ Rarely	❑ Rarely	❑ Rarely
❑ Sometimes	❑ Sometimes	❑ Sometimes	❑ Sometimes	❑ Sometimes
❑ Usually	❑ Usually	❑ Usually	❑ Usually	❑ Usually
❑ Always	❑ Always	❑ Always	❑ Always	❑ Always

When answering the next two questions about "night shift" work, please include ANY jobs held during your lifetime. By "Night shift" we mean working 3 or more hours during 12:00-5:00 AM for 6 months or more.

44. Did you ever work PERMANENT night shifts at this age?			During how many YEARS did you work PERMANENT night shifts at this age?					On average, how many PERMANENT NIGHT SHIFTS did you work PER MONTH at this age?						45. Did you ever work ROTATING night shifts at this age?		
AGE	NO	YES	1	2-3	4-5	6-7	8 or more	3	4-5	6-9	10-14	15-19	20 or more	AGE	NO	YES
Under age 30	❑	❑ →	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Under age 30	❑	❑
30-39	❑	❑ →	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	30-39	❑	❑
40-49	❑	❑ →	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	40-49	❑	❑
Age 50 or older	❑	❑ →	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Age 50 or older	❑	❑

WORK HISTORY WITH FLUOROSCOPICALLY-GUIDED OR RADIOISOTOPE PROCEDURES

46. Did you perform or assist with FLUOROSCOPICALLY-GUIDED medical radiation procedures at least once a month for a year or more? → ❑ No ❑ Yes

We are interested here in fluoroscopically-guided procedures that use catheters or other types of equipment for diagnosis or intervention, including **cardiac procedures** (such as diagnostic catheterization, electrophysiology studies, pacemaker implant), **urology procedures** (such as nephrostomy), **orthopedic procedures** (such as vertebroplasty), **gastrointestinal procedures** (such as TIPS, ERCP), **embolization procedures** (such as fibroids, liver tumor), and other **fluoroscopically-guided procedures** (such as port placement, peripheral vascular intervention). Do NOT include routine fluoroscopy exams (such as upper GI series, esophagram, barium enema).

47. Did you perform or assist with DIAGNOSTIC OR THERAPEUTIC RADIOISOTOPE procedures at least once a month for a year or more? → ❑ No ❑ Yes

If you answered YES to Question 46 or 47, you may receive a follow-up questionnaire in the future.

In case we need to contact you, please provide a telephone number and best time to reach you.

Phone number ☐☐☐ - ☐☐☐ - ☐☐☐☐
AREA CODE PHONE NUMBER

Best time to call: ❑ WEEK DAY ❑ WEEK NIGHT ❑ WEEKEND

Thank you!

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❑A ❑B ❑C ❑D ❑E